Title
Exploring Motivations and Expectations of Churches in Public Health Partnerships

Author
Allen, Monica Delores

Publication Date
2014

Peer reviewed|Thesis/dissertation

Exploring Motivations and Expectations of Churches in Public Health Partnerships

By

Monica Delores Allen

A dissertation submitted in partial satisfaction of the requirements for the degree of

Doctor of Public Health

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor Joan R. Bloom, Chair

Professor Ann C. Keller

Professor Cheri A. Pies

Professor Lonnie R. Snowden

Fall 2014

Abstract

Exploring Motivations and Expectations of Churches in Public Health Partnerships

by

Monica Delores Allen

Doctor of Public Heath

University of California Berkeley

Professor Joan R. Bloom, Chair

Partnerships between public health and faith communities have been identified as effective avenues to promote health behaviors, owing to the role of churches in the community. As the focus on resolving public health issues using the sociological model increases, the role of the church in communities, particularly communities of color, grows in importance. With the increasing attention and resources devoted to faith/public health partnerships, it is important to obtain evidence on these collaborations, particularly from the perspective of the churches, and to plan for the next generation of programs. The purpose of this study is to collect information on the involvement of churches in health promotion activities, to look specifically at why some churches choose to collaborate.

The church is an acknowledged means to implement health programs in the African-American community, and Black pastors have traditionally been leaders of their congregations and in the community at large. This study looks at faith/public health collaborations from the view of the Black pastor, to gain more insight into the faith community's partnerships with public health organizations.

Pastors of Black churches in the San Francisco Bay area were recruited for the study, which consisted of individual semi-structured interviews, conducted using an interview guide. Churches involved in health promotion activities. Analysis identified the range of themes and domains that characterize each interview, and responses from each pastor were compared, identifying similar and dissimilar themes. Observations of churches' worship services were also conducted.

Pastors from 20 churches participated in the study. The churches represented seven denominations, ranged in size from 50 members to 5,000, and were located in four Bay Area counties. Analysis indicates that pastors believe the church is important in reducing health disparities in the African-American community, and value public health organizations as resources and partners. Pastors offered insight into the reasons for churches to partner with public health organizations, prohibiting factors to such partnerships, and their views on elements of a successful partnership.

Additional findings indicated that pastors feel strongly that the church plays a primary role in their communities, and that this role extends to health. Pastors also communicated two main reasons for entering partnerships to promote heath; a responsibility to work to increase the health of their congregations and communities, and the need for resources to do so. They see obtaining these resources as a satisfactory partnership outcome.

Examining collaborations from the perspective of pastors of African-American churches offers an understanding of partnership formation, and elucidates barriers and facilitators. This study can make a contribution to the dialogue about the role of churches in health interventions and help set the foundation for developing a framework within which to think about and develop faith-based health programs in the Black community. Pastors need to be included in discussions on health disparities, what is needed to impact health in their communities and how to expand the role of churches as partners.

Acknowledgments

Dr**.** Joan Bloom for changing my life and sticking with me every step of the way

Dr. Ann Keller, Dr. Cheri Pies and Dr. Lonnie Snowden for your patience and your persistent help in making this an exponentially better product

Dr. Rena Pasick and Dr. Carol Somkin for opportunities large and small

Dr. Nancy Burke for the last minute conversation that turned it all around

Dr. Galen Joseph for gentle and consistent guidance, instruction and support

Dr. Arnab Mukherjea for advice, support, friendship and time spent in the trenches

Jen Rennell, Vicky Gomez, Rachel Donaldson, Mary Wright, Erica Jacobs and Yvonne Larrier for never asking if I was done yet, but breathing a sigh of relief and dancing for joy when I was

Dolores Ringor, my guidepost for things too numerous to mention

Monique Allen, Michelle Allen, W. Jonathan Allen, Miriam Allen Thompson and Roy Thompson; the world's best (and cutest) fan club

Weldon and Margot Allen who deserve only credit and no blame for who I have turned out to be; I appreciate and adore you

The pastors who gave generously of their time and insights, supported me wholeheartedly, and are interested in what I have to say

Dedication

To the younger members of my family; you are our future and our heart.

Hannah Bedeau Allen; when you were a baby, we called you Hannah B.; a great name, as is turns out, because you are beautiful, brilliant and so very brave. Always remember how much we love you and use that love as a springboard to realizing your incredible potential.

Quiana Oats and Leroy Hodnett; loving you has made me a better person, and I will always be grateful to you for sharing your lives with me.

In memory of Elisabeth Bedeau; whose unwavering support of me in this process sustains me still, and who I miss all the time.

Miriam Allen Thompson; you are the strongest and most courageous person I know. Your faith and determination inspire me every day, and I will be forever in your debt for the sacrifices you made so that I could realize this achievement.

Table of Contents

CHAPTER I: Introduction and Overview

Background

Public health has always been a collaborative affair. The earliest forms of public health practice, including caring for the sick, sanitation to prevent disease, and attempts to protect population fro1m epidemics were undertaken by different segments of society. Religious institutions, police departments, and local boards of prominent citizens all assisted local health departments in the promotion and protection of the health of the public; (Scutchfield and Keck 2003; Tulchinsky and Varavikova 2009; Turncock 2012). In contemporary times, city and county Local Health Departments (LDHs) provide services from education and health promotion to primary care and the management of chronic disease, with the help of an array of partners including state health agencies, academic institutions, nonprofit and voluntary organizations and the faith community. Recent decades have seen an increase in the public health practice of engaging communities to work cooperatively on their own behalf (Turncock 2012).

Collaborations between the faith community and public health programs, departments and organizations, specifically, have become increasingly important for multiple reasons. One major factor that encourages collaboration with churches is the number of people that can be reached; there is a high level of church affiliation among US adults. (McCullough, Hoyt et al. 2000; Powell, Shahabi et al. 2003; Sternberg, Munschauer et al. 2007). Faith-based partnerships are opportunities to expand health initiatives using the strength of a person's spiritual orientation (Kotecki 2002), and the positive influence of social support (Eng, Hatch et al. 1985). Church-based programs can reach entire congregations, whose members have other community affiliations, thus facilitating the diffusion of information through populations (Lasater, Wells et al. 1986; Sternberg, Munschauer et al. 2007). Duan and colleagues (Duan, Fox et al. 2000) identified partnerships between public health and faith communities as effective avenues to promote health behaviors because of the role of the church in the community. Miller (1987) speaks to the unique influence churches have in the communities they serve.

The involvement of churches in health-related activities has a long and well-documented history in the United States (DeHaven, Hunter et al. 2004). There is a strong history of churches independently and collaboratively hosting health education and screening programs, along with involvement in primary health care (Levin 1984). Multiple studies have shown active statewide, denomination-wide and individual church health ministries, with activities and attention to areas ranging from blood pressure testing to activities impacting mental health to birth outcomes. In some areas, local churches have formed coalitions to address issues in their communities (Sutherland, Hale et al. 1995). The federal government has formally recognized the contributions of churches, supporting them first with the Charitable Choice Expansion Act of 1996, and the establishment of the White House Office of Faith-Based and Community Initiatives in 2001 (Cnaan and Boddie 2002). Churches are being seen as a significant way to reach traditionally underserved populations, including diverse ethnic and low income groups, and are potentially

valuable for reducing health disparities (Sternberg, Munschauer et al. 2007; Campbell, Hudson et al. 2007).

Despite overall improvements in health for all populations, the disparities for ethnic and racial minorities remained the same or even increased in some areas, particularly for African Americans (Waston, Bisesi et al. 2003; Sternberg, Munschauer et al. 2007). The church has long played an integral role in helping to provide access to community health resources (Rodriguez, Bowie et al. 2009) and can strengthen and encourage behavior change on the part of its membership and the community at large (Eng, Hatch et al. 1985). Given the magnitude of health disparities within the black community, as many partners as possible must be engaged to gain the best improvements in health. Considering the strong role of the African-American church, it would stand to reason that it can provide an effective and culturally appropriate entry portal into the African-American community (Taylor, Thornton et al. 1987; Sutherland, Hale et al. 1995).

Since its inception, the church has had an impact upon virtually every aspect of African-American life. The importance and influence of the church on the social, economic, and political development of black communities has been well documented (Taylor, Thornton et al. 1987; Lincoln and Mamiya 1990; Pinn 2002). One of the ways this influence is reflected is in the racial differences in religious involvement; generally, blacks express a higher degree of religiosity than other races, specifically, they report higher levels of church attendance, praying and confidence in the clergy (Taylor, Thornton et al. 1987; Sahgal and Smith 2008). The significance of the church may be attributed fundamentally to the fact that it is one of the few institutions within the Black community that is primarily built, financed, and controlled by Blacks; putting it in the position of being exceptionally responsive to the needs of the community it supports (Taylor, Thornton et al. 1987). Frequently, churches serve as the largest organized expression of black communities, which enables them to set and articulate the group's interests and goals (Brown and Brown 2003).

Statement of the Issue

Considering the attention and resources being devoted to the subject of church and public health collaborations, and the potential for impact on health disparities, it is important to look closely at these partnerships, obtain evidence of the efficacy of existing efforts, and to plan for the next generation of programs. This study was initiated partially as a result of the researcher's personal interaction with both the Christian church and the field of public health. While there are many similarities between these entities that make collaborations valuable, there are also significant differences, particularly in the African-American church, that warranted further exploration. The church's attitude toward sexuality, for example, is a primary point of tension. The public health and faith community may have disagreements over the appropriate content of sexuality and sexually transmitted disease (STD) education programs (e.g., abstinence-only vs. comprehensive sex education). HIV/AIDS is another area that the church has had trouble addressing (Nunn, Cornwall et al. 2012). Additionally, individuals raised in faith traditions frequently have had very different perspectives about health and disease from those whose beliefs come from a medical and scientific viewpoint. One of the topics to be explored in this study is whether the two groups have different values and goals when it comes to defining the successful outcome of a program. The disparity in viewpoints can make it difficult to build and sustain a productive

partnership. Health interventions do benefit from both faith-based and secular support and cooperation between these two groups is an important success factor (Sternberg, Munschauer et al. 2007).

The literature on the subject of faith and public health partnerships is that it is overwhelmingly offered from the public health viewpoint. There is extensive documentation of the reasons that this type of partnership is beneficial to the field, but little discussion of how, why, or even if, these partnerships are valuable to the faith community. This research examines faith/public health partnership from the faith perspective, specifically from the view of the African-American pastor, to gain more insight into the faith community's motivations for entering or not entering partnerships with public health organizations. Black pastors have traditionally been the leaders not just of their congregations, but in the black community at large. As such, they are ideally and uniquely suited to convey health-related information, to support participation in health promotion programs, and, in the broader sense, to effect health-related behavioral change to this community (Levin 1986). Theirs is an important voice in the discussion of the best ways to structure effective faith and public health partnerships within the African-American community. The goal of this study is engage pastors in this discussion about and add their viewpoint to the existing literature.

Study Purpose

The primary purpose of this research is to explore pastors' perspectives regarding collaborations of African-American churches in health promotion activities. The literature consistently shows that a strong collaboration is necessary for successful programs of this type (Eng, Hatch et al. 1985; Lasater, Becker et al. 1997; DeHaven, Hunter et al. 2004). By examining some of the issues and motivations for collaboration from the perspective of churches and their leaders, may result in a better understanding of how these partnerships function.

Study Aims

This exploratory study aims to:

(1) Discover what motivates churches to collaborate with public health organizations in health promotion programs, from the perspective of the pastor, and to clarify some of the dynamics of these partnerships.

(2) Elucidate what pastors of churches hope to gain from these partnerships, including their definition of success.

(3) Identify specific characteristics of churches that form partnerships with public health organizations to provide health programs.

The characteristics of African-American churches most likely to be involved in collaborations can guide public health professionals in identifying those churches most likely to collaborate and be supportive of efforts to increase health promotion and disease prevention efforts (Thomas, Quinn et al. 1994).

Research Questions

1. What do pastors of African American churches see as the church's role in community health?
2. Why do some churches choose to partner with public health organizations?
3. What do pastors of African American churches hope to gain as a result of their involvement in health program partnerships?

Significance of the Study

By examining some of the issues and motivations for collaboration from the perspective of African-American churches, this seeks study to advance an understanding of why these partnerships form, and to elucidate barriers and facilitators to such partnerships from the church perspective. The goal is to take one step toward defining what a successful faith/public health partnership looks like, and to contribute to the dialogue and body of research about the impact of churches on community health interventions. This can set the foundation for developing a framework within which to think about, develop, and evaluate faith-based health programs.

Organization of the Study

Chapter I presents the background of the problem under study, its purpose, and specific aims to be addressed.
Chapter II is a review of the relevant literature. It addresses the following topics: collaboration, faith and public health partnerships, the role of the church in the African-American community, the role of the black pastor in the African-American community, and the theoretical foundations of the study.
Chapter III presents the methodology used in the study, including the research aims, the research design, human subjects' protections, the sampling procedures, data collection methods, and a description of the study sample.
Chapter IV presents the qualitative findings of the study from the semi-structured interviews with pastors of African-American churches in the Bay Area.
Chapter V presents discussion, interpretation, implication of the findings, study limitations, significance, and future directions.

CHAPTER II: Review of the Literature

Partnership and Collaboration

The literature on collaboration is replete with discussions of the need for organizations to work together to meet the health needs of populations. Some identify the increasing complexity of issues as drivers of collaboration (Logsdon 1991; White and Wehlage 1995; Meister and de Zapien 2005; Carnwell and Carson 2009), others cite the expectations of funders (Israel, Schulz et al. 1998; Weiss, Anderson et al. 2002) and institutions such the Institute of Medicine (Zahner 2005; Barnes and Curtis 2009). The terms partnership and collaboration are often used interchangeably, but in more specific literature on the topic 'collaborate' is used as a verb associated with a partnership. Carnwell and Carson (2009) view the word 'partnership' as a noun, as partnership; 'something that is', while collaboration is seen as something that one does. One of the earliest and most commonly cited authors on the subject characterizes collaboration as "a process of joint decision-making among key stakeholders" and "a process through which parties who see different aspects of a problem can explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible" (Gray 1989). Another definition of collaboration is "a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals" (Mattessich and Monsey 1992). The definition of partnership is broader; "one associated with another especially in an action" (Merriam-Webster, 2013), and is used to encompass all of the types of joining of forces (e.g., consortia, coalitions, and alliances) that bring people and organizations together (Weiss, Anderson et al. 2002). The common denominator in any collaboration or partnership is the desire to enhance the capacity of the both sides to achieve a goal, though efforts at collaboration can be arrayed across a continuum of low to high (Gajda 2004). Moreover, collaborations are not easy to establish. For example, the antecedents to collaboration include factors such as sufficient educational preparation, understanding of each other's roles, sharing of vision and outcomes and willingness to participate in formal, structured, joint working; the willingness of one party to work jointly with another (Carnwell and Carson 2009). In this research, the term partnership is used, as it is not clear that the relationships involved rise to the level of collaboration.

By bringing different perspectives together, partners have the potential to identify new and improved approaches to issues, and to support each other by capitalizing on their complementary strengths and capabilities (Lasker, Weiss et al. 2001). Examples of collaborative partnerships are many; joint ventures between the nonprofit business worlds support community engagement (Austin 2000), deal with increasing resource constraints (Bazzoli, Stein et al. 1997; Lasker, Weiss et al. 2001) and address complex problems such as violence, unemployment, and chronic disease management (Israel, Schulz et al. 1998; Gajda 2004; Meister and de Zapien 2005). Many organizations are finding it helpful, and often necessary, to find partners with whom to work toward mutually beneficial ends. (Gray and Wood 1991).

Partnering can strengthen a community's capacity to improve health by engaging people and organizations not traditionally involved in population-based health (Lasker, Weiss et al. 2001). This allows each entity to bring its unique resources to the table, and enables organizations to become involved in new and broader issues without having the sole responsibility for managing

or developing them. Partnerships can minimize duplication of effort and services, and are able to mobilize more talents, resources and approaches to influence an issue than any single organization could achieve alone (Butterfoss, Goodman et al. 1993).

Though the potential benefits of partnerships are many, it is important to recognize the challenges as well. Partnering is often time consuming, resource intensive and frustrating (Lasker, Weiss et al. 2001). Health partnerships can be particularly difficult because the collaborative process requires relationships, procedures, and structures that are different from the way people and organizations and accustomed to functioning (Mitchell and Shortell 2000). Often partners are skeptical of each others' motivations, and are not used to sharing resources or power. This is particularly true when the partners are of different professional cultures (Lasker, Weiss et al. 2001), such as the partnerships between the business and non-profit sectors, which are increasingly important due to the need for non-profits to seek different sources of funding (Austin 2000). Many partnerships do not get past the planning phase, and of those that do, many are not able to implement their plans successfully (Kreuter, Leazin et al. 2000). In recent years growing resource constraints have increased the need for, and willingness of, organizations to collaborate (Bazzoli, Stein et al. 1997), leading to increasing numbers of public-private partnerships forming across the continuum of health delivery. The current study is concerned with determining how churches look at these partnership relationships, what motivates them to become involved, how they view the concept of partnership, and what their expected outcomes of these relationships are.

Faith-based Organizations

The definitions of a "Faith-Based Organization" are many and varied. Vidal (2001) delineates three types of faith-based organizations: (1) congregations; (2) national networks, which include the social service arms of denominations (e.g. Catholic Charities and Lutheran Social Services) and networks of related organizations such as the Young Men's Christian Association (YMCA) and Young Women's Christian Association (YWCA); and (3) freestanding religious organizations, which are incorporated separately from congregations and national networks. The White House Faith-Based Initiative defines faith-based grassroots groups as local congregations offering literally scores of social services to their needy neighbors; small nonprofit organizations (both religious and secular) created to provide one program or multiple services; and neighborhood groups that spring up to respond to a crisis or to lead community renewal (House 2001). Others maintain that a faith based organization (FBO) must be connected with an organized faith community, be based on a specific religious ideology, and draw staff and leadership from a particular religious group (Scott 2003). These definitions refer primarily to organizations that are engaged in social services activities, not health-related ones. This research is concerned with health promotion activities at the church congregation level.

