



Pastors' Influence on Research-based Health Programs in Church Settings

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Abstract

Churches, in the United States, are recognized essential players in addressing our mounting health and social service needs. Yet, even though they implement a relatively large number of programs, few are research-based. Focus groups were conducted with pastors from 11 Baptist churches in a small Southeastern town to explore factors that influence the implementation of research-based health programs. Transcripts were coded for domains resulting in four themes: congregant needs, shared programming ethics, common understanding of programming processes, and care for the church and congregation. Pastors value research and seek church-based programs that enhance the health of congregants. Yet, future study must focus on how to create and maintain strong formal networks that help them to meet this goal.

Keywords

African Americans; Church; Church – Authority; Health education – Religious aspects – Christianity; Health programs; Health promotion; Health promotion partnerships; Medicine – Religious aspects; Pastors; Religious leaders Research; Southern States

Cover Page Footnote

The author is grateful for the participation of the Anderson County South Carolina Baptist churches and pastors who contributed to the study and the Clemson University, School of Nursing, Mary Lohr Research Award for funding this project.

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ABSTRACT

Churches, in the United States, are recognized essential players in addressing our mounting health and social service needs. Yet, even though they implement a relatively large number of programs, few are research-based. Focus groups were conducted with pastors from 11 Baptist churches in a small Southeastern town to explore factors that influence the implementation of research-based health programs. Transcripts were coded for domains resulting in four themes: congregant needs, shared programming ethics, common understanding of programming processes, and care for the church and congregation. Pastors value research and seek church-based programs that enhance the health of congregants. Yet, future study must focus on how to create and maintain strong formal networks that help them to meet this goal.

Key Words: research, church, health programs, African Americans, pastors, health promotion partnerships

INTRODUCTION

Over the past 10 years, churches in the United States (US) have been recognized as unique and essential players in helping to address our nation's mounting health and social service needs (Gilgoff, 2008). From President Bush's charitable choice legislation and creation of the former Office of Faith-based and Community Initiatives to the current President Barack Obama administration's Office of Faith-based and Neighborhood Partnerships, the desire for churches to implement programs that work is explicit (Winneburg, Coleman, Boddie, & Cnaan, 2008; DiIulio, 2004). This appeal is especially important for churches comprised of at-risk African American congregants whose current overall death rate (1,016) is comparable to that of Caucasians (1,012) 30 years ago (Williams & Jackson, 2005; US Department of Health and Human Services, 2008).

Not only is there a difference in the overall death rate of African Americans and Caucasians, but risk factors, incidence, and morbidity rates of leading causes of death (heart disease, cancer, stroke, respiratory disease, accidents, diabetes) are often greater for African Americans (Frist, 2005; Centers for Disease Control and Prevention [CDC], 2005; Morbidity Mortality Weekly Report, 2005). At the same time, many African Americans view the church as a respected, typical, every-day setting where they express religious faith as well as seek direction (Campbell, Resnicow, Carr, Wang, & Williams,

2007; Hatcher, Burley, & Lee-Ouga, 2008). Yet, although church-based health programs target a significant number of medically underserved African Americans, determination of the usefulness of these programs is severely limited causing some to question the worth of faith-based programs (DeHaven, Hunter, Wilder, Walton, & Berry, 2004; Hatcher et al., 2008).

Description of the Problem

Historically, African Americans view the church as a powerful community institution with pastors as respected gatekeepers for all activities that occur within it (Baruth, Wilcox, Laken, Bopp, & Saunders, 2008; Markens, Fox, Taub, & Gilbert, 2002). Pastors also influence others (deacons, health ministry volunteers, faith community nurses) who can advocate for specific programs that are implemented (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Young & Stewart, 2006) including those that focus on health. Yet, many programs implemented lack process and outcome evaluation and even fewer are research-based (DeHaven et al., 2004). Research-based programs are those shown to be effective through scientific methods, including case reports, expert opinion, or integration of best evidence (Milton, 2007; Porche, 2004). No studies were found that described pastors' perceptions about the relevance of research to health programs that target congregants or how to better collaborate with researchers on how to implement these activities. We need to discover how to implement successful research-based health programs within settings that are important to populations targeted (Glasgow, Lichtenstein, & Marcus, 2003). In addition, there is a need to understand all factors that affect health programming within churches in the hope that we can better identify and minimize barriers to those that work.

