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College of Education and Human Sciences

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Richard Hayes Johnson

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Walden University
2024

Abstract

African American Rural Pastors’ Perceptions of Collaborations with Public Health Agencies

by

Richard Hayes Johnson

MS, Walden University, 2018

BS, University of North Carolina-Charlotte, 2015

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Education & Promotion

Walden University

May 2024

Abstract

Recent research has suggested that when public health agencies (PHAs) partnered with African American (AA) pastors to deliver and promote health education to their church members, improved health behaviors in the AA community were realized. Recent studies have also shown that collaborations of this nature have yielded increases in health screenings and improvements in disease management, preventative care, and public health outreach. Because most of the previous studies focused on the perceptions of pastors who oversaw churches in urban areas, a need for research focusing on the perceptions of rural pastors was warranted. The purpose of this qualitative phenomenological research study was to explore the perceptions of AA pastors who presided over churches in rural areas regarding their thoughts on collaborating with PHAs to deliver and promote health education to their congregates. Using the theory of planned behavior, the research questions were answered by assessing the study participants' views regarding their (a) attitudes towards collaborations with PHAs, (b) subjective norms towards collaborations with PHAs, and (c) perceived levels of control during collaborations with PHAs. Data were collected through semistructured interviews with eight AA pastors of rural churches. The interviews were analyzed using inductive coding. The results of this study suggested that urban and rural pastors held favorable views of collaborating with PHAs and welcomed partnerships; however, they required a level of pastoral control of messaging. The results of this study could provide PHAs with insight into forming productive partnerships with rural AA pastors to promote healthy behaviors in their communities and thus decrease health disparities.

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Dedication

I dedicate this dissertation to my parents, Isaac and Elizabeth Johnson; my siblings, William, Tee Norlar, Donnie, Rickie, Rosilyn, Arlene, and Veronica; and my daughter, Brittany I. Johnson. I also dedicate this work to two great friends: Conley Glenn, who gave me encouragement over the years, and Anthony Degraffenreidt, who always made time to call and check on me.

Acknowledgments

I would like to take this opportunity to thank God for keeping me in his will and allowing me to complete this academic journey. I would also like to thank all the study participants who helped to make this research possible. To my dissertation Chair, Dr. Judia Yael Malachi and committee member, Dr. Kimberly Brodie, I send a hearty "Thank you" for the support and guidance that you gave. I would also like to thank Dr. Sandra Beaver, URR, and Form and Style Editor, Dan Fleischhacker for their invaluable contributions to my research.

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Table of Contents

List of Tables v

Chapter 1: Introduction to the Study..1

Background 3

Problem Statement 6

Purpose of the Study 8

Research Questions 9

Theoretical Framework 9

Nature of the Study 10

Definition of Terms..11

Assumptions...11

Scope and Delimitations 12

Limitations 13

Significance..13

Summary 14

Chapter 2: Literature Review 16

Literature Search Strategy..18

Theoretical Foundation 18

Church Attendance...20

Pastors as Gatekeepers 21

Pastors' Understanding of Health Education and Promotion 23

Pastors' Perceptions of Their Ability to Incorporate Health Education 23

PHAs' Role in Health Education in Communities 24
PHAs' Role in Health Education in AA Communities 26
Background of Collaborations Between PHAs and Churches 28
Collaborations Between AA Pastors and PHAs 30
AA Pastors' Beliefs and Attitudes Toward Collaboration 31
AA Pastors' Perceived Subjective Norms Towards Collaboration 32
AA Pastors' Perceived Control During Collaborations 34
Summary 35
Chapter 3: Research Methods 38
Research Design and Rationale 38
Central Concepts of the Study 39
Research Tradition 40
Role of the Researcher 40
Methodology 41
Participant Selection Logic 41
Instrumentation 43
Data Collection 44
Data Analysis Plan 44
Evidence of Trustworthiness 45
Ethical Procedures 46
Summary 47
Chapter 4: Results 48