Role of Churches in Communities

For many years FBOs have played major roles in society, delivering a variety of services to the public, including food, clothing, housing, and programs to address domestic violence and employment. One of the most important roles of churches is the provision of social support networks, which is cited as one of the reasons for the positive impact of religion on health (Oman and Thoresen 2005). Churches can also serve as agents of social change, as in the African

American community during the civil rights movement, and have a played a vital role in the development of communities. They serve an important role in the underserved populations; a study by Bloom and colleagues (2013) found Spanish speaking Latinas were significantly less than White women to belong to social groups such as support or service groups, but more likely to regular, frequent church attendees. Churches are specifically positioned to fulfill these various needs based on principles that most espouse, including the intrinsic worth of each person, the community of people joined as one body, and the basic tenant that everyone deserves respect (Rausch 1998). They are also seen as valuable to the community in that they involve people across the lifespan, as opposed to touching people at a specific point in their lives, as do schools and most businesses. Religion can help to promote a values base that often leads to more responsible decision-making (Elkin and Roehlkepartain 1992).

Churches in Community Health Interventions

A centuries old relationship exists between religion and health, and the relationship has had a major impact on the contemporary approaches to health and healing. In many cultures priests and/or priestesses acted as healers, and many religions espoused a duty to the poor and sick, resulting in spiritual institutions becoming involved in health care (Sutherland, Hale et al. 1995; Streiner, MacPherson et al. 2011). Health and wellness are still common themes in the practice of many religions, with some faiths specifically prescribing good health habits; for example, Seventh-day Adventist and Mormon faiths, which prohibit the use of alcohol, tobacco and caffeine. Most religions teach members to respect and care for their bodies (George, Ellison et al. 2002). Many local churches, individually and collectively, and entire denominations have recognized this relationship and have implemented health ministries for their members and the larger surrounding communities (Sutherland, Hale et al. 1995).

The advantages of locating health interventions in faith-based settings in terms of community access and legitimacy are generally acknowledged within health education practice. Miller (1987) noted that since the church has historically been associated with health and healing, it is an ideal setting for health programs to take place. He also argued that religious institutions have a unique influence on the communities they serve. Studies of faith-based health programs have shown significant increases in adherence to healthy behaviors and increased nutrition (Campbell 1999).

Faith and Public Health Partnerships

As organized groups that touch the lives of a large percentage of people in their communities, churches have been identified as a potentially major force in bringing health messages to communities, particularly specific ethnic groups, vulnerable populations, and the underserved (Simpson and King 1999; Markens, Fox et al. 2002). The mission of public health combined with the ministry of the faith community can align the strengths of both for a successful relationship to improve the lives of the community (Davis-Carroll 2005). Churches often occupy pivotal roles in their communities with respect to economic, educational, civic, political, and social welfare concerns, which provided them with significant community legitimacy. This legitimacy is enhanced by the organizational structures and roles that can facilitate the incorporation of relevant health programs within church and community settings. This placement in the community provides a solid foundation for public health organizations to develop new collaborative arrangements with an important organization and institution, and to work toward

expanding the roles of churches and clergy with respect to community health (Chatters, Levine et al. 1998). There is also a growing literature that suggests that both involvement in a religious community and personal commitment to religious beliefs and practices are positively associated with health outcomes (Oman and Thoresen 2005). Faith-based health promotion programs and partnerships between public health agencies, academic researchers, voluntary health organizations, and faith-based institutions are effectively creating new portals for the infusion of needed health information and culturally appropriate interventions intended to eliminate health disparities among African Americans (Airhihenbuwa and Liburd 2006).

One valuable resource churches bring to partnerships is their ability to provide sustained social support in implementing and maintaining healthy behaviors. Their multidisciplinary membership enables them to communicate healthy messages to congregation members and hard-to-reach family members, and have expertise in mobilizing volunteers in implementing and supporting programs (Davis-Carroll 2005). Black churches, in particular have served in this role for their members; the comprehensive roles and functions of churches in Black communities make them second only to the family as an important social institution (Taylor and Chatters 1988). This social support is increasingly seen as having a positive impact on health (Ellison and George 1994).

Collaborative partnerships with faith communities do have their share of challenges. Obstacles often arise from differences between religion and science. People raised in spiritual traditions may have different perspectives about health and disease than those who come from a medical or scientific viewpoint (Sternberg, Munschauer III et al. 2006). Even with a common concern such as the health of communities, opinions differ in the framework of public health interventions. For example, disagreements over the appropriate content of sexuality and sexually transmitted disease (STD) education programs (e.g., abstinence-only vs. comprehensive sex education programs), in which the health professional and the faith-based community clearly advocate different values and goals, are quite possible (Chatters, Levine et al. 1998).

Faith and public health partnerships often fail to fully account for the particular features, characteristics, and dynamics operating within the church and broader community settings. (Chatters, Levine et al. 1998). These often involve issues of territorial encroachment, disputes concerning the appropriate roles of clergy versus health professionals, and authority to define particular behaviors as illness or as moral limitations. In addition, for religious institutions in minority communities (e.g., Black churches), resistance to public health interventions may reflect long-standing mistrust of formal institutions, prior patterns of underutilization of health services as well as being underserved, and discrimination and prejudice on the part of the health and medical professions in dealing with minority communities (Chatters, Levine et al. 1998).

Despite these difficulties, many communities are seeing the formation of partnerships between local congregations and public health organizations. In this era of complex social conditions and declining resources, collaboration is becoming a more important part of public health programs. By collaborating, public health and churches can maximize their existing resources and generate new ones. This research seeks to better understand, from the perspective of pastors, why some churches choose to collaborate with public health organizations specifically, and what they hope to maximize or gain from the partnership. The general consensus is that programs offered in

conjunction with churches have great potential for increasing knowledge of disease and improving health promoting behavior (Lasater, Becker et al. 1997; DeHaven, Hunter et al. 2004; Campbell, Hudson et al. 2006), and this research aims to determine if these outcomes align with the expectations of church leaders.

Health Disparities in the African American Community

There is much discussion about the term "African American' and Black. The terms are frequently used interchangeably, though there are those that feel the term African American incomplete, as it does not encompass populations of Caribbean and Latin American heritage. The two will be used interchangeably in this research, and will refer to the population and the institution, as in 'African American community,' 'Black people,' and the 'Black church.'

Disparities in the morbidity and mortality of African Americans as compared to other ethnic populations are widely documented. In 1985 the release of the Heckler report brought the fact that the health status of African Americans was significantly worse than that of Whites to the attention of the United States (Mays, Cochran et al. 2007). The following year, publication of the Secretary's Task Force Report on Black and Minority Health exposed the large and long-standing differences in health status among African Americans, and initiated a national agenda to study health disparities and take them on (Airhihenbuwa and Liburd 2006). These efforts include the establishment of the Office of Minority Health, and other major initiatives in this area, particularly in the last few years. National Institutes of Health and Centers for Disease Control offer significant support of research to better understand racial disparities in health outcomes. Healthy People 2010 and 2020 included the elimination of health disparities part of their mission and goals (National Institutes of Health ; CDC Health Disparities & Inequalities Report 2013; Healthy People 2020 framework 2014).

In spite of these efforts, the health gap between White and non-White Americans has continued, and in some cases, has worsened in recent years. Death rates from coronary heart disease were comparable for blacks and whites in 1950, but by 2000, blacks had a death rate that was 30 percent higher than that for whites. Blacks moved from having a lower cancer death rate than Whites in 1950 to having a rate that was 30 percent higher in 2000 (Williams and Jackson 2005). Cancer death rates for Whites have been relatively stable over time, with the mortality rate in 2000 being almost identical to the rate in 1950. In contrast, cancer mortality for Blacks has been increasing, with the rate in 2000 being 40 percent higher than in 1950. Over time, lung and ovarian cancer death rates increased for both racial groups, while mortality from colorectal, breast, and prostate cancer markedly increased for Blacks but was stable or declined for Whites (Williams and Jackson 2005). Currently, the rate of diabetes is three time higher in Blacks than Whites; heart disease is more than 40 percent higher, prostate cancer rates among Black are more than double those of Whites; HIV/AIDS rates are seven times higher in Blacks than Whites; even though Black women are diagnosed with breast cancer at lower rates then White women, their death rates are higher; and infant mortality in the Black community is twice that of the White community. This all adds up to a marked disparity in life expectancy; Black men have an average life expectancy of 68 years, and Black women 75; compared to Whites, with 75 and 80 years expectancy, respectively (Livingston 2004).

To better understand the root causes of these health disparities, it is important to study the environment in which these conditions exist. Socioeconomic status (SES) is a strong predictor of variations in health, whether measured by income, education, or occupation. Americans with low SES have levels of illness in their thirties and forties that do not appear in higher SES groups until thirty years later (Williams and Jackson 2005). All of the indicators of SES are strongly patterned by race, to the extent that racial differences in SES contribute to racial differences in health (Williams and Jackson 2005). This extends to multiple measures of SES, including education, income, and occupation (Fernandes-Taylor and Bloom 2010), and there is disproportionate representation of people of color in the lower socioeconomic level (Smedley, Stith et al. 2003).

Some scholars argue (Williams and Jackson 2005) that the presence of racial differences in health after individual differences in SES are accounted for may be explained by the contribution of residential segregation and neighborhood quality to racial disparities in health. Middle-class Blacks live in poorer areas than Whites of comparable economic level, and poor Whites live in much better neighborhoods than poor Blacks. Other racial minority groups are less segregated than Backs; residential segregation is inversely related to income for Latinos and Asians, yet segregation of African Americans is high at all levels of income (Williams and Jackson 2005). Racial differences in SES contribute to reduced levels of health insurance coverage for African Americans, and limited access to medical care plays a role in racial differences in disease. In addition the racial gap in unemployment, median income, and poverty remains large and fairly stable (Williams and Jackson 2005). Excess psychosocial stress may also be another link between race and health status. Chronic exposure to stress impacts a variety of health conditions, and people of low social status, including Blacks, report higher levels of stress. Blacks also experience higher levels of strain due to many stressors including discrimination and racism, even among those that are of higher low income (Williams and Jackson 2005; Braithwaite, Taylor et al. 2009).

In order to resolve the disparities in African American health and improve outcomes, it is essential to make changes across multiple systems. Economic, social and political shortcomings must all be addressed and in order to achieve any success in this community it is necessary to build on the existing strengths, one of which is its strong faith orientation (Airhihenbuwa and Liburd 2006).

The Role of the Church in the African American Community

In spite of historical experiences of hostile social, political, and economic circumstances, African Americans have a rich heritage of adapting and surviving, and much of this resilience is attributed to spirituality and the action of the church (Mays, Cochran et al. 2007). Both historically and in contemporary society, the church has had an impact upon virtually every aspect of African American life, and a strong influence on the development of black communities. Historically, the mission of the Black church in America has extended well beyond the traditional functions of worship and spiritual growth. Many Black churches also contribute to the social, economic, and political welfare of their congregants, as well as the community at large. The church has filled many roles: community center; social welfare agency; as well as the protector of the norms, values, and ethos of the Black experience (Taylor, Thornton et al. 1987; Campbell, Hudson et al. 2007).

Research on racial differences in religious involvement reveals the importance of both religion and the church as an institution in the lives of Black Americans. In general, Blacks express the highest degree of religiosity; 85 percent versus 56 percent of American Whites according to Gallup polling (Newport 2006), and 79 percent compacted to 56 percent of all U.S. adults in a Pew Forum survey (Sahgal and Smith 2008). The African American population is unique in that those with higher levels of income and education report greater religious involvement than their non-Black peers (Taylor, Thornton et al. 1987). In general, Americans become less likely to say religion is very important in their lives as their level of education and income increase (Newport 2006). Because of its historical and trusted role, and the level of engagement of this population, African American churches are considered promising partners to engage in the conduct of efforts to decrease health disparities in this community.

Health promotion programs within in the Black Church are increasing in the field of public health. Organized programs for prevention based in or affiliated with the black church have operated throughout the country for many years, addressing such issues as HIV/AIDS, cardiovascular risks, fruit and vegetable consumption, and cancer screening (Campbell 1999; Markens, Fox et al. 2002; Braithwaite, Taylor et al. 2009). Many churches serving African American communities believe health to be a part of their mission (Sternberg, Munschauer et al. 2007). Churches are often the largest organized expression of Black communities, which allows them to set goals and to articulate the group's interests (Brown and Brown 2003). The church's unique in its position within the community it serves, and best able to be responsive to the needs of the community members; as such it can provide an effective and culturally appropriate gateway into the African American community (Sutherland, Hale et al. 1995).

Role of the Black Pastor

As the head of the Black church, the Black pastor has an important leadership role in the Black community at large, and frequently works for improvement of the general status of Black people. Where the church has filled the needs of African Americans, the pastor has directed these efforts, and, by example, has facilitated the church's further involvement in developing and filling other roles to serve the Black community (Levin 1986). Community-wide roles occupied by the Black pastor range from cultural leader to social activist, political leader, community organizer and agent of economic, and social change.

The position of the pastor within the Black church is even more elevated; churchgoing African Americans members express a high level of confidence in their pastors; over half of churchgoing Blacks agree that in a crisis situation, they might turn to the Black preacher for advice (Levin 1986; Taylor, Thornton et al. 1987). Part of the reason for the importance of the Black pastor is the perception that he or she is called by God to be a minister. This concept of calling to a divine mission is as old as the Black church, and is particularly useful to the promotion of health; their words, healing touch and sermons on health are valued by their congregants (Meyers 1994; Hampton, Gullotta et al. 2010). As leader of the preeminent institution in the Black community, the Black pastor is especially prepared to respond to and take the lead in meeting the critical needs of his or her constituents (Levin 1986); as they are seen as being anointed by God, their word is highly trusted by their followers (Hampton, Gullotta et al. 2010).

By virtue of their "divine" authority and their central place in the community, Black pastors are ideally positioned to communicate health-related information, and when health education and other preventive medicine activities are located within Black churches, the enthusiastic participation of pastors is critical to their success. Many such programs have proven effective in the past, and with the current emphasis on health promotion as a means of improving the health of populations, "promoter of health" should be a role that pastors continue playing. By endorsing the use of their churches as health promotion sites and by encouraging their congregants to live right and maintain their bodies as "temples of God," pastors are well positioned to help achieve many health promotion objectives (Levin 1986). This research focuses on the pastors of Black churches in their role as leaders in the Black community. One area of focus is their attitudes toward partnerships between health promotion organizations and the faith community.

Theoretical Conceptualization

This study was guided by a conceptual framework (see Figure 1) that takes an ecological approach to the role of Black pastors in health promotion by acknowledging the place of the church in the Black community. In order to fully capture this phenomenon, the framework also draws from organizational and sociological theories, including:

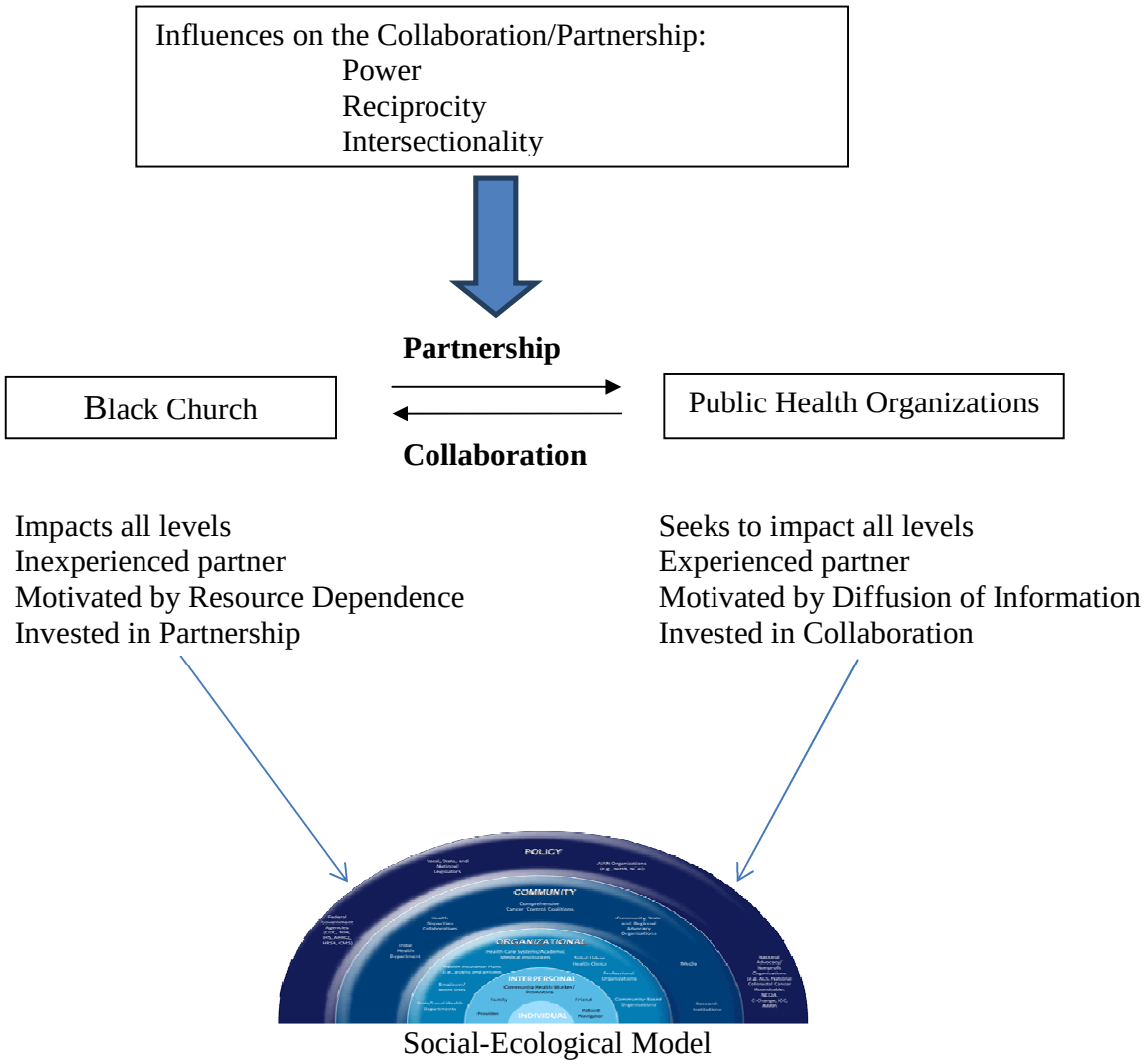
1) Resource Dependence (Pfeffer and Salancik, 1978)
2) Reciprocity (Kolm, 1994)
3) Intersectionality (McCall, 2005)
4) Diffusion of Innovations (Valente and Davis, 1999)

Because the role of churches in communities is so strongly social; they provide not only support but also service programs, and in some cases leading to social action; it has not been customary to think about applying organization theory to churches' activities. Because so much religious activity is also highly organized at community, denominational and national levels, it has become more acceptable to apply organizational theory to the study of churches (DiMaggio 1998). By viewing churches through an organizational lens, it will be possible to more fully examine motivation, expectations and community orientation. All churches have members who belong to other organizations, and work in a variety of settings, increasing their reach into communities. This reach can allow churches to be useful in increasing the diffusion of health education into homes and throughout communities (Lasater, Becker et al. 1997), which be of great benefit public to health organizations in health promotion partnerships. A framework that includes organization and diffusion of innovations theories guides the development of this study and offers a possible explanation of how the two primary systems, the Black Church and public health organizations, view their relationship with each other, and for the differing motivations each has for entering a partnership. There is also consideration given to the factors that influence the perspective that the Church brings to any relationship with a non-faith partner.