Purpose

This study investigated pastors' perceptions about research and health promotion programs within churches. Two questions were addressed: 1) what are pastors' attitudes and beliefs about factors that influence research-based health programming and 2) what are pastors' attitudes and beliefs about the role churches play in this effort.

METHODS

Design

Focus groups were used as a qualitative methodology to address the study questions. This methodology afforded respondents the opportunity to provide information about their feelings through group interviews that generated interactive brainstorming. Semi-structured interviews are useful for uncovering concepts and providing descriptive information about phenomena (Krueger, 2000). Respondents were free to talk with others and shape their thoughts based upon collective dialogue. Having the opportunity to listen to others, who share a common experience, helps to stimulate memories, ideas, and experiences with the intent to discover all views about the topic. Focus group methodology was selected for this exploratory study since it is concerned with identifying and describing concepts versus measuring them.

In addition, group interviews allowed trust between the group facilitator and respondents to be strengthened (Krueger, 2000). Although all of the respondents knew the facilitator, the informality of the interviews helped to build this relationship. The facilitator is a member of the same Baptist Association as the participants and has been invited to present a number of health ministry related educational sessions to their congregations in the past.

Sample

Prospective respondents were identified using the most current database (yellowpages.com) of all churches (103) in one South Carolina (SC) county (Anderson). All were members of their respective Baptist Association (Seneca, Rocky River), thereby assuming a common mission relative to this religious denomination. Baptist was selected since it constitutes the largest African American membership in the state.

A purposive sample of 18 churches was selected and their pastors recruited using inclusion criteria: a) African American, b) English speaking, c) SC resident, and d) majority African American congregation. Churches with larger congregations were prioritized, as it was known from published and unpublished literature that larger organizations are more likely to implement health programs and activities (Reid, Hatch, & Parish, 2003). A study informational letter was addressed and mailed to the primary pastor of each church. Volunteers responded by telephone, were thanked for their willingness to participate, and provided the schedule for the two focus groups. All were later contacted by telephone and reminded of the scheduled session at 40 and 24 hours prior to each. The goal was to recruit 6 to 8 participants for each group. However, due to “no-shows,” seven participated in group one and four in group two.

Data Collection

The Clemson University Institutional Review Board (IRB) approved the study prior to obtaining consent. The principal investigator facilitated each group with the intent to explore views on the role of research and health programming in church-based settings. Data were collected at a community center over a 6-week period as enough participants per focus group were recruited. Each interview lasted 2-hours and followed a semi-structured guide (see Table 1) comprised of seven primary items. Groups were homogeneous enough to allow for open discussion as all consisted of African American men who were leaders within the same community.

Table 1. Semi-structured Interview Guide Questions

1. What comes to mind when you consider the role of the church in providing quality health programs to its members?
 2. Think about the tools that are crucial to implementing effective health programs and describe them.
 3. What comes to mind when you think about research in relation to health programs implemented within your church?
 4. What comes to mind when you think about the evaluation of health programs implemented within your church?
 5. What comes to mind when you think about making decisions to implement health programs within your church?
 6. Describe any barriers to evaluating health programs implemented or disseminated within the church.
 7. What comes to mind when you think about consequences to conducting health research involving your congregation as subjects?
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The interview guide included open-ended questions followed by more specific ones used to clarify and generate new information (Krueger, 2000). Positive questions were posed before negative ones to encourage “light” conversation and a free-flow of ideas. Questions were asked with the aim to generate all possible responses and ended when saturation or no new ideas and thoughts were being discussed (Strauss & Corbin, 1998). All interviews were tape-recorded and transcribed verbatim.