Pilot Study....................49
Setting....................49
Demographics....................50
Data Collection....................51
Data Analysis....................52
Evidence of Trustworthiness....................53
Credibility....................53
Transferability....................54
Dependability....................54
Confirmability....................55
Results....................55
Research Question 1....................56
Research Question 2....................59
Research Question 3....................61
Summary....................64
Chapter 5: Discussion, Recommendations, and Conclusions....................66
Interpretation of the Findings....................66
Attitudes Towards Collaborations....................67
Perceived Subjective Norms....................69
Perceived Levels of Control....................70
Limitations of the Study....................71
Recommendations....................72

Implications 74

Conclusion 77

References 79

Appendix A: Interview Guide 88

Appendix B: Sample Read Receipt 91

List of Tables

Table 1. Research Questions and Emergent Themes 56

Chapter 1: Introduction to the Study

In 2019, the leading causes of death in the United States were preventable diseases, such as heart disease, cancer, and stroke (Centers for Disease Control and Prevention [CDC], 2023). According to the 2018 Person County Health Assessment, Person County, North Carolina exceeded the statewide rate for 8 of the 15 leading causes of death (Person County Health Department [PCHD], 2019). The health assessment also indicated that African Americans (AAs) in Person County were 13% more likely to die of cancer, 18% more likely of heart disease, 11% more of cerebrovascular disease, and 70% more of diabetes than their White counterparts. These data show the disparity in death rates of AA Person County residents due to preventable diseases.

Located near the Durham-Chapel Hill Metropolitan area, Person County is a small rural county of approximately 39,196 residents, of which 69% are White and 27% are AA (PCHD, 2019). The average age of Person County residents is 42.8 years, nearly 5 years older than the average population of North Carolina. The average income of Person County residents is $751 per week per worker compared with the statewide weekly average of $1,034 (PCHD, 2019). According to the Community Health Assessment, the poverty rate of Person County residents is 18.5% (PCHD, 2019). Although data suggests health disparities within this community, the causes of such differences can be variable. Social determinants of health (SDOH), such as access to education, health care, the economic, built, and social environment, and community context, contribute to health disparities (Ozturk & Kilic, 2019). Although health education may decrease health disparities in a community, some community members may not benefit due to SDOH.

For example, if an individual in a community needed access to health care, an SDOH, then providing health education alone would not be enough to help reduce health disparities.

Brand (2019) suggested that decreasing health disparities in the rural and urban AA communities could be accomplished through utilizing churches and other faith-based organizations to promote health education. In addition to reducing health disparities, health education can also help improve populations' quality of life (Ozturk & Kilic, 2019). The church has proven to be a significant source of information and guidance for the AA community (Brewer & Williams, 2019; Williams & Cousin, 2021). According to Pew Research, 38% of historically AA Protestants attend church monthly (Nortey, 2022). Considering the frequency of attendance, the church may provide an ideal environment to promote healthy behaviors through health education. Existing studies have addressed the role of AA pastors as health promoters and partners with public health agencies (PHAs) in urban communities (Howard et al., 2018; Lynch et al., 2020; Wright et al., 2020). However, studies have not directly assessed how the pastors of AA churches in rural Person County perceive their role as health promoters and their willingness to collaborate with PHAs. In the remainder of this chapter, I provide the background for this study, problem statement, purpose, research questions, theoretical framework, nature of the research, definitions, assumptions, scope and delimitations, limitations, and significance of the study. This chapter will conclude with a summary.

Background

The church is a significant source of information and guidance for the AA community (Brewer & Williams, 2019; Williams & Cousin, 2021). Harmon et al. (2018) implied that one of the roles of the AA pastor is that of the gatekeeper of disseminated information in their church and community. Brand and Alston (2018) examined ways to empower faith-based organizations and churches to improve health outcomes in the AA community. Williams and Cousin (2021) found that pastors were a critical resource for disseminating information through their sermons. The authors also implied that the role of the church leadership was unique in facilitating public health education.

Recent researchers have sought to understand the relationship between AA pastors and the health literacy of their congregations. Harmon et al. (2018) used a qualitative approach to understand AA pastors' views on influencing the health behaviors of their communities. The researchers used thematic analysis of semistructured interviews to determine the significant concerns of AA pastors and their ability to change their congregants' health behaviors. Williams and Cousin (2021) implied that AA pastors were favorable toward providing health education via their sermons; however, the messages could not conflict with the church's religious convictions.