The social-ecological model is rooted in the work of Urie Bronfenbrenner (1994), who posited that in order to be fully understood, human development must be considered within the entire ecological system in which growth occurs. This system is composed of five socially organized subsystems that are identified as Intrapersonal (Individual), Interpersonal, Institutional, Community and Public Policy (McLeroy, Bibeau et al. 1988). The model has been increasingly used to address the

complex health conditions facing contemporary communities, and forms the foundation of this theoretical framework. The framework proposes that the Black Church, because of its position in the African-American community, is able to influence all levels of the ecological system, and that public health organizations, seeking to influence health behavior at all levels, desire to collaborate with churches to maximize their own impact.

Figure 1



Social-Ecological Model

Resource Dependence

The resource dependence perspective is based on the premise that in order to survive, organizations must be able to acquire and maintain resources. Pfeffer and Salancik (1998) hypothesize that since no organization is completely self-contained, in other words, no organization is in complete control of everything it needs to operate, it must depend on other organizations to provide some of the resources it needs. In order to obtain these resources,

organizations must engage, or transact, with other organizations. These other organizations make up the environment in which the organization functions. This environment, or context (Pfeffer 1981), has a large impact on an organization's outcomes. Changes in its environment that impact an organization's ability to obtain resources require organizations to change accordingly, in order to survive. One of these changes is to establish interdependant relationships with others in order to obtain needed resources.

In order to function, health promotion programs need certain elements. They must have clients to serve; there must be equipment, space, specialized knowledge, and staff to assure that clients are able to access the program services. At the very least, there must be enough money to be able to obtain the needed elements. All of these elements are viewed as resources and many community organizations lack resources, or access to all of the needed resources, to be able to accomplish their objectives (Levine and White 1961). In order to obtain access to needed resources, organizations enter into relationships where they exchange resources with other organizations. This exchange of resources can create a dependent relationship between two organizations, or an interdependent relationship, depending on several factors. Jun and Armstrong (1997) identify division of labor and specialization as contributors to interdependence; Pfeffer and Salancik (1978) cite the nature of the relationship; competitive or symbiotic. Levine and White (1961) list three factors in the interdependence between organizations: (1) The ability of each organization to access needed resources outside of the relationship, (2) the objectives of the organizations and particular functions of the resources controlled by each, and (3) the degree to which consensus exists among the organizations.

One aspect of the resource dependence perspective relates to the concept of power. If the exchange of resources is unbalanced; that is, if one organization is in the position to provide more of the resources to the other, or if the exchange is more important to one organization than to the other, one organization is in a more powerful position (Pfeffer and Salancik 2003). Organizational success is defined as organizations maximizing their power (Pfeffer 1981), and characterizes the links among organizations as a set of power relations based on exchange of resources. An organization uses its power to obtain more resources, which helps it survive. This thinking can be applied to the concept of faith-based health promotion program collaborations. The resources exchanged, including the church's congregation as the primary client base, and an agency providing the staff with specialized knowledge, program curriculum and materials, can provide the basis for the negotiation of effective partnerships. One of the areas this study would like to shed light on is why churches choose to enter interdependent relationships with other organizations, and their view of this concept of power.

Intersectionality

Intersectionality is the study of "the relationships among multiple dimensions and modalities of social relationships and subject formations" (McCall 2005). The theory holds that biological, social and cultural categories such as gender, race, class, and other forms of identity interact on multiple and often concurrent levels, contributing to systematic injustice and social inequality.

Although intersectionality is based on feminist theory, it is also recently seen as a way to view health disparities (Weber and Fore 2007), particularly since it has always focused on gender, race, and class, positing that these systems coalesce to create inequality (Viruell-Fuentes,

Miranda et al. 2012). Instersectionality makes the argument that gender, race, ethnicity, sexuality, and class intersect in the lived experiences of people who occupy and negotiate different social locations in systems of power in the health care system and in the larger society (Yeon Choo and Marx Ferree 2010). The application of this theory suggests that a person or an organization does not bring just one perspective to bear when making decisions; everything that comprises them has an impact. Specifically, all of the history of oppression of and discrimination against African-Americans comes into play in the consideration of partnering with outside organizations and the framing of these relationships.

Reciprocity

Reciprocity is the concept of responding to an action with a similar one. Reciprocity figures prominently in cultural anthropology, evolutionary psychology, social psychology and in economic, social exchange, and rational choice theory, and is seen as a social norm, on the basis of social relations (Gouldner 1960; Kolm 2006). Because the Church is a relatively independent organization, and is able to obtain most of its resources from within its own community, it interacts less with other organizations (Levine and White 1961). The framework of this study puts forth the concept that the Black Church enters into relationships with public health organizations expecting reciprocity, and mutual benefits to their communities. This mutual exchange builds solidarity in society, and is beneficial not only to the parties directly involved, but to the community in general, enhancing trust and regard (Molm, Collett et al. 2007).

Diffusion of Innovations

Diffusion is the process by which abstract ideas and concepts, technical information, and actual practices are communicated through certain channels over time among the members of a social system. Everett Rogers is credited with popularizing the Diffusion of Innovations theory, which aims to explain how, why, and at what rate new ideas and technology spread through cultures (Rogers 2003). The basic premise of the theory, confirmed by empirical research, is that new ideas and practices spread through interpersonal contacts. Valente and Davis (1999) found that social contacts, social interaction, and interpersonal communication were the most important influences on the adoption of new behaviors at the individual level. At the organizational level, adoption is often based on the ability to make a change with large-scale historical consequences, or to change their environment (Wejnert 2002). This concept can be used to discuss the changes churches make to improve health within their congregations and communities.

An essential link in the promotion of public health is successful communication of important messages to enhance the wellness of populations and communities. As the field of public health is concerned with promotion and maintenance of the health of a community or population, disseminating effective messages regarding health education and health behavior is a critical component of most public health programs. In the area of public health, the outcomes of innovations can have significant impact on the wellness of communities and populations, and the field is responsible for a significant number of diffusion publications (Rogers 2003). The diffusion of innovations model serves as valuable method to enhance the spread of health messages within a community (Haider and Kreps 2004), and the church serves as an ideal system within which to use this model. The role of the Black Church in the African-American community extends beyond religious beliefs and practice and has the ability to influence the

quality of life for many African-Americans through the involvement of its members in numerous and varied secular activities (Rodriguez, Bowie et al. 2009).

The discussion of innovations concept, requires four specific elements; an idea, or practice that is considered new (innovation), means for messages to travel between individuals (communication channels), the period in which the innovation decision is made (time) and a structured system of interrelated units (social system) (Rogers 2003). In the case of public health, the units in the social system are the persons in the population to whom the messages are targeted. Given the importance of interpersonal contacts in diffusion, it is important to identify individuals who are more central to a community and thus perhaps more influential. The basic diffusion network model uses these individuals, or opinion leaders, to initiate the diffusion of a new idea or practice. Opinion leadership is the degree to which an individual is able to influence other individuals' attitudes or behavior. Opinion leaders play an important role in diffusion networks, and are often identified and utilized in diffusion programs. A change agent is an individual who attempts to influence individuals' decisions in a direction that is deemed desirable by those initiating the change (Rogers 2003). Opinion leaders and change agents can function as champions for the new practice and accelerate the diffusion process (Valente and Davis 1999); given their role in the church, pastors are ideally suited to serve in this capacity. If they are in agreement with the public health message and goals, pastors can be instrumental to public health organizations in the dissemination of health promotion messages.

Gaps in the Literature

There is extensive documentation of the reasons that the faith-public health partnership is beneficial to the field; including the influence of the church on the community (Miller 1987), their potential to serve as access points to underserved populations (Simpson and King 1999; Markens, Fox et al. 2002), and their ability to help bring legitimacy to health promotion efforts (Chatters, Levin et al. 1998). One major issue in the literature on the subject of faith and public health partnerships is that it is public health viewpoint is the main one that is represented. Thus, there is little discussion of how, why, or even if, these partnerships are valuable to the faith community, from their own point of view. Nor has the perspective of community partners on their experiences in the intervention process been well studied (Rodriguez, Bowie et al. 2009), and this research is an attempt to add to this body of knowledge.

Not enough research has been conducted to help understand the perspectives that pastors have on faith and public health partnerships. By virtue of their roles as leaders, pastors of Black churches command significant influence within communities and the church; however, little is known about how these roles are transferable to engagement in health promotion activities or their expectations for involvement. Without an understanding of these expectations, attempts to engage church leaders and their members in collaborations are likely to fail (Ammerman, Corbie-Smith et al. 2003). This study aims to add to the literature on the perspectives of pastors, specifically pastors of African American Christian churches, about their involvement in collaboration efforts to impact the health of communities.

CHAPTER III: Methods

Overview

The primary purpose of this research is to obtain the perspective of pastors of churches regarding partnerships to provide health promotion activities; specifically, it is to examine the factors that encourage churches to collaborate with public health organizations, and the churches' expectations for these partnerships. There is an extensive body of literature exploring the motivation of public health in the initiation of faith and public health partnerships, and of the benefits to the field of public health. The most commonly cited benefits are increased access to a wide range of populations (Campbell, Hudson, et al. 2006), the inherent social and support networks present in congregations (Peterson, Atwood et al. 2002) and the high regard for churches and church leaders in their communities (Chatters, Levin, et al. 1998). The latter benefit suggests that pastors are likely to be influential leaders in health promotion activities.

It has consistently been demonstrated that strong collaboration is necessary for successful programs (Eng, Hatch et al. 1985; Lasater, Becker et al. 1997; DeHaven, Hunter et al. 2004). In practice, however, churches are often reluctant to enter into collaboration with non-religious entities. Throughout the literature on the collaboration between churches and public health, there is little exploration of the perspective of the churches and their leaders. By entering into discussion with pastors and listening to their ideas about such partnerships, this study intends to bring some balance to the discussion of public health programs within and in conjunction with faith communities and to clarify some of the dynamics of these partnerships, from the viewpoint of the Black pastor.
This chapter includes a description of the process and procedures utilized in this study. The research design and questions, participant recruitment, and data collection, analysis, and interpretation will be discussed.

Research Aims and Questions

This exploratory study aims to:

1. Discover what motivates churches to collaborate with public health organizations in health promotion programs, from the perspective of the pastor, and to clarify some of the dynamics of these partnerships
2. Elucidate what pastors of churches hope to gain from these partnerships, including their definition of success
3. Identify specific characteristics of churches that form partnerships with public health oranizations to provide health programs

In order to achieve these aims, this exploratory study is guided by the following questions:

1. What do pastors of African American churches see as the church's role in community health?
2. What do pastors of African American churches hope to gain as a result of their involvement in health program partnerships?
3. Why do some churches choose to partner with public health organizations?

This is a qualitative study using primary data exclusively. Researchers use qualitative methods when they are hoping to gain a better understanding of the topic of interest. It implies a focus on the qualities of the subject matter that cannot be measured through quantitative methods, and often precedes a quantitative or survey methodology. This type of research attempts to answer questions related to how social experience is created, and achieves meaning (Denzin and Lincoln 2003). Qualitative data describe and capture someone's experience in their own words, to tell their story (Patton 2002). Marshall and Rossman (1999) identify traditional purposes for qualitative research as; 1) to explore or discover, 2) to explain or understand, and 3) to describe or develop. In this exploratory study, the nature of the research questions is such that the qualitative interviews provided the most effective method for answering them. By engaging in semi-structured interviews with pastors, the goal was to gain insight into what drives churches to enter public health partnerships (motivation), and what their expected outcomes are (expectations), from the perspective of the churches' leaders. These concepts are not easily measured through quantitative means, and the give and take of an interview allowed for deeper inquiry. Speaking directly with the pastors provided the opportunity to obtain more in-depth understanding of the topics of interest. Attending and observing services at the study churches offered another layer of information with which to compare and analyze the information obtained.

Data Collection

Interview Guide

The data in this study was collected using a specifically developed semi-structured interview guide. The Resource Dependence perspective informed the design of the guide. The Resource Dependence perspective is based on the premise that in order to survive, organizations must be able to acquire and maintain resources. Pfeffer and Salancik (1978) hypothesize that organizations must depend on other organizations to provide, at least, some needed resources. In order to obtain these resources, organizations must engage, or transact, with other organizations. This theory was used to guide the part of the discussion on partnerships, to determine if the pastors perceived public health organizations as avenues to acquire needed resources.

The initial interview guide focused primarily on 1) partnerships - identifying health-focused partnerships and the reasons for entering those partnerships, along with the expected outcomes and criteria for success; and 2) community - the term "community" is used very broadly, and can be used to mean everything from geographic to ethnic groups. This section of the guide focused on the ideas that pastors have about their definition of, and their churches' responsibilities to, the people that they serve, particularly their perceived responsibility to the community beyond their immediate congregation. This information was to contribute to developing the answer to the research question about role of churches in the health of their communities.

After the development of the initial interview guide, it was pilot tested to determine if there were flaws, limitations, or other weaknesses with the interview design. Given that a pilot test should be conducted with participants that have similar interests as those that will participate in the study (Turner 2010), the researcher tested the guide on three pastors of different denominations, obtaining their feedback on the subjects covered, relevance to them and wording of questions.

In June 2008, the interview guide (Appendix A) was submitted as part of the application to the Office for the Protection of Human Subjects (OPHS) at the University of California, Berkeley. The study protocol was granted exempt status later in the month, and the researcher initiated the first round of interviews.

Because qualitative studies explore broad contexts, they typically begin using open-ended questions, and become more focused as responses guide further exploration (Ulin, Robinson et al. 2005), and this occurred in this study. After eight interviews using this guide and reviewing the information data collected, it became apparent that it was necessary to make some revisions for the reasons discussed later in this chapter. The goal was to collect data that was more specific to the interview questions, to obtain more depth in to the interview questions, and to ask questions that were more open ended to encourage the pastors to be more genuinely forthcoming. After consulting with a qualitative research expert at the University of California, Berkeley School of Public Health, the researcher revised the interview guide, re-wording some questions and adding others to provide specific information on:
1) Spirituality/Health - a question on the links between spirituality and health, and church or religion's views on health. This helped provide information on what motivated churches to engage in health promotion programs. 2) Church's responsibility for health - this information contributed to developing the answer to the research question about role of churches in the health of their communities. 3) Expectations of partnership – by probing the pastors' thoughts about what a successful partnership looks like, it was able to gain a better understanding of what their expectations are for partnership outcomes.

Even though an interview guide was used in both rounds, it was only a framework for the conversation. Probing and follow up questions elucidated relevant data and concepts of this study; in addition, participants were encouraged to add information and observations they deemed relevant, but may not have been explicitly asked by the interview guide. In the second round each interview began with the question "How did you come to be in ministry?" in order to help put the pastors at ease, and get them in the mood to talk. The question "Is there anything else you think I should know about working with the African-American faith community?" was asked at the end of each interview to give pastors further opportunity to offer their input. Interviews lasted 15-65 minutes, and were audiorecorded and transcribed verbatim.

Consent

All study participants were provided with information about the study prior to their interview. Immediately before the interview started, they were reminded that their participation was voluntary, completely confidential, and that they were free to stop the interview at any time. Each pastor was requested to, and signed, a 'Consent to Participate in Research' that was approved by the UC Berkeley School of Public Health Committee for Protection of Human Subjects (CPHS). The consent form included information about confidentiality, that the interviews would be taped, and that there would not be an incentive to participate in this study. Pastors were offered a copy of the consent form for their own records.

The audio files of the interviews are kept on a password-protected computer, and all identifying information was removed from the transcripts, to maximize participants' privacy. Each participant is identified by a code, which is used on all audio and document files.