A 43-item questionnaire was also used to collect demographic information about respondents (e.g., age, education, income) and their churches (e.g., age of facility, ownership status of building, number of paid staff). At the conclusion of interviews, informants were thanked for participating, provided a \$25 gift certificate from a local home improvement store, and informed that a summary of the data would be provided to them for review prior to final analysis.

Data Analysis

Transcripts were analyzed using the constant comparative method to inductively review, code, and categorize data within themes (Hewitt-Taylor, 2001). This process began with grouping initial observations (data) into codes based on the frequency, intensity, and consistency of supporting observations. Grouping continuously fed back into the data collection and coding process based upon similarities of observations. In this way, analysis occurred in an iterative fashion and allowed observations to be constantly compared with previous ones (Hewitt-Taylor). Codes were then labeled as domains and presented in relation to their most representative theme.

Care was taken to make judgments only about observations that were significant and meaningful to the aim of the study ensuring that codes and themes emerged out of the data (Strauss & Corbin, 1998). Themes were revisited (after initial coding) until it was clear that no new ones had emerged. Finally, representative quotes were selected as an audit trail to demonstrate how the domains and themes evolved from the data. Respondents were given the opportunity to assess the preliminary analysis for fit with the purpose of the study. In addition, one outside collaborator, a former director of a statewide alliance to engage African American Baptist churches in successful health program ministry reviewed the analysis for relevance.

RESULTS

Sample Characteristics

Over half (57%) of the respondents had completed seminary. They held doctoral (14%), baccalaureate (59%), and associate (28%) degrees and annual income levels ranged from \$25,000 to \$75,000 with number of weekly hours worked ranging from 10 to 60. Participants’ churches also varied as depicted in Table 2.

Table 2. Characteristics of Churches (n=11)

Characteristic	Range
Congregation Size	151-500
Operating Budget	\$200,001- 400,000
Age of Congregation (years)	51-100
Age of Church Building (years)	21-50
Number of Paid Staff	1- 4

Results are presented using ten overlapping and interrelated domains--each represented within four themes (see Table 3). Implementation of research-based programs within churches was contingent upon the degree to which programs reflect: a) congregant needs, b) shared programming ethics, c) a common understanding (by pastors and researchers) of research and program evaluation processes, and d) care for the church and congregants.

Table 3. Factors that Affect Research-based Programs in Churches

Themes	Domains
I. Congregant Needs	1. Health Promotion 2. Non-intrusiveness
II. Shared Programming Ethics	1. Credibility 2. Culture of Program Personnel 3. Financial and Human Resources 4. Disclosure of Program Motives
III. Common Understanding of Programming Processes	1. Interpretation of Research 2. Interpretation of Program Evaluation
IV. Care for the Church and Congregation	1. Advocate for Health 2. Protection: Censorship and Privacy

Congregant Needs

Participants expressed the need to meet congregants' needs when asked about the kinds of research-based programs that the church was more likely to endorse and maintain. They valued activities that address problems actually experienced by its members and prioritized a focus on health promotion and adopting healthy lifestyles. Respondents believed that many African Americans are overburdened with illness and at extreme risk for disease, sickness, and overall poor quality of life. They believed that the high prevalence of illnesses (e.g., diabetes, cancer, hypertension) among congregants is due to long-term lifestyle habits that contribute to "overweight, high blood pressure, and stress." One person summarized: "We have folks still saying, 'you know I've done this all my life'...you have a time getting through to some of those folks...say you need to change that lifestyle...that's probably part of what we also need to be doing because no matter what numbers we have, they're going to start diminishing because folks are not living well." Unhealthy habits were believed to be due, in part, to financial stress. One person added, "I think one of the things that we're facing is serious in our congregation, is people are living but they don't have any quality of life... many can't even afford health insurance."

Respondents believed that congregants lacked basic knowledge about the signs and symptoms of disease and that this deficit significantly contributes to unhealthy behaviors. They prioritized activities that increase knowledge: "Education, education, education," as stated by one person.