Researchers have also sought to determine the factors that facilitate or hinder health education and promotion in communities. Brand and Alston (2018) identified resources, physical structure, personnel, funding, and social support as factors that could facilitate health promotion in the AA church. Brand (2019) later added that the size and participation level of the congregation are facilitators of health education programs,

discovering that when the size of the congregation increased, the level of participation in health education programs increased. In addition to Brand and Alston's findings, Wallace and Behringer (2020) found that introducing pastors to health information technology encouraged participation in health-promoting activities in their churches. Although research has suggested multiple facilitators of health education in churches exist, Adimora et al. (2019) implied that there are also barriers, such as conflicts between religious convictions and the subject matter of the education that impede pastors from disseminating such information.

Recent literature showed that the church is a valuable source that provides information and guidance to the AA community. Tucker et al. (2019) evaluated the effectiveness of a church-based intervention that promoted health literacy. The researchers separated the study participants into two groups: The first group received intervention, and the second group did not receive the intervention. After 6 weeks of intervention, the first group demonstrated significant increases in their level of health literacy, and the second group did not show any increase in health literacy. Tucker et al. concluded that using the church to provide health literacy effectively promotes positive health outcomes.

The importance of having pastors promote health education in their churches was demonstrated by Augustin et al. (2019) who sought to determine if providing breast cancer education to church congregations would increase their intent to participate in cancer screening programs. Augustin et al. found that the congregates' extent of participation was significantly greater when the programs were associated with the role of

the pastor as a health promoter. In a related study, Payán et al. (2019) evaluated the effectiveness of incorporating HIV messaging in pastoral sermons. The researchers used AA pastors from Los Angeles, California to deliver essential HIV-related information to program participants. Payán et al. found some inconsistencies in the messages' fidelity. For example, out of the 10 HIV sermon objectives to the pastors, the Catholic priest completed nine, the Baptist pastor completed seven, and the Pentecostal pastor completed five (Payán et al., 2019). Although there were inconsistencies in delivering the sermon objectives, Payán et al. did find that the pastors embraced their roles as health promoters.

Although the pastor delivers most of the church's information, PHAs are significant sources of information as well. For example, Berkley-Patton et al. (2019) evaluated the effectiveness of Taking It to the Pews (TIPS), an HIV education and testing initiative. The TIPS program enabled PHAs to deliver health education via community churches. The researchers found a significant increase in HIV testing rates among study participants after initiating the TIPS program (Berkley-Patton et al., 2019). In a similar health initiative, public health researchers sought to discover ways to improve the health of the church and community members of the West Side of Chicago (Lynch et al., 2020). The health researchers formed West Side Alive (WSA), a partnership with the pastors and church members in the segregated AA area of West Side Chicago. The participants in the WSA project provided health screenings to the target community, and the results of the health screenings were instrumental in determining the health and social needs of the target community (Lynch et al., 2020). Berkley-Patton et al. and Lynch et al. (2020)

agreed that PHAs could work with churches to deliver health education that may promote positive health behaviors.

Augustin et al. (2019), Tucker et al. (2019), Payán et al. (2019), Berkley-Patton et al. (2019), and Lynch et al. (2020) demonstrated that using AA churches, pastors, and PHAs to promote health education was an excellent way to improve the health outcomes of the AA community. Their research also showed that the pastor is an important figure in the AA church and controls the kinds of information that is disseminated. However, few studies have addressed pastors' perceptions of promoting health education through health collaboratives (Ellis & Morzinski, 2018; Maxwell, 2019; Tucker et al., 2019). Additionally, most current research has utilized pastors who lead churches in urban areas. Because recent research addressed the views of urban pastors, a gap in the literature addressing rural pastors becomes apparent. In the current study, I addressed the perceptions of rural AA pastors regarding promoting health education in their churches and communities through public health collaboration.