Observation

The researcher attended services at the majority of the churches in the study. By participating in the activities of worship, speaking to congregants, and listening to the sermons, more information about the denomination, beliefs and priorities of the pastors was obtained, and added more depth to the study.

Sampling and Participant Recruitment

This study targeted pastors of Christian, primarily African-American, congregations in the San Francisco Bay Area. The San Francisco Bay area encompasses major cities along with smaller urban, suburban, and rural areas. The area is known for its diversity, and is home to Oakland, one of the most diverse cities in the country, with an African-American population of 28% and Richmond, which is 27% African-American (American Fact Finder 2010). Churches from both of these cities are included in the study. The Bay Area is made up of nine counties, and pastors of churches in four Bay Area counties were interviewed for the study. A total of 21 pastors participated in the study, representing 20 churches. The pastors were recruited and interviewed in two rounds.

Round One

A convenience sampling strategy was used to recruit participants through a variety of methods, first seeking community coalitions and groups of pastors. The Alameda County Faith Advisory Council is an organized group of faith leaders, child advocates, and supporters of child welfare improvement in Alameda County. Membership is open, and the group meets monthly. Approximately 80% of the organizations involved in this group are churches with more than 45 congregations represented. The organizer allowed the researcher time on their agenda to speak to the assembled pastors, explain the study, and ask for their participation. After participation by the researcher in two of the group's meetings, four pastors volunteered through this process and were interviewed.

Another faith-connected program in the Bay Area is the UCSF Abundant Life Health Ministry Initiative (ALHMI). The ALHMI works with churches to reduce the burden of and inequities in cancer among African Americans by strengthening church health ministries. The ALHMI functions through the Faith Communities Committee, which meets monthly. Through the ALHMI Faith Communities Committee, one pastor was recruited to participate in this round of interviews. The researcher initially spoke in person to all the pastors recruited through community meetings, and provided them with a written description of the research, then communicated with them via phone or e-mail to set up a time to meet for the interview.

Two other pastors agreed to participate after they were contacted upon referral by a member of their church. In this case, each pastor was contacted initially by an e-mail, introducing the researcher, giving the name of the person who provided referral, and requesting an interview. A description of the research was attached to the e-mail. The interviews were then scheduled by phone, in one case through the church secretary. In this round the researcher interviewed a personal friend who is the senior pastor of a church. A total of eight pastors were interviewed in

Round One. All interviews were conducted in the pastor's church. One interview was lost, as the recording was not usable, so the first round of the study includes seven interviews.

Sample size in qualitative research is driven by the concept of saturation. Saturation is a term that is defined as data adequacy, meaning that data is collected until no new information is obtained (Morse 1995; Strauss and Corbin 1998). O'Reilly and Parker (2012) approach the concept differently, addressing multiple aspects of qualitative data, including not only the adequacy of the data but the appropriateness, and state that true saturation means that not only the breadth, but also the depth of the information sought has been achieved. They define the adequate sample size as one that sufficiently answers the research question.

In this study, the concept of saturation arose early. The pastors being interviewed in the first round had similar responses to the questions, which is the basic definition of saturation, but this left open whether the data was appropriate. After initial analysis, revisions were made to the data collection instrument (interview guide) as detailed earlier in this chapter, and another round of interviews was conducted, recruited as described below.

Round Two

In January, 2011 after revision of the interview guide as described below, the researcher began recruitment for a second round of interviews. In qualitative research sampling usually relies on smaller numbers with the aim of studying in depth and detail; there are no defined rules for sample size. The sample is selected purposefully as opposed to randomly, in order to provide rich data about a particular area of inquiry. Purposeful sampling seeks to recruit research participants according to criteria determined by the research purpose, but is also guided by what is learned as the data being collected. (Tuckett 2004). According to Patton (2002), the term purposeful sampling is derived from the selection of information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research. This is the logic as well as the power of purposeful sampling. This is compared to the concept of representative sampling in qualitative research, in which a sample is specifically selected to proportionally represent the characteristics of a given population. With purposeful sampling in a qualitative study, the representation is of specific groups. In this study, representation of multiple denominations, church sizes and Bay Area counties was sought.

The churches for the second round were selected a sample from the total of more than 50 churches affiliated with the Abundant Life Health Ministry Initiative (ALHMI). They were selected utilizing a purposeful sampling methodology to include churches of varying sizes, denominations, and located in multiple Bay Area counties. The pastors in this round were interviewed using the revised interview guide (Appendix B).

In the second round of data collection, the researcher re-interviewed the pastor from the first round whose recording was not usable, and interviewed the assistant pastor of her own church. A total of 14 pastors participated in this round of interviews, representing 13 churches.

Sample Description

The sample of the first round of interviews consisted of seven pastors, representing seven churches. Six of the pastors were male and senior pastors. The one female was an associate pastor, the Minister of Health and Social Services at her church. Each pastor in this round was African-American, and represented four different denominations; Baptist (2), Disciples of Christ (1), Seventh-day Adventist (1), and African Methodist Episcopal (1). Two churches were non-denominational Christian. Six of the churches in this round were located in Alameda County, one in Solano County, and they ranged in size from 25 to 5,000 members.

The size of the second round sample was 14 pastors, 12 male and two female, representing 13 churches. This round consisted of ten senior and two associate pastors; both of the female pastors in this round were senior pastors of their churches. There was one non-denominational church in this round, and six denominations were represented; Catholic (2), African Methodist Episcopal (2), Baptist (4), Church of God in Christ (2), Seventh-day Adventist (1), United Methodist (1). The churches in this round were located in three Bay Area Counties, Alameda (5), Contra Costa (3), and San Francisco (5). The churches in the second round ranged in size from 50 to 3,000 members. Even though all of the churches defined themselves as African-American, two had Caucasian pastors. Table 1 (page 13) summarizes the characteristics of the research participants in both rounds.

Data Analysis

Qualitative analysis involves a process designed to condense raw data, or text, into categories or themes based on valid inference and interpretation. This process uses inductive reasoning, by which themes and categories emerge from the data through examination and comparison, and pays attention to unique themes that illustrate the range of the meanings of particular passages or concepts (Zhang and Wildemuth 2009). Inductive analysis refers to approaches that primarily use detailed readings of text to develop concepts, themes, or a model through interpretations. The goal of the inductive method is to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data (Thomas 2006). The inductive process was followed in this study; within a specific set of parameters the researcher followed the guiding principles of the research questions and aims with openness to different themes that emerged during data collection. This allowed the opportunity to reflect the participants' responses and perceptions. The researcher began with the intent of discovering pastors' thoughts on the church's role in community health, and their motivations for, and expectations of partnerships to impact community health. As the initial interviews were completed and analyzed, the guide was revised to focus and probe deeper and more specifically into these and other themes that were brought forth in the first round of interviews.

Each interview was audiotaped, and transcribed verbatim. The researcher then listened to the tapes and compared them to the transcripts to assure accurate transcription. This process also allowed for a different perspective by hearing, instead of just reading the interviews. The completed transcripts were loaded into ATLAS.ti, a qualitative software program. ATLAS.ti

supports the analysis of qualitative data by offering a way to store, manage and display large amounts of text.

The researcher began the analysis by reading all transcripts and using open coding to identify meaningful statements by the pastors. An iterative code building process was used, by reading and re-reading the transcripts, identifying individual concepts, and breaking the text into analyzable units. A code list was developed by identifying patterns of responses and ideas that were repeated by multiple respondents. The final code list included concepts and themes related to the original study aims and research questions, along with new ones that emerged. New concepts were seen as important themes if they were repeated throughout interviews. The code building process was complete when it was evident that the list of codes presented a full picture of the concepts specified in the study aims. The final code list consisted of 52 individual codes. The codes identified in the final list related to the pastors' views on the importance of the Black church in the African-American community, the role of the Black church in the health of communities, reasons to enter partnerships to impact health, conceptualization of partnership and successful outcomes.

Based on the final list of codes, all transcripts were re-read and coded using the defined codes. Many times a segment of text was assigned more than one code, to document the co-occurrence of concepts within one statement. During each process, memos were written and attached to specific statements to document the reader's impressions of the data and to highlight interesting, important or unique statements.

Once all transcripts were coded, the coded quotations were conceptually or thematically grouped into code "families." The code families that were identified were Importance of Black Church, Church's Role in Community, Black Church's Role in Health, Influence of Pastor in Black Church, Motivation for Partnership, Concept of Partnership and Expectations from Partnership. Additionally, the participants were assigned to document families by county, church size and denomination. This development of groupings allowed for comparison of similarities and differences across and between groups and concepts.

CHAPTER IV: Results

Introduction

This chapter focuses on the findings from the study aims, which were grounded in literature, previous studies, and theory. Findings related to each aim will be explored in detail below.

The study included pastors of African-American churches in four San Francisco Bay area counties. Seven denominations are represented, along with non-denominational churches. The sample is summarized in Table 1 below.

Table 1 - Sample Description

Church Information **N= 20**

Denomination		**County**		**Church Size**	
African Methodist Episcopal	(3)	Alameda	(11)	Small-Membership <150	(4)
Baptist	(6)	Contra Costa	(3)	Medium - Membership 151-500	(11)
Catholic	(2)	San Francisco	(5)	Large - Membership 151-500	(5)
Church of God in Christ	(2)	Solano	(1)		
Disciples of Christ	(1)				
Non-Denominational Christian	(3)				
Seventh-day Adventist	(2)				
United Methodist	(1)				

Pastor Information **N=21**

Role		**Sex**		**Race**	
Senior Pastor	(18)	Male	(18)	African-American	(19)
Associate Pastor	(3)	Female	(3)	Caucasian	(2)

Unanticipated Themes

Analysis of the semi-structured interviews used to collect data in this study led to identification of other emergent themes, not directly related to the aims or questions, but very important to looking at work in the Black church. These themes are explored below.

Importance of Black Church

The place of the church in the Black community is well studied. The institution has been identified as the preserver of the Black ethos (Levin 1984) and the center of the promotion of business, education, and political activism (Markens, Fox et al. 2002). Though not a specific aim or research question in this study, the topic was frequently brought up by the pastors, particularly about the credibility of the church among African-Americans.

> "So when you're coming from the African-American church perspective and the collaboration, the church is still seen as, even though - well it's still I think something like 80 something percent of Americans across the board affiliate themselves with Christianity, and then with an African-American community, I think it's a higher

statistic… whenever you desire to accomplish something significant within an African-American community, you have to involve the church, well you should involve the church." *Pastor, Non-Denominational church*

"So if you want to affect the health and the happiness of the African-American community, if you don't target -- So how can we be most effective, okay? Where's the largest block? Church...So the church brings the people, the church brings loyalty." *Pastor, Non-Denominational church*

"The way we visualize it is that, you know, God puts a church in the midst of the people and when the people see the church, they see God, they're supposed to. They realize hey, if I need something I can go there and get some help. So that's what we try to portray. *Pastor, Baptist church*

"Wanting our people to be educated in as many facets or many areas. From spiritual to practical things. I want our people to know how to start a business. I want our people to know what I need to do to get in college. At the same time, I want our people to know, "How do I become a better Christian?" You know, so, community, which leads to the educational aspect—" *Pastor, Baptist church*

"The church will have to drive the health piece for African-Americans. It'll have to be driven by the church. I think we use other people, but no other agency in the community speaks for African-Americans like the church." *Pastor, Church of God in Christ*

"Regardless, the church still is the most influential, powerful social body, if you want to call it that, in our communities because of the history, because of the background of the African-American church." *Pastor, Church of God in Christ*

Because of this importance, the pastors believe that the church has great reach into the Black community, in all areas of life.

"You know, churches are strange and you know you may have sister Betty in the church but she's got four or five other cousins that are not in the church, but in a church around the corner. So when you start, you get sister Betty going and she start talking to them, you're reaching other churches, not just your church. So in lots of other programs, when they jump in, people really don't trust them because they don't have a relationship with the church. And believe it or not, even those on dope, our African-American believers are strong in church, they believe in church. That's one of our greatest beliefs." *Pastor, Baptist Church*

"But one of the things that we recognized is that the Black Church is a life experience which means that the church leads not only in terms of our doctrinal beliefs, but you must lead in life experience. You have to be there for people. So we become the voice and we don't see a large gap between what goes on Monday through Saturday and what goes on on Sunday morning. So Sunday morning, we celebrate. But yet, at the same time, we

challenge and lead the fight for people who are voiceless. And the Black Church still fills that role." *Pastor, Church of God in Christ*

"What the church has is they have inroads in the communities nobody else can get into." *Pastor, Church of God in Christ*

"And even people who are not members on a daily basis still claim the church is--the voice of that leader represents their community. And that's why I think it really is a bully pulpit when it comes to that person's perspective." *Pastor, Church of God in Christ*

"So they're not living necessarily in the physical boundaries, of physical boundary of this parish. People come from all over the map to come -- It's a community of intention, which is a little different from most Catholic Churches 'cause most people just go to what their local church is…Because of the African-American spirituality and the gospel choir and the overall feeling, of feeling at home." *Priest, Catholic Church*

Influence of the Pastor in the Black Church

The pastors in this study take the responsibility of their role very seriously, and feel that they are important in impacting the community.

"And people expect credibility from that pulpit. People do not expect that that pastor's going to get up there and lie to them about what's really going on." *Pastor, Church of God in Christ*

"The pastors are the key. It's not going to happen with people in the audience. It's got to come from key leaders who would endorse this and say, "Hey, this is what we do." *Pastor, Church of God in Christ*

"Yes, ultimately the pastor has full control. The pastor, depending on his style, will set up councils and listen to them or just kind of go and kind of be a strong leader and have people follow." *Priest, Catholic Church*

One reason for this exalted place is the belief that pastors are called by God to be leaders of His people, a thought reinforced by pastors in this study.

"Well the Bible says that who God qualifies, He edifies and He glorifies, so -- 'cause studying basically is me studying the word of God, meditating on the word of God. Some preachers go to theological school, they go to school. I have not been to school. The wisdom of God is on me. I've been tested and I've been rounded up and found with God." *Associate Pastor, Baptist church*

> "Well we, as pastors, we think that we had a call from God directing us, you know, how to conduct ministry, what to do and we believe that he gives us words to say. I was a young man, maybe about 18 at that time. -- So through the years, just growing in the ministry, following God's voice, you know, believing that He's talking, and proceed."
>
> *Pastor, Baptist church*

> "You know, that's something that I don't think people can teach you…Because if it can be taught, then anyone can do it. As far as the spiritual aspect of it, it requires a lot of time praying, a lot of time meditating. Getting in touch with, "What is God saying about this situation?" And you can't teach that. That's something that is…it's an experience."
>
> *Pastor, Baptist church*

> "Well, we believe and accept the fact, on the testament, there is a special, divine revelation from God to the individual to become a pastor or elder or minister. So I received that divine revelation to do it." *Pastor, Church of God in Christ*

Many of the pastors in this study used their influence to forward the health messages and activities in their church.

> "A couple of Sundays ago, the ladies had a program, which they're doing quite well called The Biggest Loser. And it went very well. They gave out some awards. And so I got up and I said, "Hey, we've got three months before Christmas. The men want in on this. I'm leading this case. You guys watch me." And I said, "By Christmas, I'm not going to look like I look now. Y'all watch." And I said, "I've got some other brothers who want to come along with me." All of these guys jump up and say, "We're with you, Pastor." So now we're putting together our strategy. They've already gone out to the Health and Wellness Ministry and got somebody to work with us with our workouts and stuff like this here. But just me standing here saying, "Let's do this," 15 to 20 guys walk up and say, "Pastor, I need to lose 20 as well." *Pastor, Church of God in Christ*

> "I walk four times a week, about an hour power walking. Now they have created an organization called [Pastor's Name]'s Walkers…I challenged the men here because of my age and these young guys are scared to walk with me…I do that to challenge them, to get them involved." *Pastor, Church of God in Christ*

> "My first sermon on health was the sermon called 'Body by God.'"
>
> *Pastor, Baptist church*

The findings on the specific aims of the study are detailed below.

Aim 1: Pastors' Motivations for Churches' Collaboration with Public Health Organizations in Health Promotion Programs

In order to address this aim during the semi-structured interviews, the discussion centered around three areas:

How pastors view the role of the Black church in the community

The pastors in the study feel their spiritual obligations to the community strongly, in fact; they believe that believe that their responsibility is much broader. When questioned about the role of the church in the community, they overwhelmingly expressed the belief that the church plays a great role in the community.

> "So yes, we owe the community. It's our job. Everything we do is supposed to project or interject the community, and that's why everybody run [sic] to the church. "
>
> *Associate Pastor, Baptist church*

> "What can you do to impact the community in a positive way, that it impacts that community in a way that would make it more positive? To me, the churches sit there to be a strong role model, to exemplify the ethics and principles of the church that will affect families and those people that come in contact with it."
>
> *Pastor, Church of God in Christ*

Two pastors in different counties made the same point about the visible impact of the church using almost exactly the same words**.**

> **"**Well, the one thing I say often, if in fact, you close the doors, put a chain on the lock, and the community does not suffer, the community does not miss us, then we have not done our job -- not members; I'm talking about the community at large. So we have to be here." *Pastor, African Methodist Episcopal church*

> "I asked our church once, I said, 'If our church burned down yesterday, would this community miss us?' And if the answer is no, then we're not doing a good job."
>
> *Pastor, Baptist church*

Some expressed that outreach to the surrounding community is, if not more important than, at least a precursor to the church's spiritual mission.