Informants also described the act of 'testimony' as a valuable health promotion tool for congregants. For example, when church members become aware of another's illness experience through testimony about how the ill person 'came through,' 'overcame,' and/or lived with the illness, better health could be had by all. Testimony was thought to foster spiritual and emotional fortitude, as stated by one respondent: "90% of the persons who had cancer, admitted, and took pride in testifying to that." Finally, initiatives not suited to congregants' needs were described as non-sustainable: "They will start up, maybe get your people excited or get your people focused and then it fizzles out."

Non-intrusiveness

Participants favored programs that are not overly taxing on congregants' time and involvement or that interfere with the church's routine schedule of services. When questioned about the level of involvement in research that would be endorsed by the church, one person indicated: "It depends on how deep you ask them to participate; if you ask them to complete a general survey, yes; I think most congregations would answer that for you...but, if you ask me to physically take part in something, I think you're going to find, no." Respondents stressed that usually, research requires a large time commitment. They noted: "Sometimes things will come through...some health initiatives...they're too intrusive; you can't do that from a church because the church has its limitations just like everyone else."

Credibility

Participants valued implementing programs that had already been researched or tested. Replicated interventions were believed to be much more credible than untested ones which were deemed to not be in the best interest of the church: "If someone is coming in our church to say we're going to have a research to see if we can help your church 'do such and such'... and we're guaranteed that something is going to get done as a result of this study, then yes; but research to see if we can do it probably won't happen because nothing is guaranteed." When asked further about this concern, respondents expressed disdain for the possibility that congregants might be "used as guinea pigs." Almost simultaneously, they all recalled the US Public Health Service Syphilis Study wherein unethical treatment was administered to African American male subjects during the 1930s (Feldshuh, 1993).

Respondents expressed deep concern about the negative impact that 'non-credible' programs have on the church. All feared that these programs jeopardize confidence in the church as well as its leadership: "If the information given to the people is not accurate, is misleading, or if the intent of the people that are coming is bad, the consequences could be that your ministry loses the credibility to initiate that process again." One person concluded: "That is what most ministers think about--credibility."

Culture of Program Personnel

Program coordinators or initiators who reflect a similar ethnicity or culture to congregants' were valued. Those who were non-members of the church were referred to as outsiders: "It depends on who is doing the research." Respondents believed that program sponsors are more trust-worthy and influential if they share cultural and/or life experiences with the program's target group and are members of the congregation. Still, another participant offered: "I don't think it implies a matter of color, but it's a matter of whom you're representing when you make this presentation to the people."

Financial and Human Resources

Having adequate finances and staff were identified as critical to implementing health programs, especially more resource intensive research-based activities. Respondents agreed: "Money, money, money is the key; so if you want the program to continue, you got to have some type of grant or some type of finance to keep things going." Sufficient funding could also support access to adequate personnel: "Volunteers are good, but volunteers get tired." Qualified staff must be actively involved in programming efforts. Respondents described the need for staff who can work with the church to plan and implement the program from beginning to end. If adequate staff is not available within the church, respondents believed that community partners with whom they trusted could help to meet this void.

Participants also expressed interest in developing the church's capacity to compete for competitive program grants. They viewed access to grant funding as a vehicle for procuring needed program supplies and staff. Several respondents indicated an interest in building the program implementation infrastructure of their churches through 501(c)3, not-for-profit organization status. While some believed that this designation could bolster their chance of being awarded grant funding, others were cautious: "I've even heard the view in a lot of congregations that you don't want to fool with grants because grants give the government the opportunity to come in and see what you are doing." Respondents believed that both benefits and disadvantages to accepting grant funds had to be mediated.

Disclosure of Program Motives

Disclosure of motives underlying research-based programming was identified as critical to it being endorsed by the church, as disclosure helps to avoid untested, unwarranted, activities that 'take advantage of' congregants. Researchers and program coordinators who did not have a sincere intent to solve problems experienced by the church were cited as an example of those who 'take advantage of.' All respondents reiterated: "We gotta put our guard up to keep you from coming in here and fleecing us and taking advantage of us...that's the view in a traditional Baptist church." When asked how program motives could best be relayed, respondents described frequent communication and follow-up, as well as an established relationship with program partners.

Interpretation of Research

When asked about their views on research and church-based programs, all respondents believed that research requires a great deal of skill. They defined research as experimental or testing solutions to determine if they work. All valued this process and perceived it as worthwhile. Yet, no one mentioned non-experimental uses of research. Neither were they confident that adequate safety precautions (human subjects protection) were inherent aspects of the research process. One suspecting person summarized this view: "They have placed things in our community," specifically referring to the prevalence of the human immunodeficiency virus in the African American population. Others concurred with this possibility.

Participants welcomed assistance to understand research and how it could benefit their programming efforts. They offered that not only was research complicated, but that the term is misunderstood: "We assume that people will understand what that means, and I question that." One individual noted: "Sometimes when we're using big terms, we get lost, ourselves." Respondents expressed a desire for church personnel to engage in activities that could help them understand research and increase their comfort with the process. Respondents even suggested that the term (research) be replaced with one less threatening. However, when asked to recommend a more favorable term, they were unable to offer an alternative. They did add that since the term continues to be associated with the US Public Health Service Syphilis Study (Feldshuh, 1993), more time would have to pass before African Americans forget the negative feelings that it currently stirs. One participant summarized: "You can't live that down."

Interpretation of Program Evaluation

When asked about the role of evaluation and church-based programs, participants indicated that all of their programs are evaluated. However, further questioning revealed that their interpretation of evaluation differed from the systematic process of assessing goals, processes, and impacts that normally characterize this process. Instead, respondents viewed evaluation as asking general questions about some aspect of the program. One person clarified: "Evaluation techniques have

been if good people show up...if they enjoy it...would they come back?" Another added: "We pull everybody together and say, what's wrong?"

Along with an informal view of evaluation, respondents conveyed that traditionally, African American church leaders have relied upon verbal versus written evaluation processes. They often consider input offered by program participants to judge the merits of the activity: "Did it work or did it not work?" Respondents believed that their evaluation methods were acceptable and after further discussion, concluded: "There are ways of evaluating that we haven't looked at...there must be some standard...we haven't done all these things all that good to just be doing it; there must be some mechanism that we can point to."

Advocate for Health

Respondents were questioned about the role of the church in implementing research-based programs. They indicted that when environmental factors negatively affect the well-being of congregants whose needs are not being met within the community, the church intercedes. In this way, the church serves as a 'link' between congregant needs and community services: "I advocate for things that people are not receiving and what they should be receiving...whether we're doing it or not doing it as effective as we should is another question." Not only did pastors value their responsibility to church members, they wished to strengthen this role.

Protection: Censorship and Privacy

When considering the implementation of research-based programs, respondents indicated the intent to protect congregants from un-invited censorship. They stated that when the church opens itself to outsiders, it relinquishes a degree of control and exposes itself to scrutiny: "I've even heard the view in a lot of congregations that you don't want to fool with grants, because grants give the government the opportunity to come in and see what you are doing." Respondents believed that generally, African Americans are skeptical about providing too much personal information about themselves due to fear that disclosure can ultimately be used against them. They noted that programs requiring long periods of engagement are also apt to require divulging more information and would likely be met with resistance. One respondent mirrored this view: "There's a very private kind of thing that goes on...some open...but you got some very private, especially an older person."

DISCUSSION

This study used focus groups to engage Baptist pastors in brainstorming about research-based programming within the church. Although an institution of importance to many medically underserved African Americans, the church implements numerous programs that lack demonstration of their benefit. The study uncovered factors (disclosure of program motives, privacy and protection from censorship, shared culture of program personnel) that influence health program outcomes. Findings also provide support for factors documented elsewhere in the literature: health promoting, non-intrusiveness, and credibility status; shared understanding of research and evaluation; and available resources and health advocates. For example, Baruth et al. (2008) identified lack of financial resources, congregant motivation and time, and pastor as role model as key barriers to implementing a church-based study conducted to evaluate a physical activity intervention. Although the study found no significant changes in outcomes, the researchers revealed that church personnel who implemented the research might have needed more training in program implementation than the limited instruction that they received.