> "Community involvement is big. It is probably number one. And more so, let me say, more so not the preaching of the gospel, but the living of the gospel."
>
> *Pastor, Baptist church*

> "…of course, of course, community involvement. If we are not involved in our community, let's take the name church off, and put social club, because that's all we are."
>
> *Pastor, Baptist church*

> "But we have to meet the immediate need. The way we do it, it's a 5-mile radius around the church, north, south, east, west. We call it "our area" and whatever happen in that area, we're concerned about it. We need to be a part of it."
>
> *Pastor, Baptist church*

One pastor felt that there is Biblical precedent for these activities;

> "And that's how Jesus did it. No matter what it was, he would bring them -- And that ought to be the mission and the strategies of the churches, you know, 'cause everybody not going to come to church. We got some folk, they ain't concerned about no church 'cause they feel that the church is trying to get your money and that's the old belief that's been around for a long time. But that's not so, you know. Some churches are broke but still reaching out and doing their ministry. They believe that God will sustain the ministry." *Pastor, Baptist church*

Some even went so far as to insist that the church is the central organization in all communities;

> " The church is always -- It doesn't matter what society defines as the greater entity. The bottom line is that the church has always been it. And so the church started out, so we have an obligation to not only go out to the community and police, but we have to teach them how to do it, how to live and what it means - the importance, the significance of it. So it's not just a one/two, but a three-way, you know, a tag team thing and it all comes back to the church." *Associate Pastor, Baptist church*

> "I mean, if we can't be a place in the community where people can come and feel safe and get the information that they need in order to be viable citizens or in order to get themselves out of the predicament that they're in, what good is it?" *Pastor, African Methodist Episcopal church*

One pastor of a large church in Alameda County takes responsibility even for the safety of the community;

> "But before we could do that [build the church], we had to secure this neighborhood. We had to literally--you couldn't just build a church. You couldn't just buy a church or erect a church. You had to take on not only the property where the church was, you had to take on the entire--it came as a package. But it came with a price; you had to take on everything that went with it. So you had to take on every crack dealer, every alcoholic, every person who was working above the crack dealers. You had to take the entire system on if you wanted to build a church here. And you had to embrace that entire community; otherwise, you would not have a right to build here." *Pastor, Church of God in Christ*

Do pastors feel that the church should address the health issues in the Black community?

Pastors believe that the church's strong role in community extends to health

> "The church has the responsibility, the obligation is mandated actually to not only uphold its members but teach the members, educate the members spiritually concerning their health, the way that the body's supposed to be taken care of. " *Associate Pastor, Baptist church*

"So we're involved in community health. Matter of fact, I'm a community health worker. I got that certificate at City College" *Pastor, Baptist church*

"We want this place being a focal point for the community, where we become an information center as far as the health related issues, survival issues."
Pastor, African Methodist Episcopal church

Again, pastors expressed that this is in line with Biblical example;

"I would say physical health and religion relates because, you know, Jesus did healings and he met the physical need and the spiritual needs of the people. And we try to do the same thing, you know, so that's why our Health Ministries are here."
Pastor, Baptist church

"So I think sometimes we forget that even Jesus had a twofold ministry, both – you know, when He went from place to place, He did not -- He spent more time healing than preaching." *Pastor, African Methodist Episcopal church*

"And you see the ministry of Jesus and you kind of, he was a pretty healthy cat, you know. He walked around a lot and he had a kosher diet and he was always concerned about people's hunger, you know, take care of these people, how much is it going to cost to feed these people? So when it comes to your physical health and the church, I think they kind of go hand in hand." *Pastor, Baptist church*

Several pastors acknowledge that the church has not always been supportive of health behaviors;

You know, the church has been blamed for bad eating, you know, the fried chicken on Sunday, the collard greens with the fat back, the dressing with all that carbohydrates and the bread and potato salads and nothing balanced and just eating, just eating. And we finding all that, that's what's destroying our people. And a lot of it's happening at the church. *Pastor, Baptist church*

"It's very unfortunate to me, in my opinion, this is my opinion, it's very unfortunate, that as Christians who call ourselves disciples of Christ, that we lack the most self-control, and when it comes to the area of food." *Pastor, Baptist church*

"And when we sell dinners at the church, traditionally, we've always sold the kind of things that are probably not the best for us, you know, fried chicken, barbeque and that kind of stuff. So I think the church is going to have to drive doing this differently."
Pastor, Church of God in Christ

"And we intend to lose some weight. Okay. Get on with what we need to do. The church can do that. Okay? The church can do that. But we also set the standards for

wrong behavior as well when it comes to eating… it's just part of the culture that we embrace." *Pastor, Church of God in Christ*

Multiple pastors mentioned that their denominations have a policy of focus on health

"We pride ourselves on being on the cutting edge as African Methodists. Our mission is to minister to the spiritual, intellectual physical, emotional needs of people which is in our discipline, the first few pages. And so that gives us the leeway then to want to launch off and be active in health issues." *Pastor, African Methodist Episcopal church*

"You can see that in the Catholic tradition with all of the religious orders that have hospital systems…We've got this huge health -- So it is a focus of, well it's a way to serve the community when nobody else was serving them. And I think there's a real - it's taking care of the poor, the widow and the orphan, you know, it's out of that."
Priest, Catholic church

"Well now the denomination does stand strong on health. I think in the past they've probably leaned on some of the larger platforms like AIDS or prostate cancer, breast cancer, you know, some of the more worldly type of platforms, although they are moving more into nutrition. This last year or last two years has probably been the best two years as far as nutrition is concerned. Because in the past, it's pretty much been AIDS and make sure you get your AIDS test and, you know."
Pastor, African Methodist Episcopal church

"Well, the Church of God in Christ, we're concerned about social welfare in all that. Matter of fact, in our official manual we have an area in that talking about how we should be concerned about community, our neighborhood, housing, health, substance abuse, and anything that affects humanity. "
Pastor, Church of God in Christ

Pastors' reasons for churches to partner on public health programs

After establishing their viewpoints on the church's responsibility for community health, the interview discussion moved on to partnerships to impact the health of communities. Questions in this section asked included

'<u>What would encourage you to consider entering a partnership to conduct health activities?</u>' and

'<u>Describe how you think public health and churches should work together.'</u>

Pastors talked at length about their need for resources to impact the health of their members and communities.

"We can bring in lots of resources from the different healthcare systems, from the Department of Public Health. We can collaborate with private/public partnerships. We can bring in as many resources as we can as a community and end up addressing a

lot…And get grants. Of course grants, we've got grant writing and looking for resources 'cause the church can't, I mean, a local church can't do these things all on its own but I think all of us working together." *Priest, Catholic church*

"Well, I think for resources -- I mean, you know, unless you are a, you know, T. D. Jakes or someone who has 10,000 members and has resources for everything -- but generally, the smaller-sized churches are always struggling for resources. That's a major issue, you know, across the board; even for a four or 5,000-member church, its resources…So I think, you know, just being kind of true to myself, that's the number one reason. You know, they want to do this, they want to try that, they want to expose this, but they don't have the resources." *Pastor, African Methodist Episcopal church*

"I mean, the resources is, you know, probably the key, you know. I mean, and we -- and those resources include a gamut of things -- you know, sometimes individuals come down to assist. So, yeah, I think that's the number one, the resource and support." *Pastor, African Methodist Episcopal church*

"Yeah, I think it's the only way to go really. I mean, 'cause the only other thing you can do is if there happened to be someone in your parish that has a talent or a skill...There are resources downtown that I see so we can tap into that… I think more on a local level about the community. *Priest, Catholic Church*

"So I'm looking for organizations who come in and help our people, sure." *Priest, Catholic Church*

"And then also if, in fact-because really we don't have enough money, like we'd like to, to do some of the things that we need to do with the group, so I'll see if they've got any funds to help us, look for that." *Pastor, Church of God in Christ*

"We need a program that would allow different churches to send one or two persons there to be trained as the health officer for their church that offer some type of a credential after they're finished with their training." *Pastor, Church of God in Christ*

The pastors do, however, understand and acknowledge the expertise of outside professionals. They are aware of, and appreciate; the need to seek and obtain valuable and useful health information, from other organizations.

"You have your professional organizations, universities and the city health department, your federal and all of that. Those persons have really went and prepared themselves, so naturally they'd have more in-depth information as to how it could actually be done. The church members are part of that community, too, so if the church teaches about that and gives a thorough understanding, both the professionals and the church working together, that's where they can do a better job. The church can push and encourage." *Pastor, Church of God in Christ*

> "I mean, I think anytime you're able to collaborate with others to address specific issues or even broader issues helps. I mean, we can only -- the reality is we can only reach so many, because of the, I say, limited resources that we have currently. And just -- sometimes just having a person able to discuss things more in detail or -- you know, we have taken it to a larger scale." *Pastor, African Methodist Episcopal church*

> "We want someone that's going to be able to say, 'You know, we've been doing some research in conjunction with yours, we've been doing some things along with you, parallel with you, and here's what we've come up with.' You know, "Do you think these things may help in your area?' 'Yeah. Can you train us on how to do that?'"
> *Pastor, African Methodist Episcopal church*

> "I look for good, clean information so that I can be confident that the instruction, the teaching is going to be very good and do what it says. Those are some of the things, credibility and stuff like that. " *Pastor, Church of God in Christ*

There is an awareness that, while the church is an important institution, it cannot provide everything a community needs.

> "How do we save our children, how do we save our sons and our daughters? So those are the partnerships. But again, with the limited resources within the church, we're constantly looking outside of the church for financial assistance."
> *Pastor, African Methodist Episcopal church*

> "Collaboration is very important. You can't do it by yourself. And a lot of times churches have been guilty trying to stand off alone, an island by themselves, and they don't work. So you've been in collaborations." *Pastor, Baptist church*

While willing to partner with non-religious organizations, pastors have very specific ideas about what partnership means, and the church's role.

Aim 2: Pastors' Expectations of Partnerships, Including Their Definition of Success

Pastors' Concept of Partnership

There was much discussion around the concept of the church as a leader in the community, as noted above. The pastors in this study absolutely see that concept of collaboration is in their interest, but compromise is a more of problem. One reason for this is the way pastors feel about the role of the church, particularly the black church. The feeling is that because of their role in the community, churches should not have to compromise, but be the center of all activity.

> "Everybody have to have a major issue, you know. And I think all the organizations would bring something different to the table but we would have that main line, that mainstream issue, like we are here to preserve life, you know, and that's a control factor."
> *Associate Pastor, Baptist Church*

> "Just the impact of them coming to me would be a blast…Everything should flow through the church, every and anything should flow -- the good, the bad and the ugly should flow through the church, because that's who Jesus died for."
> *Associate Pastor, Baptist Church*

Additionally, pastors are very aware that churches are religions institutions, and the responsibilities that must be foremost in the consideration of collaborations and potential partners.

> "Whoever you partner with, you can never--it can never be a partnership that conflicts with your spiritual beliefs because then your credibility is gone. So there may be some situations where you--it's not best for you to partner there because if you have to violate what you believe, then it's not a good partnership." *Pastor, Church of God in Christ*

> "Planned Parenthood couldn't come in here, for example. That would not be a group - because the Catholic Church believes in life from conception to a natural end. So you would really be running in the face of that. You know, no matter what any one person would feel or think about that, that just wouldn't work. So you have to be politically astute." *Priest, Catholic Church*

> "Well, we're a nonprofit organization. You have to make sure that you don't impact your nonprofit status. Then, let's say you partner with someone that's not upfront and that's not credible. That's going to affect your image. It's going to put you in the same situation where they'll be suspicious. Those are some of the areas I would say you have to be kind of cautious and watch for." *Pastor, Church of God in Christ*

This did not stop some pastors from being explicit about what they wanted from a partner.

> "On the provision part, is, you know, what they can provide would be whatever you can give us, you know, free. A lot of time we don't have the money to actually go there and buy that. But if you can work with us, we can work with you, anybody. "
> *Pastor, Baptist Church*

What pastors hope to gain as a result of their involvement in health promotion partnerships

This concept of expectation turned out to be very closely related to the motivation; pastors made it very clear that they anticipate obtaining needed resources in their relationships with outside organizations. The most common expectation among the pastors was that the partners have something to provide to the churches.

> "You know, if we go out and find a community organization that's going to lift us all up, of course." *Priest, Catholic Church*

”But again, with the limited resources within the church, we’re constantly looking outside of the church for financial assistance.”

Pastor, African Methodist Episcopal church

”They may have money to their avail but they also may know of places in which we can get money in order to perfect the ministry. But we want to move with the same goals, the same objectives.” *Pastor, African Methodist Episcopal church*

“Everybody should bring something to the table because DPH wants something, the church wants something so bring the same thing to the table. -- So, you know, just collaborate and being truthful and bringing something to the table. Don’t expect me to come to the table if you don’t have nothing.” *Pastor, Baptist Church*

“That person would go out and get information and invite health professionals in, speakers or classes, or we may zero in on a specific, whether it’s prostate cancer or high blood pressure, whatever. And then they’d bring literature and stuff like that and bring the professionals in so people could really learn that certain habits that you have is not good. It’s creating problems or it’s bringing on certain diseases and all that stuff. That’s the way I see that. So that can work.” *Pastor, Church of God in Christ*

“I look for people that we have a relationship with that’s not going to tell us, ‘Yeah, yeah, yeah,’ then turn around and don’t do it 'cause then you’re going to lose the people. So if they say they’re going to do it, we look for them to do it and be responsible for what they do with us, as a church. If not, we just drop the relationship and look for other folk.”

Pastor, Baptist Church

This extensive focus on obtaining resources from partners turned out to be one of the overarching themes of the study, and is best expressed by the exchange below with a pastor in Alameda County.

INT: So one of the other things we want to talk about or hear about is partnerships that the church has with organizations around the area of health or to get resources for health. Are you involved, is [your church] involved in any partnerships with organizations outside of itself?

FSPKR: Financial, that help us financially?

INT: Or I mean, another relationship, that they might come in and do -- Like the event that I was at, where the American Heart Association, they came in. Do you have partnerships like that with folks like American Cancer Society, American Diabetes Association, American Heart Association, people like that?

FSPKR: I don't know if it would be considered a partnership or an available resource. So they would be more available resources. Yeah, we have resources available to us that can come in and do workshops and provide material and stuff.

INT: And how would you view the difference? What would you consider a partnership?

FSPKR: If they help get me some money.

INT: Okay. So a partnership though assumes that there's a give and take.

FSPKR: And I guess we do have a partnership. We have a partnership from the standpoint that we have a grant so we are expected to deliver what we said. And so I assume that that would be a partnership. *Pastor, Church of God in Christ*

The pastors also had specific ideas about their role in the partnership; they expected to be approached and treated as equals, if not more, due to the role of the church in the community.

"So, you know, a church or such entity would be able to say, 'Okay. I need you, and you need me; this is an equal partnership.' You know, where you may bring the resources, I bring the masses. You know, I bring the ability to communicate it to a larger scope, you know. Now, even if I only have ten members, well, my ten members know ten people, so that -- that thing of multiplication. So that automatically puts me in a position of -- or should put me in a position -- of equal." *Pastor, African Methodist Episcopal church*

"As equal partners, clearly understanding your interrelationship and interdependence, you know, and knowing -- So it's likewise knowing and defining what the lines of demarcation are, what's your responsibility and roles in it, and then having the level of trust and relationship and knowing when to pass the baton, and then having accountability in the - it's kind of like, you know, right brain/left brain communication, being able to go back and forth so that it's equal partners in that process based upon what your defined roles are." *Pastor, Non-Denominational church*

The pastors' expectations of their partners tended to be more process than outcome oriented;

"What a partnership should look like, everybody being truthful."
Pastor, Baptist church

"Well an openness, an ability to communicate, recognition that we both have a goal to serve the people, and that we're basically on the same page and that we have some sort of MOU, a Memorandum of Understanding, that would help us, you know, if there were ever difficulties, that we could refer back to it, and good communication."
Pastor, Catholic church

> "I mean, we have an expectation for them, and they have one for us. So, as long as we're able to communicate and ensure that those things are being met, you know, in a reasonable fashion, that creates a success. So whether it's in the church doing the same thing, you know, expectations. You know, it's almost similar to a relationship: you have these expectations on what you want out of the relationship and vice versa. And so, as long as we're able to talk about that, then we should be able to have a successful relationship." *Pastor, African Methodist Episcopal church*

In order to shed more light on expectations, pastors were asked to describe a successful partnership. The pastors' views of a successful partnership are very different from how the public health community views them.

Again, there were process-oriented concepts considered as success;

> "So there's a level of success because we got over that hurdle, we crossed that hurdle, we've got an alliance, we've got a partnership."
>
> *Pastor, Non-Denominational church*

> "I think our goals are the same and we're serving the same community, the needs that are perceived, and that we work well together in order to achieve them."
>
> *Pastor, Catholic church*

And in some cases, a successful partnership was measured with a focus on what the church would receive;

> "Understanding one another, being able to communicate. Say call you on the phone, say, 'We're trying to do a health fair. Can you help us?' Then you come over, set it up."
>
> *Pastor, Baptist church*

> "I mean, you know, there is a coming together, sharing information. There is accountability. There's training…So, I mean, whatever it is we don't have, we can ask them, and they will find either a class or a workshop or some type of way of providing the information. So whatever it is we're lacking, sometimes they'll do the research for us, and then all we have to do is show up, or participate."
>
> *Pastor, African Methodist Episcopal church*

Very few pastors brought up, or even considered, measurable or behavior change outcomes or the effect of health promotion programs as an indicator of a successful partnership;

> "Number two is based upon whatever -- that alliance or that partnership had to have some goals in mind to transform something, to inform, to teach, whatever that purpose is, to teach, to inform, to transform, to whatever it is. So then you have to measure then the success to how closely you accomplish whatever those goals are."
>
> *Pastor, Non-Denominational church*

"When we see people actually changing their lifestyle or actually putting what we've taught them into effect and going out and telling more people and bringing them in so that we can share information with them, becoming a focal point for the community where they can come in and get information, where they can get resources, where we can have -- And that's kind of what we want to work towards."

Pastor, African Methodist Episcopal church

"Well, it's actually achieving, it's doing what it says, people are being helps and they feel good about it and they can explain the changes, positive and stuff like that."

Pastor, Church of God in Christ

Potential Barriers to Faith and Public Health Partnerships

While the pastors in this study expressed a strong willingness to partner with public health organizations, they were very clear about their role as a religious institution. They

"Whoever you partner with, you can never--it can never be a partnership that conflict with your spiritual beliefs because then your credibility is gone. So there may be some situations where you--it's not best for you to partner there because if you have to violate what you believe, then it's not a good partnership." *Pastor, Church of God in Christ*

"So some churches, that's just what they're - they just believe it contradicts a core value of theirs to collaborate. With a secular organization, they feel as if everything we need is in the church, so let's just keep it that way so that no one else can dictate, influence or control what we do." *Pastor, Non-Denominational church*

"Yeah, they're always a risk factor, these partnerships are always a risk factor of you making enemies because of your position, your stance, your belief, power struggles, you know. " *Associate Pastor, Baptist church*

"Planned Parenthood couldn't come in here, for example. That would not be a group - because the Catholic Church believes in life from conception to an natural end. So you would really be running in the face of that. You know, no matter what any one person would feel or think about that, that just wouldn't work. So you have to be politically astute. *Pastor, Catholic church*

"With our HIV, we admit that we don't pass out condoms, so we made that very clear. And I think that the agency that we partner with, they have an issue with that but they have to respect us for who we are, you know. So that's one of the partnerships that was said well, maybe it's lived its life because the subject keeps coming up. But we won't end the ministry though 'cause all we'll do is start a support group for that population, you know, where we're not tied to certain standards because it's government related. So we still get to keep our personality." *Pastor, Baptist church*

The next chapter discusses the findings of this research, their implications, and provides recommendations for future research.

CHAPTER V: Discussion

This chapter elaborates in detail the findings from the study aims. The findings are put into the context of prior research, and recommendations are made for future research. The study limitations are also addressed.

Study Summary

The role for churches as partners in promoting health and reducing health disparities has been of increasing interest to public health professionals for the last 30 years (Olson, Reis et al. 1988; Lasater, Becker et al. 1997; Campbell, Hudson et al. 2007). The Black church is in even sharper focus now, owing to its strong role in the Black community and the significant health disparities in the African-American community (Taylor, Thornton et al. 1987; Markens, Fox et al. 2002; Goldmon and Roberson 2004). In spite of the prominent role of pastors in both the Black church and community, they are not well studied. The goal of this study was to shed light on the motivations and expectation of pastors of Black churches in health partnerships with public health organizations. The literature consistently shows that a strong collaboration is necessary for successful programs (Eng, Hatch et al. 1985; Lasater, Becker et al. 1997; DeHaven, Hunter et al. 2004), and by examining motivations for collaboration from the perspective of churches and their leaders, it is possible to gain a better understanding of how these partnerships function. Through semi structured interviews, this study aimed to gain a better understanding of the pastors of Black churches and both the role of church and the pastor in health promotion. Specifically to:

1. Discover what motivates churches to collaborate with public health organizations in health promotion programs, from the perspective of the pastor, and to clarify some of the dynamics of these partnerships.
2. Elucidate what pastors of churches hope to gain from these partnerships, including their definition of success.
3. Identify specific characteristics of churches that form partnerships with public health organizations to provide health programs

Summary of Findings

Aim 1

With regard to the first aim, pastors discussed their views on the role of the Black church in the community, the role of the church in the health of communities, and their motivations for participating in partnerships to improve health.

The role of the Black church in the community

Pastors feel strongly that the role of the church is to serve its community. This view includes both the geographic community and Black people as a group. Some pastors stated that they felt that the church is the most important institution in the community, and should lead out in everything from education to health. Several of the pastors believe that the church's

responsibility for outreach to its community is on par with its spiritual mission to its congregants. While there is much study devoted to the role of churches in communities, there is minimal literature devoted to understanding pastors' views on the subject. Thomas and colleagues (Thomas, Quinn et al. 1994) obtained similar results when they conducted a computer-assisted telephone interview during 1990 and 1991 among a sample of 635 churches in the northern region of the United States. When senior pastors were asked about the main role of the present-day Black church; service to the congregation or service to the community, only five percent prioritized serving the membership only. Nine percent believed service to the community only was most important, but the vast majority (86%) indicated that the role of the church is to serve its members and the community. Included in this concept of caring for the community is positively impacting community health.

The church should address the health issues in the Black community

The pastors in this study believe that the role of the church in the community extends to health. They felt that the church does have a responsibility for health, that this is a Biblical mandate, and that there is a relationship between spirituality and health. The pastors also mentioned that they are aware of the church's role in promoting unhealthy behaviors, namely unhealthy foods, but many denominations now have health as a focus. Most pastors mentioned the health issues in the African-American community, although not all framed them in the context of disparities. Further, they believe that the church, because of the its importance in the Black community, is a good way to make a positive impact on the health of Black people. This finding is consistent with previous studies; Hale and Bennett (2003) surveyed 98 pastors, 72% of whom indicated that it is very important for churches to address the health needs of their congregations. In a study about HIV/AIDS in the African-American community, pastors indicated that that churches and specifically faith leaders, should lead out in addressing the HIV/AIDS epidemic (Nunn, Cornwall et al. 2012).

Reasons for churches to partner on public health programs

The literature documents many motivations for partnerships between organizations, including shared purpose, the desire to reach a common goal, a need to protect one's own interests, to maximize efficiency, and to gain strategic advantage (Gray and Wood 1991). At the root of all partnership efforts is both the need and the potential for each party to gain some benefit (Wood and Gray 1991). With regard to specific partnerships between faith-based organizations and the field of public health, it is widely acknowledged that the most pressing health issues cannot be resolved by one entity alone (Butterfoss, Goodman et al. 1993; Lasker, Weiss et al. 2001). There is extensive literature on the benefits to the public health field. These include access to underserved populations and legitimacy in these communities (Simpson and King 1999; Markens, Fox et al. 2002), organized volunteer bases (Davis-Carroll 2005), and resources to conduct programs such as meeting rooms and kitchens (Campbell, Hudson et al. 2007). The pastors in this study were very clear that they believed the church to be the best way to reach the African-American community, specifically citing the trust of the institution by the community, and the fact that the church occupies a central role in the community; supporting social, educational, and other activities, not just spiritual ones. They did not speak of church as a resource to meet the physical needs of community members, but as a place that people trust, and would come to for information. The pastors viewed this as a definite incentive to any potential partner, and their main contribution in a relationship.

There is much less documentation of what motivates the participation of the church; the general consensus is the increased knowledge of disease and improvement in health promoting behavior (Lasater, Becker et al. 1997; DeHaven, Hunter et al. 2004; Campbell, Hudson et al. 2006). One study (Ammerman, Corbie-Smith et al. 2003) surveyed pastors of churches that had participated in a research study on dietary change in African-America churches. In that study, cancer prevention, nutrition education, and concern for their congregations' health were the pastors' most commonly cited reasons for participation. The pastors in this study overwhelmingly expressed very specific reasons for their partnerships to conduct health programs. They understand that while the church is very important, it cannot provide for every need and that there is much knowledge and expertise to be accessed by affiliating with outside health professionals. These pastors, similar to those in study quoted above, do have the desire to impact the health of their congregants and communities, but they express it very differently; their most commonly cited reason for partnering is to obtain resources for making this impact. They expressed a need for funding primarily, expecting that a partnering organization would either provide funds or resources to gain funds. Pastors also reached out for materials to use when conducting health programs, training, and other support. This expression of their motivations for partnership is very closely related to their expectations.

Aim 2

The main purpose addressing the second aim was to understand the outcomes expected by these pastors when they enter partnerships. To this end, the pastors were asked share their thoughts on how churches and public health organizations should work together, and what they considered a successful outcome of such a partnership.

Pastors' expectations of their involvement in health program partnerships

The pastors in this study have high expectations of their partners in health promotion programs. They believe that, as the center of the Black community, the church provides integrity and has the trust of the people, so that providing participants for programs, partners should provide significant resources, including funding, materials, staff, expertise, and ongoing support. These expectations are similar to those found in a study of pastors whose churches participated in a randomized trial on dietary change. Ammerman et.al. (2003) surveyed 74 pastors participating in a research partnership. Those respondents identified the university interacting with church participants as partners and adequate help from the university in implementing the project as extremely important elements of a good church/university partnership. The pastors also identified the university providing financial resources to cover costs associated with research project as a very important element of the partnership. Multiple pastors in this study expressed similar ideas as those above; they expected to be viewed as an equal, if not senior partners, and viewed finances a high priority in the partner relationship. In terms of adequate help, the expectations of the pastors in this study was that they would provide access to their congregations and communities, and the partner organization should be willing to supply the rest, including financial resources.

Pastors' view of partnership success

While exploring their definition of success, it became clear that pastors have a different idea about outcomes than do public health professionals. Pastors want resources for their churches, and see obtaining these resources as a satisfactory partnership outcome. Their expected outcomes are more focused on the process; several expressed that the formation of the partnership is in itself an acceptable outcome, as is receiving a service, or access to the desires resources. Goldman and Roberson (2004) note something similar; that churches and public health institutions were interested in the same thing, reducing health disparities, but have different perspectives of how to effectively address an issue. The explanation provided is that these perspectives are due to the central differences between theology and science. While the desired outcome of both institutions is improved health, the priorities are distinctly different. Churches tend to measure the success of projects by how they helped to provide immediate response to perceived needs. To achieve this, churches look to the provision of tangible and sustainable service. This way of thinking was very clearly expressed among the pastors in this study. This means that the methods to determine success are not necessarily measurable; in fact only a very small minority of the pastors mentioned behavior change or any measurable outcome as an expectation of the partnership.

Aim 3

The third aim was to identify specific characteristics of churches that form partnerships with public health organizations to provide health programs.

Denominational differences

It is worth noting that congregations are not equally likely to collaborate. Among congregations with programs, large mainline Protestant, theologically liberal congregations with more college graduates are significantly more likely than others to collaborate (Thomas, Quinn et al. 1994; Chaves and Tsitsos 2001). This study, however, found no difference between denominations, likely due to a small sample size and a focus on churches already partnering. None of the churches in this study, however, defined themselves as conservative, nor did they fit into the standard definition of conservative denominations (Roof and McKinney 1987). The Catholic churches consistently devoted the most resources to their health related activities; one priest stated that their church devotes equal finances to the running of the church and their community programs. The other Catholic church has funds for the church's health program designated in the annual budget. This might indicate a lesser need to partner with outside organizations for the resources alone.

Pastor Priorities

Most of the pastors in the study listed outreach or community service as one of the top three priorities for their church. This is an important aspect, as pastors of predominantly Black churches have great power to initiate and implement congregational programs of their choosing (Chaves 1999). Public health organizations will have more of an opportunity to initiate partnerships with churches whose pastors have this type of orientation.

Church Size

Previous studies have found that larger churches provide more services, simply due to having more resources (Chaves and Tsitsos 2001), but in this study, the two smallest churches had the most community outreach focus; with one church running a clinic offering primary care services. It is possible that this community orientation is seen as a way to grow the congregation.

Previous Collaboration

Most health and social services activities done by churches are done in collaboration with other organizations. Studies have found that 84 percent of congregations that do social services and 71 percent of churches that conduct health promotion programs have at least one secular agency as a collaborator (Thomas, Quinn et al. 1994; Chaves and Tsitsos 2001). With one exception, all of the churches in this study were currently involved in a partnership with an outside organization, and all pastors expressed a willingness to continue to collaborate, and/or initiate new collaborations. This is very encouraging for public health agencies seeking partnerships with churches.

Unanticipated Findings

Analysis of the semi-structured interviews used to collect data in this study led to identification of other emergent themes, not directly related to the aims or questions, but very important to looking at work in the African-American church. These themes are discussed below.

Importance of the Black Church

The place of the church in the Black community is well studied. The institution has been identified as the preserver of the Black ethos (Levin 1984) and the center of the promotion of business, education, and political activism (Markens, Fox et al. 2002). Though not a specific aim or research question in this study, the topic was frequently brought up by the pastors, particularly about the credibility of the church among African-Americans. They also addressed the role of the church in civic life, education, and of its reach to people beyond its congregations. The general consensus among this group was that the church is the best way to impact the Black community in all aspects of their lives.

Because of their role, respect and level of activity in the Black community, churches are ideal for transmitting health-related information into an underserved community. Diffusion of health information is problematic in public health, and the literature on the subject indicates that churches can be used to increase this process (Lasater, Becker et al. 1997; Oldenburg and Glanz 2008). The responses of pastors in this study support these findings, and encourage the use of the church for this purpose.

Influence of the Pastor in the Black Church

The role of the pastor in the black church is acknowledged in the literature, and in the community outside of the church. As respected leaders in the community, their buy-in to health promotion activities has been identified as very important, to legitimize programs and facilitate adoption of information (Markens, Fox et al. 2002; Goldmon and Roberson 2004) and serve as agents of change (Levin 1986). Goldmon and Roberson (2004) identified potential roles for

pastors of Black churches in health programs, including designing and planning interventions; serving as advocates to effectively communicate information between health professionals, church, and community members; and assisting in the development of comprehensive, sustainable health ministries.

One reason for this exalted place is the belief that pastors are called by God to be leaders of His people. Each of the Black pastors in this study discussed their personal call when asked how they came to be in ministry. They take the responsibility of their role very seriously, and feel that they are important in impacting the community. Many of them use their influence to forward the health messages and activities in their church, by preaching sermons about health, taking part in health-related activities, and publicly setting and working toward specific personal health goals.

Partnership as Resource Acquisition

There is extensive literature and multiple definitions of the concept of partnership, or collaboration, but the consensus is that people or organizations working together are collaborating, or partnering. The various motivations for partnerships are well documented, and include community access and legitimacy (Miller 1987). Even though this research was not intended to focus on the pastors' concept of partnership, it became clear early on that this was a very important finding. The most prominent motivation for partnering is to obtain resources; it was also their primary expectation and desired outcome.

Theoretical Implications

This study was guided by a conceptual framework that acknowledged the place of the church in the Black community, and viewed it as an institution through an organizational lens. This approach more easily facilitated the view of churches as potential partnerships with other organizations.

This concept of partnership as a source of resource acquisition closely mirrors the resource dependence theory (RDT). Resource dependence theory describes the relationships between organizations as a set of power relations based on exchange of resources, and proposes that participants lacking important resources will seek to establish relationships with others in order to obtain them (Pfeffer and Salancik 1978). The pastors in this study were very clear that whether it was materials, finances, or information, churches are looking outside of their membership for way to get non-spiritual needs met. As churches look to provide services not traditionally within their expertise, they are seeking relationships to assist them in meeting these goals. The theory suggests the organizations that are complementary will choose to develop relationships (Lincoln and McBride 1985). This is a logical explanation for the churches reaching out to public health organizations, they are seen to have a common goal, that is the desire to improve the lives of the people within their community (Davis-Carroll 2005), and the churches need resources to accomplish it.

Power and dependence are very important concepts in RDT. Power refers to the knowledge, influence, authority and other factors required to bring about a desired achievement. Power comes in multiple forms including social, political, and economic, which can be categorized as

tangible and intangible. Tangible power is readily recognized and measured, while intangible power is often more difficult to determine (Goldmon and Roberson 2004). Churches already have intangible power, social and spiritual being among the most prominent. The pastors in this study view this power as the most important in the lives of Black people, and frequently use it to impact the lives and health of their congregations and communities. RDT is also concerned with the interdependence of organizations that are in exchange relationships. This interdependence is very evident in relationships between churches and public health organizations; as detailed earlier, each has resources that are needed by the other. Gray and Wood (1991) argue that organizations are focused on maintaining their own autonomy even as they increase their dependence on other organizations to obtain resources, but this does not appear to be the perspective of the pastors in this study. They are willing to remain in relationships as long as they are able to continue to get the resources they desire. The nature of their organization, the church, is such that they always remain largely independent, due to their very specific function, so there seems to be little attention paid to this. The separation of church and state may also play a role in this lack of concern about dependence. Likewise, there does not seem to be a concerted effort to increase their power through public health organizations, only the desire to gather as many resources as possible.

While RDT is a very valuable framework for looking at the results of this study, it is important to note a distinct difference. RDT posits that an organization's power over another is directly linked to the other's need for resources; these pastors view their role as the most powerful, even as they make themselves dependent on other organizations, and vice versa, in order to obtain resources. They are very willing to become interdependent, but not to cede their power. This is reasonable, given the church's unique position, and even helpful, as it is this power that public health institutions intend to leverage to meet their own need. Findings showed that RDT is a useful starting point but is limited, given the unique nature of the various organizational structures within the Black church.

The work of Karl Weick is also useful when viewing churches through and organizational lens. Weick developed the concept of 'loose' vs. 'tight' coupling when describing the organizational structure of educational intuitions (Weick 1976), but this concept can be applied to religious denominations. The degree of coupling within an organization depends on the interconnection of the activities it conducts. An organization is said to be loosely coupled when its varying elements are linked and responsive to each other, but each retains its own identity and separateness. A tightly coupled organization has a set of mutually understood, enforceable rules. The organization of denominations can be examined in the context of coupling; denominations with strong organizational and financial linkages can be said to be tightly coupled. Seventh-day Adventist, Catholic and Methodist denominations are examples of this; and a Church of God in Christ pastor described that structure;

> "A church is constructed basically you have your local congregations. You have what we called districts, and that can be from three churches up to eight or ten. Then we have what we call the jurisdictions. That can be maybe 8 or 10 or 20 districts. Over that, you have your jurisdictional bishop and then you have your national organization and the international."

This type of tightly coupled organization, with direct requirements and reporting, can be limiting to the autonomy that a local pastor may have when engaging in a partnership with a noon-faith organization, including public health.