In addition, Young and Stewart (2006) tested a 6-month, church-based physical activity intervention that also resulted in no significant changes in outcomes. The researchers revealed that the affiliate pastors refused to allow recruitment of congregants from their organizations without them receiving a guaranteed 'treatment.' As in the current study, pastors were only willing to endorse interventions already tested and deemed reliable versus those that were not.

This study's findings also complement an early, yet seminal study (Markens et al., 2002), that explored pastor-level factors that affect successful recruitment and implementation of community-based health promotion programs in African American churches. Pastors, in the study, affirmed their role as holistic health advocates and caretakers of their congregants. The researchers also found that pastors held an inaccurate understanding of research and were often wary of outsiders who attempt to forge programming partnerships with the church. Yet, participants were willing to override suspicion and welcome community collaborations when health promotion programs were aligned with congregants' needs.

Research-based programs require skill to develop and implement. Since pastors, in this study, embraced assistance to implement successful interventions, partnerships with researchers are likely to influence the quality of their program outcomes (Young & Stewart, 2006; Israel et al., 2006; Savage et al., 2006). Young and Stewart attributed a 30% participant attrition rate (while examining a church-based physical activity intervention) to lack of interest and willingness. The researchers surmised that subjects were lost because of weak collaborations with participating churches that prohibited a sense of ownership by respondents. "Churches were a site to conduct the intervention rather than a true partner in the research process (p. 112)."

Similarly, Israel et al. (2006) espoused the importance of successful partnerships to community-based participatory research (CBPR), a process whereby researchers and community members jointly contribute to research initiatives and that results in stronger outcomes. Not only has CBPR been reported to build capacity for conducting partnership research (Christopher, Gidley, Letiecq, & Smith, 2008), it has also been found to develop social capital which is able, in turn, to improve health outcomes (Michael, Farquahar, Wiggins & Green, 2008). CBPR highlights a potential follow-up to this study: to test interventions that build capacity for researchers and churches to engage in collaborations that produce church-based health programs that work. To this end, strategies for partnership development for research-based health programs in churches are presented (Table 4).

Table 4. Partnership Development for Research-based Health Programs in Churches

1. Recruit pastors to serve on long-term committees (e.g., IRB, project planning) that afford access to knowledge about research and program evaluation.
 2. Involve pastors early in the research/program planning process to facilitate disclosure of program motive and trust with researchers.
 3. Tailor the research/program goal to compliment health promotion needs prioritized by congregants.
 4. Implement research procedures that are efficient and require minimal time commitment by the church and congregants.
 5. Recognize and adapt the research/program to church's assets (e.g., advocate for health) and barriers (e.g., limited finances, staff).
 6. Ensure equitable funding and resource sharing when implementing research/program projects.
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Limitations

The study has a few limitations. First, focus groups were only conducted with Baptist pastors. Therefore, information obtained may be unique to this religious denomination. Since Baptist churches represent the largest African American group in South Carolina, it is possible that this group has more access to resources that shape their endorsement of health programming. Second, all participants were men. This is common since 'pastoring' continues to be a customarily male role. However, women, as traditional caregivers, may have responded differently by giving even more priority to research programs thought to generate superior outcomes. Third, findings are only generalizable to the study sample. Still, a number of concepts and themes were uncovered that addressed the research questions. Similarly, it is not possible to confirm that the group interviews evoked all possible responses. Additional research would strengthen the study by supplementing these results.

CONCLUSIONS

Implementing research-based health programs within churches requires attention to a number of factors: congregant needs, shared programming ethics, having a common understanding (pastors and researchers) of research, and overall concern for the welfare of the church. Attention to these factors can play a critical role toward successful partnerships that help to generate research-based outcomes that work.

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