The Baptist denomination is an excellent example of loose coupling, as described by one Baptist minister;

> "So, with the Baptist, it's not, you know, so much, it's a denomination in name, but not a denomination as far as an organization…That's why you can have Missionary Baptists, Progressive Baptists, American Baptists, Southern Baptists. They're associating more with the conventions but there is no, per se, that I'm aware of, Baptist denomination, other than I attend a Baptist church, which gives us the autonomy that a lot of the other churches don't have.

Non-denomination churches have the loosest coupling of all, they are each independent and individually run.

The level of coupling can impact what a pastor is willing or able to do in a partnership with a public health organization, pastors in more loosely coupled denominations have the flexibility to make more decisions about who to partner with, and what activities to engage in. In this study, it was the pastors in more tightly coupled denominations that expressed any concerns at all about who they might partner with; citing abortion, homosexuality, and even concerns about losing non-profit status as issues that could impede partnership.

The pastors of churches that belong to more loosely coupled denominations have more ability to engage with their environment and adapt to the requirements of a partnership with an outside organization such as a public health organization. Meyer and Rowan (1977) address the myth of formal organizational structures, and posit that organizations incorporate the practices that are defined by society in order to survive. Given what we know about the Christian church and its general doctrine on topics such as homosexuality, sex outside of marriage and abortion, it would seem that more pastors would express reservations about partnering with public health organization, particularly, as they are known for addressing these issues specifically, in a politically and socially liberal way. Yet, most of the pastors in this study stated that they would be willing to partner with any organization that has resources to offer. It brings forth questions about what adaptations churches are willing to make to obtain resources, but how deep the adaptations really reach. Two examples are offered to illustrate this; one pastor of a Baptist church stated that he would partner with any organization, and when pressed specifically about issues of sexuality, stated that any groups would be welcome. When attending service during Pride week, the researcher listened to a sermon on the evils of homosexuality, and statements that gay men are "not real men." One possible explanation for this is that the pastor, knowing that he was addressing an older, more conservative congregation, said what he believed that they expected to hear. Another explanation is that knowing the political climate, particularly in the Bay Area, he gave the researcher what he deemed to be suitable response. It is to be noted that this pastor's church has engaged in partnerships with multiple non-faith organization, including the University of California, San Francisco (UCSF), the local public health department, and Kaiser Permanente. A pastor of a Seventh-day Adventist church, when discussing the separation

of church and state in applying for government grant to fund programs in churches stated, that "We should take the money, in the end it's all going to burn." This is a reference to the general doctrine of Christianity that at the end of the world, those who follow God's laws will be taken to heaven, and the 'sinful' earth will be destroyed by fire. When the same pastor was discussing non-church members participating in church-run programs, he thought that it would be fine, as long as they were first vetted by a panel of church members; "to make sure they're not gay." These examples demonstrate the dichotomy of thinking about church and non-faith partnership, and may offer some insight on the lengths that pastors may be willing to go, superficially at least, to obtain resources for their church's programs. It is also worth considering that, initially, it may be easier for public health organizations to approach churches with partnership options that are less likely to be controversial from the religious perspective.

Study Limitations

While this exploration and analysis of motivations and expectations of pastors of Black churches in public health partnerships, there are two main limitations to be noted. The first limitation is related to sample size. With 21 subjects, the sample for this study cannot necessarily be said to speak for the Black pastor in general. However, the sample does include multiple denominations and, with the exception of two denominations, multiple churches within each represented denomination. This provides a broader perspective than might otherwise be possible in a sample of this size.

The second limitation is geographic; by only studying churches in the Bay Area, a very urban area noted for its liberal orientation, it leaves open the question of how pastors of churches in more suburban or rural areas might respond. In other areas of the California or the United States churches may play a different role in the community, more or less dominant in the lives of the people in and around them.

Despite these limitations, this research provides valuable insight to consider in future research and practice related to church involvement in partnerships for health promotion and disparities reduction. Some implications for practice and further research are listed below.

Implications for public health practice

With an eye toward maximizing the potential of faith and public health partnerships; below are some considerations for public health organizations seeking effective partnerships with Black churches:

- Make effective use of pastors. It is clear that pastors are very valuable to the partnership, and it is important to make sure they are involved. Because of their role in the church, they may not have the time to participate in every aspect, so it is important that their role be defined early in the process, and that they are on willing to utilize their authority to further the partnership and program goals.
- Look for churches with community oriented pastors, already or previously involved in collaboration with outside organization. Churches are frequently involved in social services partnerships such feeding, or helping the homeless before they address health issues. These are the churches that would be most inclined to enter a health related

partnership, and because of previous experience, may be more informed about what could be required of them.

- Acknowledge differing viewpoints, particularly on outcomes. One of the major findings of this study is that pastors have very specific views of what a successful partnership looks like, and have different definitions of outcomes. When initiating partnerships, it is important that these are defined and understood by both sides from the beginning. Being very explicit about what is being offered and the desired outcomes are will greatly reduce disappointments and make it easier to evaluate programs.
- Explicitly address the issue of health disparities with the Black church early with potential faith partners. The participants in this study understand health issues in the Black community, and feel that church is a good way to bring health messages, but they are not necessarily well informed on the serious disparities in health status and health outcomes that exist in this group. Clarifying the this issue may help with an understanding of what that the needs really are, and can lead to productive conversation and action on expanding the role of the church in resolving health issues in the Black community.
- Begin the partnership process with non-controversial health issues. The pastors in this study expressed a willingness to partner with non-religious organizations, but topics such as sexuality and contraception were brought up as potential barriers. Partnerships around addressing diet, physical activity and weight loss may be better places to start building relationships.

Implications for research

This study has laid a foundation for future research with faith leaders. There are a few key areas detailed below, that would be useful to explore.

Ideological – Each of the churches in this study was Christian, and as other religions, such as Muslim, are increasing in the United States, it is useful to study them, as they will be reaching larger populations.

Ethnic – Church is clearly an important venue to reach African-Americans, but other populations have strong faith traditions that with houses of worship that can serve as avenues to reach them. Historically, Latinos have deep roots in the Catholic faith, and are a growing population in the Evangelical community. There is also a large Korean Methodist population, and other Asian ethnic groups are strongly Buddhist. These are excellent areas for future study as these populations increase in the United States.

Churches that are not involved in collaborations with a non-faith-based organization - With one exception, each of the churches in this study is currently involved in a partnership with a non-faith-based organization. It is expected that their positive views of such partnerships, and willingness to be involved with non religious organizations is colored by this. It would be interesting, and possibly more useful, to gather the viewpoints of pastors of churches that do not choose to partner with outside organizations. Some topics to consider would include separation of church and state, views on spirituality and health, availability of resources, and denomination.

African-American specific health issues - During the interviews in this study, certain topics arose that are germane to the health of the Black community, but were not pursued. One area that was brought up by multiple pastors is diet. Pastors acknowledged that the Black church has not traditionally supported healthy diet. Given the disparities in diabetes, obesity and other issues impacted by diet, this is a topic that would be useful to study further. It would be helpful to understand if the pastors understand fully the connections between diet and health. Given the admission of problems in this area, it would be interesting to determine if pastors of African-American churches be willing to support changes to the food served to their congregations.

Conclusions

The first aim was to explore pastors of Black churches' motivations for entering partnerships to conduct health promotion programs. Multiple areas were discussed with the pastors to achieve this aim, including the role of the church in the community, its responsibility for health, and why churches look outside of their organization for help with health promotion programs. Major findings indicated that pastors feel strongly that the church plays a primary role in their communities, and that this role extends to health. Pastors also communicated two main reasons for entering partnerships to promote heath; a responsibility to work to increase the health of their congregations and communities, the need for resources to do so. A minor finding was that pastors understand and acknowledge the expertise and knowledge of outside health professionals, and see partnerships as a way to access this. The second aim was to understand the outcomes expected by these pastors when they enter such partnerships. Pastors have a different idea about outcomes than do public health professionals. Pastors want resources for their churches, and see obtaining these resources as a satisfactory outcome. A very small minority of the pastors in this study mentioned behavior change or any measurable outcome as an expectation of partnership. The third aim was to determine if there are any specific characteristics common to churches that enter health promotion partnerships. This study found consistencies with existing literature, and made some connections between the work of Karl Weick and the structure of denominations.

The relationship of the Black church to the larger community is changing. Traditionally a fairly, insular, self contained organization, resource scarcity and complex health challenges have driven churches to seek partners to provide services to impact health in their communities. Pastors see churches as a good way to improve health in the Black community, and are willing to partner with public health organizations to achieve this, but their expectations are not really linked to the outcomes that are needed to positively impact health in the African-American community. Pastors need to be included in discussions on health disparities, what is needed to impact health in their communities and how to expand the role of churches as partners.

REFERENCES

Airhihenbuwa, C. O. and L. Liburd (2006). "Eliminating Health Disparities in the African American Population: The Interface of Culture, Gender, and Power." Health Education & Behavior **33**(4): 488-501

American Fact Finder (2010). "US Census Bureau." Retrieved 4/12/12, from http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml.

Ammerman, A., G. Corbie-Smith, et al. (2003). "Research Expectations Among African American Church Leaders in the PRAISE! Project: A Randomized Trial Guided by Community-Based Participatory Research." American Journal of Public Health **93**(10): 1720-1727.

Austin, J. E. (2000). "Strategic Collaboration Between Nonprofits and Business." Nonprofit and Voluntary Sector Quarterly **29**(1): 69-97.

Barnes, P. A. and A. B. Curtis (2009). "National Examination of Partnerships Among Local Health Departments and Faith Communities in the United States." Journal of Public Health Management Practice **15**(3): 253-263.

Bazzoli, G. J., R. Stein, et al. (1997). "Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships." The Milbank Quarterly **75**(4): 533 - 561.

Bazzoli, G. J., R. Stein, et al. (1997). "Public-Private Collaboration in Health and Human Service Delivery: Evidence from
Community Partnerships." The Milbank Quarterly **75**(4): 533-561.

Bloom, J. R., S. L. Stewart, et al. (2013). "Quality of life of Latina and Euro-American women with ductal carcinoma in situ." Psycho-Oncology **22**: 1008–1016.

Braithwaite, R. L., R. J. Taylor, et al., Eds. (2009). Health Issues in the Black Community Jossey-Bass.

Brown, R. K. and R. E. Brown (2003). "Faith and Works: Church-Based Social Capital Resources and African American Political Activism." Social Forces **82**(2): 617-641.

Butterfoss, F. D., R. M. Goodman, et al. (1993). "Community coalitions for prevention and health promotion." Health Education Research **8**(3): 315-330.

Campbell, M. K., et. al. (1999). "Fruit and Vegetable Consumption and Prevention of Cancer: The Black Churches United for Better Health." American Journal of Public Health **89**(9): 1390-1396.

Campbell, M. K., M. A. Hudson, et al. (2006). "Church-Based Health Promotion Interventions: Evidence and Lessons Learned." Annual Review of Public Health.

Campbell, M. K., M. A. Hudson, et al. (2007). "Church-Based Health Promotion Interventions: Evidence and Lessons Learned." Annual Review of Public Health **28** 213–234.

Carnwell, R. and A. Carson (2009). The Concepts of Partnership and Collaboration. Effective Practice in Health, Social Care and Criminal Justice: A Partnership Approach. Wrexham, UK, McGraw - Hill Education. **2:** 312.

CDC Health Disparities & Inequalities Report (2013). CDC Health Disparities & Inequalities Report (CHDIR). Morbidity and Mortality Weekly Report (MMWR),, Centers for Disease Control (CDC). **Vol. 62, Supplement No. 3:** pg. 1-187.

Chatters, L. M., J. S. Levin, et al. (1998). "Public Health and Education in Faith Communities." Health Education & Behavior **25**(6): 689-699.

Chatters, L. M., PhD, J. S. Levine, PhD, MPH, et al. (1998). "Public Health and Health Education in Faith Communities." Health Education & Behavior **25**(6): 689-699.

Chaves, M. (1999). "Religious Congregations and Welfare Reform: Who Will Take Advantage of "Charitable
Choice"?" American Sociological Review **64**(6): 836-846.

Chaves, M. and W. Tsitsos (2001). "Congregations and Social Services: What They Do, How They Do It, and with Whom." Nonprofit and Voluntary Sector Quarterly **30**(4): 660-683.

Cnaan, R. A. and S. C. Boddie (2002). "Charitable Choice and Faith-Based Welfare: A Call for Social Work." Social Work **47**(3): 224-235.

Davis-Carroll, H. R. (2005). Power in the Pews. Faith-Based Initiatives, Tennessee Department of Health.

Davis-Carroll, H. R. (2005). "Power in the Pews." Tennessee Department of Health, Faith-Based Initiatives. from www2.state.tn.us/health/faith.

DeHaven, M. J., I. B. Hunter, et al. (2004). "Health Programs in Faith-Based Organizations: Are They Effective?" American Journal of Public Health **94**(6): 1030-1036.

Denzin, N. K. and Y. S. Lincoln (2003). Strategies of Qualitative Inquiry. Thousand Oaks, CA, Sage Publications, Inc.

DiMaggio, P. (1998). The Relevance of Organization Theory to the Study of Relgion. Sacred Companies: Organizational Aspects of Relgion and Religious Organizations
N. J. Demerath III, P. D. Hall, T. Schmitt and R. H. Williams. New York, Oxford University Press**:** 7-23.

Duan, N., S. A. Fox, et al. (2000). "Maintaining Mammography Adherence Through Telephone Counseling in a Church-Based Trial." American Journal of Public Health **90**(9).

Elkin, C. H. and E. C. Roehlkepartain (1992). "The Faith Factor: What Role Can Churches Play in At-Risk Prevention?" Source Newsletter.

Ellison, C. G. and L. K. George (1994). "Religious Involvement, Social Ties, and Social Support in a Southeastern Community." Journal for the Scientific Study of Religion **33**(1): 46-61.

Eng, E., DrPH, J. Hatch, DrPH, et al. (1985). "Instutionalizing Social Support Theory Through the Church and Into the Community." Health Education Quarterly **12**(1): 81-92.

Eng, E., J. Hatch, et al. (1985). "Institutionalizing Social Support Through the Church and into the Community." Health Education & Behavior **12**(1): 81-92.

Fernandes-Taylor, S. and J. Bloom (2010). The Effect of Socio-Economic Status on Cancer. Handbook of Psycho-Oncology, Springer.

Gajda, R. (2004). "Utilizing Collaboration Theory to Evaluate Strategic Alliances." American Journal of Evaluation **25**(65).

George, L. K., C. G. Ellison, et al. (2002). "Explaining the Relationships Between Religious Involvement and Health." Psychological Inquiry **13**(3): 190–200.

Goldmon, M. V. and J. T. Roberson (2004). "Churches, Academic Institutions, and Public Health: Partnerships to Eliminate Health Disparities." North Carolina Medical Journal **65**(6): 368-372.

Gouldner, A. W. (1960). "The Norm of Reciprocity: A Preliminary Statement." American Sociological Review **25**(2): 161-178.

Gray, B. (1989). Collaborating: Finding Common Ground for Mulitparty Problems.

Gray, B. and D. J. Wood (1991). "Collaborative Alliances: Moving from Practice to Theory." The Journal of Applies Behavioral Science **27**(1): 3-22.

Gray, B. and D. J. Wood (1991). "Collaborative Alliances: Moving from Practice to Theory." The Journal of Applied Behavioral Science **27**(3).

Haider, M. and G. L. Kreps (2004). "Forty Years of Diffusion of Innovations: Utility and Value in Public Health." Journal of Health Communication: International Perspectives **9:S1**: 3-11.

Hale, D. W. and R. G. Bennett (2003). "Addressing Health Needs of an Aging Society Through Medical–Religious Partnerships: What Do Clergy and Laity Think?" The Gerontologist **43**(6): 925-930.

Hampton, R. L., T. P. Gullotta, et al., Eds. (2010). Handbook of African American Health. New York, NY, The Guilford Press.

Healthy People 2020 framework (2014). from http://www.healthypeople.gov/.

House, W. (2001). Unlevel Playing Field: Barriers to Participation by Faith-Based and Community Organizations in Federal ocial Service Programs. Washington, DC, White House Office of Faith-Based and Community Initiatives.

Israel, B. A., A. J. Schulz, et al. (1998). "Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health." Annual Review of Public Health **19**: 173-202.

Jun, S. P. and G. M. Armstrong (1997). "The bases of power in churches: An analysis from a resource dependence perspective." The Social Science Journal **34**(2): 105-130

Kolm, S.-C. (2006). Reciprocity: Its Scope, Rationales, and Consequences Handbook of the Economics of Giving, Altruism and Reciprocity. S.-C. Kolm and J. M. Ythier, North Holland. **Amsterdam:** 371-539.

Kotecki, C. N. (2002). "Developing a Health Promotion Program for Faith-Based Communities " Holistic Nursing Practice **16**(3): 61-96.

Kreuter, M. W., PhD, N. A. Leazin, MPPM, et al. (2000). "Evaluating Community-Based Collaborative Mechanisms: Implications for Practiioners." Health Promotion Practice **1**(1): 49-63.

Lasater, T. M., D. M. Becker, et al. (1997). "Synthesis of Findings and Issues from Religious-Based Cardiovascular Disease Prevention Trials." Annuals of Epidemiology **7**(S7): S46-S53.

Lasater, T. M., PhD., D. M. S. Becker, MPH, et al. (1997). "Synthesis of Findings and Issues from Religious-Based Cardiovascular Disease Prevention Trials." Annuals of Epidemiology **7**(S7): S46-S53.

Lasater, T. M., B. L. Wells, et al. (1986). "The Role of Churches in Disease Prevention Research Studies." Public Health Reports **101**(2): 125-131.

Lasker, R. D., MD, E. S. Weiss, PhD, et al. (2001). "Promoting Collaborations that Promote Health." Education for Health **14**(2): 10.

Lasker, R. D., E. S. Weiss, et al. (2001). "Parnership Synergy: A Practical Framework for Studying and Strengthening the Collaborative Advantage." The Milbank Quarterly **79**(2): 179-205.

Lasker, R. D., E. S. Weiss, et al. (2001). "Promoting Collaborations that Improve Health." Education for Health **14**(2): 163-172.

Levin, J. S. (1984). "The Role of the Black Church in Community Medicine " Journal of the National Medical Association **76**(5).

Levin, J. S. (1986). "Roles for the Black Pastor in Preventive Medicine." Pastoral Psychology **35**(2): 94-103.

Levine, S. and P. E. White (1961). "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships." Administrative Science Quarterly **5**(4): 583-601.

Levine, S. and P. E. White (1961). "Exchange as a Conceptual Framework for the Study of Interorganizational Rlationships." Administrative Science Quarterly **5**(4): 583-601.

Lincoln, C. E. and L. H. Mamiya (1990). The Black Church in the African American Experience, Duke University Press.

Lincoln, J. R. and K. McBride (1985). "Resources, Homophily, and Dependence: Organizational Attributes and Asymmetric Ties in Human Service Networks." Social Science Research **14**: 1-30.

Livingston, I. L., Ed. (2004). Praeger Handbook of Black American Health. Westport, CT, Praeger Publishers.

Logsdon, J. M. (1991). "Interests and Interdependence in the Formation of Social Problem-Solving Collaborations." The Journal of Applied Behavioral Science **27** (23): 23-37.

Markens, S., S. A. Fox, et al. (2002). "Role of Black Churches in Health Promotion Programs: Lessons From the Los Angeles Mammography Promotion in Churches Program." American Journal of Public Health **92**(5).

Marshall, C. and G. B. Rossman (1999). Designing Qualitative Research. Thousand oaks, CA, Sage Publications.

Mattessich, P. W. and B. R. Monsey (1992). Collaboration: What Makes it Work A Review of Research Literature in Factors Influencing Successful Collaboration. St. Paul, Minnesota, Amherst H. Wilder Foundation.

Mays, V. M., S. D. Cochran, et al. (2007). "Race, Race-Based Discrimination, and Health Outcomes Among African Americans." Annual Review of Psychology **58**: 201–225.

McCullough, M. E., W. T. Hoyt, et al. (2000). "Religious Involvement and Mortality: A Meta-Analytic Review." Health Psychology **19**(3): 211-222.

McLeroy, K. R., D. Bibeau, et al. (1988). "An Ecological Perspective on Health Promotion Programs." Health Education & Behavior **15**(4): 351-377.

Meister, J. S. and J. G. de Zapien (2005). "Bringing Health Policy Issues Front and Center in the Community: Expanding the Role of Community Health Coalitions." Preventing Chronic Disease **2**(1).

Meyer, J. W. and B. Rowan (1977). "Institutionalized Organizations: Formal Structure as Myth and Ceremony." American Journal of Sociology **83**(2): 340-363.

Meyers, W. H. (1994). God's Yes Was Louder Than My No: Rethinking the African American Call to Ministry. Grand Rapids, Michigan, William B. Eerdmans Publishing Company.

Miller, J. T. (1987). " Wellness programs through the church: Available alternative for health education." Health Values **11**(5): 3-6.

Miller, J. T., EdD (1987). "Wellness Programs Through the Church: Available Alternative for Health Education." Health Values **11**(5): 3-6.

Mitchell, S. M. and S. M. Shortell (2000). "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice." The Milbank Quarterly **78**(2): 241-289.

Molm, L. D., J. L. Collett, et al. (2007). "Building Solidarity through Generalized Exchange: A Theory of Reciprocity." American Journal of Sociology **113**(1): 205-242.

Morse, J. M. (1995). "The Significance of Saturation." Qualitative Health Research(5): 147-149.

National Institutes of Health. from http://search.nih.gov/.

Newport, F. (2006, November 29, 2006). "Religion Most Important to Blacks, Women, and Older Americans." from http://www.gallup.com/poll/25585/Religion-Most-Important-Blacks-Women-Older-Americans.aspx.

Nunn, A., A. Cornwall, et al. (2012). "Keeping the Faith: African American Faith Leaders' Perspectives and Recommendations for Reducing Racial Disparities in HIV/AIDS Infection." PLoS ONE **7**(5).

O'Reilly, M. and N. Parker (2012). "'Unsatisfactory Saturation': a critical exploration of the notion of saturated sample sizes in qualitative research." Qualitative Research **13** (2): 190-197.

Oldenburg, B. and K. Glanz (2008). Diffusion of Innovations. Health Behavior and Health Education Theory, Research, and Practice. San Francisco, CA, Jossey-Bass**:** 313-333.

Olson, L. M., J. Reis, et al. (1988). "The Religious Community as a Partner in Health Care." Journal of Community Health **13**(4).

Oman, D. and C. E. Thoresen (2005). Do Religion and Spirituality Influence Health? Handbook of the Psychology of Religion and Spirituality. R. F. Paloutzian and C. L. Park. New York, The Guilford Press**:** 435 - 459.

Patton, M. Q. (2002). Qualitative Research and Evaluation Methods. Thousand Oaks, CA, Sage Publications.

Pfeffer, J. (1981). Power in Organizations. London, Pitman Publishing Inc.

Pfeffer, J. and G. Salancik (2003). The External Control of Organizations: A Resource Perspective. Stanford, CA, Stanford Business Books.

Pfeffer, J. and G. R. Salancik (1978). The External Control of Organizations: A Resource Perspective. . Stanford, CA,], Stanford Business Books.

Pinn, A. B. (2002). The Black Church in the Post-Civil Rights Era. Maryknoll, NY, Orbis Books.

Powell, L. H., L. Shahabi, et al. (2003). "Religion and Spirituality Linkages to Physical Health." American Psychologist **58**(1): 36-52.

Rausch, J. S. (1998). "Developing Communities." The Newsletter of the Brushy Fork Institute **8**(3): 1-4.

Rodriguez, E. M., J. V. Bowie, et al. (2009). "A qualitative exploration of the community partner experience in a faith-based breast cancer educational intervention." Health Education Research **24**(5): 760–771.

Rogers, E. (2003). The Diffusion of Innovations. New York, The Free Press.

Roof, W. C. and W. McKinney (1987). American mainline Religion, Rutgers University Press.

Sahgal, N. and G. Smith (2008, Janyary 30, 2009). "A Religious Portrait of African-Americans." from http://www.pewforum.org/a-religious-portrait-of-african-americans.aspx.

Scott, J. D. (2003). The Scope and Scale of Faith-Based Social Services, The Roundtable on Religion and Social Welfare Policy**:** 88.

Scutchfield, D. F. and W. C. Keck (2003). Principles of Public Health Practice. Clifton Park, NY, Thomson Delmar Learning.

Simpson, M. R. and M. G. King (1999). ""God Brought All These Churches Together": Issues in Developing Religion-Health Partnerships in an Appalachian Community." Public Health Nursing **16**(1): 41-49.

Smedley, B. D., A. Y. Stith, et al. (2003). Unequal treatment, Institutes of Medicine.

Sternberg, Z., F. E. Munschauer, et al. (2007). "Faith-placed cardiovascular health promotion: a framework for contextual and organizational factors underlying program success." Health Education Research **22**(5): 619-629.

Sternberg, Z., F. E. Munschauer III, et al. (2006). "Faith-Placed Cardiovascular Helath Promotion: a Framework for Contextual and Organizarional Factors Underlying Program Success." Health Education Research: 11.

Strauss, A. and J. Corbin (1998). Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory. Thousand Oaks, Sage.

Streiner, D. L., D. W. MacPherson, et al. (2011). Public Health. Shelton, CT, Peopel's Medical Publishing House.

Sutherland, M., Ed.D., MPH, CHES, C. D. Hale, EdD., CHES, et al. (1995). "Community Health Promotion: The Church as Partner." The Journal of Primary Prevention **16**(2): 201-216.

Sutherland, M., C. D. Hale, et al. (1995). "Community Health Promotion: The Church as Partner." The Journal of Primary Prevention **16**(2).

Taylor, R. J. and L. M. Chatters (1988). "Church Members as a Source of Informal Social Support." Review of Religious Research **30**(2): 193-203.

Taylor, R. J., M. C. Thornton, et al. (1987). "Black Americans' Perception of the Sociohistorical Role of the Church." Journal of Black Studies **18**(2): 123-138.

Thomas, D. R. (2006). "A General Inductive Approach for Analyzing Qualitative Evaluation Data." American Journal of Evaluation, Vol. No. , **27**(2): 237-246.

Thomas, S. B., S. C. Quinn, et al. (1994). "The Characteristics of Northern Black Churches with Community Health Outreach Programs." American Journal of Public Health **84,**(4): 575-579.

Tuckett, A. (2004). "Qualitative research sampling-the very real complexities. ." Nurse Researcher **12**(1): 47-61.

Tulchinsky, T. H. and E. A. Varavikova (2009). A History of Public Health. The New Public Health, Second Edition: An Introduction for the 21st Century. Burlington, MA, Elsevier**:** 1-32.

Turncock, B. J. (2012). Essentials of Public Health. Sudbury, MA, Jones and Bartlett Learning.

Turncock, B. J. (2012). Public Health What It Is and How It Works. Burlington, MA, Jones and Bartlett Learning.

Turner, D. W. (2010). "Qualitative Interview Design: A Practical Guide for Novice Investigators." The Qualitative Report **15(**3): 754-760.

Ulin, P. R., E. T. Robinson, et al. (2005). Qualitative Methods in Public Health A field Gude for Applied Research. San Francisco, CA, Jossey-Bass.

Valente, T. W. and R. L. Davis (1999). "Accelerating the Diffusion of Innovations Using Opinion Leaders." The Annals of the American Academy of Political and Social Science (556): 55-67.

Vidal, A. C. (2001). Faith-Based Organizations in Community Development. Washington, DC, U. S. Department of Housing and Community Development Office of Policy Development and Research.

Viruell-Fuentes, E. A., P. Y. Miranda, et al. (2012). "More than culture: Structural racism, intersectionality theory, and immigrant health." Social Science & Medicine **75**: 2099-2106.

Waston, D. W., L. Bisesi, et al. (2003). "The Role of Small and Medium-Sized African-American Churches in Promoting Healthy Life Styles." Journal of Religion and Health **42**(3).

Weber, L. and M. E. Fore (2007). Race, Ethnicity, and Health: An Intersectional Approach. Handbook of the Sociology of Racial and Ethnic Relations. H. Vera and J. R. Feagin. New Your, New York, Springet Science**:** 191-216.

Weick, K. E. (1976). "Findings showed that RDT is a useful starting point, but is limited, given the unique nature of the various organizational structures with thin the Black church." Administrative Science Quarterly **21**(1): 1-19.

Weiss, E. S., R. M. Anderson, et al. (2002). "Making the Most of Collaboration: Exploring the Relationship Between Partnership Synergy and Partnership Functioning." Health Education & Behavior **29**(683).

Wejnert, B. (2002). "Integrating Models of Diffusion of Innovations: A Conceptual Framework." Annual Review of Sociology **28**: 297-326.

White, J. A. and G. Wehlage (1995). "Community Collaboration: If It Is Such a Good Idea, Why Is It so Hard to Do?" Educational Evaluation and Policy Analysis **17**(1): 23-38.

Williams, D. R. and P. B. Jackson (2005). "Social Sources Of Racial Disparities In Health." Health Affairs **24**(2): 325-334.

Wood, D. J. and B. Gray (1991). "Toward a Comprehensive Theory of Collaboration." Journal of Applied Behavioral Science **27**(139).

Yeon Choo, H. and M. Marx Ferree (2010). "Practicing Intersectionality in Sociological Research: A critical Analysis of Inclusions, Interactions in the Study of Inequalities." Sociological Theory, Volume , Issue , pages , **28**(2): 129-149.

Zahner, S. J. (2005). "Local Public Health System Partnerships " Public Health Reports **120**(January - February 2005): 76-83.

Zhang, Y. and B. M. Wildemuth (2009). "Qualitative Analysis of Content."

APPENDICES

Appendix A – Interview guide, Version 1

Lead Investigator: Monica D. Allen, MPH
Protocol Title: **Exploring Motivations and Expectations of Churches in Public Health Partnerships**

Interview Guide (Semi-structured)

[Review survey, if completed, clarify any unclear answers, ask any appropriate questions. -- Explain purpose of research. Give written information to key informant for reference.]

Do you have any questions for me before we begin?

[Begin audiotaping]

Thank you for agreeing to participate in this research study about collaboration between churches and public health organizations. You are free to not answer any questions or end the interview at any time.

As Needed - *You have said on your survey that your church engages in multiple health activities. What is the primary reason for your church's involvement in health promotion activates?*

Now I'd like to talk about the concept of partnership between public health and churches to provide health programs. Is your church currently involved in a health-related collaboration?

Partnering –
Type of organization partnering with
( ) Hospital ( ) Community Clinic ( ) Local Health Department

Why was this partnership originally formed?
___ To address a need in the congregation
___ To address a need in the community
___ To expand services to congregation
___ To increase the church's presence community
___ Don't know
___ Other (Please describe): _____

Who initiated the formation of this partnership?

___Church ___Partner Organization

___Other _____

Is the partnership ongoing or on a project-specific basis?

_____

How did you determine which organization(s) you would collaborate with?

How was that decision made to enter into partnership for health promotion activities?

___ Pastor
___ Other Church Leader (specify position) _____
___ Denomination leadership
___ Congregation
___ Other (*please specify*) _____

Tell me how important you think it is organizations you partner with have compatible spiritual beliefs?

Is this partnership project-specific, or conducted on an on-going basis?

How long has this partnership been in existence?

___ Less than 2 years
___ From 2 to 3 years
___ More than 3 years but less than 5 years
___ Five years or longer
___ Don't know

In what types of activities has this partnership been engaged?

___ Community health education
___ Congregation health education
___ Health promotion program development
___ Health promotion program implementation
___ Other *(please specify)* _____

What does the organization you collaborate with contribute to the partnership activities?

___ Financial resources
___Staff time
___ Staff for programs
___ Recruitment of program participants from congregation
___ Recruitment of program participants from community
___ Program planning

___ Presenters for program
___ Other _____

What does your church contribute to the partnership activities?

___ Financial resources
___Staff time
___ Staff for programs
___ Recruitment of program participants from congregation
___ Recruitment of program participants from community
___ Program planning
___ Presenters for program
___ Other _____

Does your denomination contribute support to this partnership?

___ Yes ___ No ___ Don't know

If yes: *what support?*

_____

Now, I'd like to talk about the concept of community, and church responsibility for its community. You have indicated that you believe your community to be _____. How does your partnership enhance your ability to provide the services to your community?

___ Provides extra money
___ Provides training and materials to church
___ Provides training and materials to community
___ Provides entire program
___ Other _____

How did you and your collaborative partner reach agreement on program goals?

_____

What did you expect from this partnership when you entered it?

_____
___

How successful do you feel this partnership is, overall?

___ Very successful
___ Generally successful
___ Somewhat unsuccessful
___ Very unsuccessful

As needed - *What do you think would make the partnership more successful?*

Do you and/or your partner measure and document the outcomes of your programs or health promotion activities?

___Yes ___No

If so, who is primarily responsible for documenting program outcomes?

___Church ___Partner

___Other _____

How are outcomes documented?

Non-Partnering –

Is there a specific reason that your church has not entered a partnership with a public health organization?

___No opportunity
___No infrastructure
___No interest

___Other_____

[Probe about rationale, philosophy, other]

Is there any other information that you feel is important for public health professionals to know in working with churches to provide health programs to diverse communities in the United States?

Do you have any questions for me?

Thank you for taking the time to participate in this interview. If you have any questions or concerns, please do not hesitate to contact me, my Faculty Advisor, or CPHS at UCB.

[End audiotaping]

Appendix B – Interview guide, Version 2

Lead Investigator: Monica D. Allen, MPH
Protocol Title: **Exploring Motivations and Expectations of Churches in Public Health Partnerships**

Interview Guide (Semi-structured)

[Explain purpose of research. Have participant sign written consent. Give copy for reference.]

Do you have any questions for me before we begin?

[Begin audiotaping]

Thank you for agreeing to participate in this research study about churches and public health. You are free to not answer any questions or end the interview at any time.

Tell me how you came to be in ministry?
[Probe about calling, need to help people, philosophies about religion]

What are the basic beliefs of your denomination; how is it different from other denominations?

What do you think are the most pressing issues facing you in your ministry?

In your opinion, is there relationship between religion and health?
[Probe about physical and spiritual concepts, body, as temple, caring for selves in this life vs. eternal life]

Do you feel that it is important for the church to be involved in the health of its members?
[Probe about health activities vs. proselytizing]

Does your church conduct any health-related activities? Tell me about them.

One important concept in public health is community. How do you define ' community?'

Do you feel there is a role for the church to the health of its community?

Describe how you think public health and churches should work together.

Have you reached out to anyone outside the church to provide health-related activities to your members and/or community? Tell me how this works?

[Probe about joint activities, expectations, outcomes]

How was the decision made to enter into partnership for health promotion activities?

[Probe about partnership formation]

Tell me how important you think it is organizations you partner with have compatible spiritual beliefs?

Do you consider this partnership to be successful?

[If yes, probe about factors contributing to success. If no, probe about what is lacking]

What would encourage you to consider entering a partnership to conduct health activities?

What would be prohibitive?

Is there any other information that you feel is important for public health professionals to know in working with churches to provide health programs to diverse communities in the United States?

Before we finish, I want to ask you to participate in the second part of this research, which is a survey to collect some statistical information that is also important to this research.

[Provide copy of survey]

Do you have any questions for me?

Thank you for taking the time to participate in this interview. If you have any questions or concerns, please do not hesitate to contact me, my Faculty Advisor, or CPHS at UCB.

[End audiotaping]