Problem Statement

The 2018 Person County Health Assessment data illustrates a significant disparity in the death rate of AAs in Person County due to preventable diseases (PCHD, 2019). This disparity in the mortality rate of preventable disease could be related to SDOH, such as income and access to affordable insurance. For example, the Person County Community Health Assessment 2018 informed that 29.3% of Person County's AA population lives in poverty compared to their White counterparts at 14.1% (PCHD, 2019). This income disparity may contribute to AA residents' ability to obtain health

insurance. In Person County, 13% of AA residents are uninsured compared to their White counterparts at 8% (PCHD, 2019). The lack of health insurance could be a factor in the rate of hospital emergency department visits. For example, Person County AAs accounts for 57% of all diabetes-related hospital emergency department discharges and 47% of inpatient discharges (PCHD, 2019).

Although there is no financial data available specifically for Person County, preventable disease substantially affects health care costs in North Carolina and the United States. For example, the financial burden of diabetes in North Carolina was around $10.6 billion dollars in 2017 (American Diabetes Association [ADA], n.d.). A broader measure of costly preventable diseases is heart disease. Between 2016 and 2017, heart disease costs the U.S. health care system $363 billion in treatment modalities and loss of productivity (CDC, 2022). This data highlighted the need to explore more ways to decrease the prevalence of preventable diseases.

Brand (2019) suggested that promoting health education could decrease health disparities. Williams and Cousin (2021) informed that the AA church had been a source of leadership in their community. Previous research confirmed that using the church, pastors, and PHAs to promote health was influential in encouraging healthier behaviors in AA communities (Berkley-Patton et al., 2019; Howard et al., 2018; Lynch et al., 2020; Wright et al., 2020). Although current studies showed that providing health education via the church was adequate to improve health behaviors, many existing studies did not address the pastors’ perceptions of promoting health education through partnerships with PHAs, thus creating a gap in the literature. In addition, these studies focused on

participants from urban communities, and since recent research did not address rural communities, a second gap in the literature exists. I conducted this study to address the need to decrease the prevalence of preventable diseases in rural AA communities through collaborations between rural AA pastors and PHAs.

Purpose of the Study

The 2018 Person County Health Assessment data illustrated a significant disparity in the death rate of AAs in Person County due to preventable diseases (PCHD, 2019). Preventable diseases also substantially affect health care costs in North Carolina and the United States. For example, the financial burden of diabetes in North Carolina was around $10.6 billion dollars in 2017 (ADA, n.d.). A broader measure of costly preventable diseases is heart disease. Between 2016 and 2017, heart disease costs the U.S. health care system $363 billion in treatment modalities and loss of productivity (CDC, 2022). This data highlighted the need to explore more ways to decrease the prevalence of preventable diseases.

Brand (2019) suggested that promoting health education could decrease health disparities. Williams and Cousin (2021) informed that the AA church had been a source of leadership in their community. Previous research confirmed that engaging the church, pastors, and PHAs to promote health was influential in encouraging healthier behaviors in AA communities (Berkley-Patton et al., 2019; Howard et al., 2018; Lynch et al., 2020; Wright et al., 2020). Although current studies showed that providing health education via the church was adequate to improve health behaviors, many existing studies did not address the pastors’ perceptions of promoting health education through partnerships with

PHAs. In addition, these studies focused on participants from urban communities. Because recent research did not address rural communities, a gap in the literature existed. I designed this study to explore ways to decrease the prevalence of preventable diseases in rural AA communities through collaborations between rural AA pastors and PHAs. For example, coalitions that promote disease prevention programs and health improvement initiatives.

Research Questions

The research questions that dictated the focus of the current study were:

RQ1: What are AA pastors' attitudes towards collaborating with PHAs to improve the health status of their congregations in rural Person County, North Carolina?

RQ2: What are AA pastors' perceived subjective norms towards collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

RQ3: What are AA pastors' perceived levels of control when collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

Theoretical Framework

I used the theory of planned behavior (TPB), as described by Glanz et al. (2015), as the theoretical framework for this study. Glanz et al. stated that the TPB emerged from the theory of reasoned action in 1980 as a tool to predict an individual's level of intent to participate in a behavioral change. Glanz et al. noted three key constructs of the TPB:

perceived attitudes about the behavior, perceived subjective norms about the behavior, and perceived control of performing the behavior. These three constructs influence the level of intent to perform the behavior.

Using the TPB, I examined the views of rural AA pastors regarding collaboration with PHAs to promote health education in their churches. I also explored the pastors' perceived attitudes and subjective norms relating to partnerships with health agencies to promote health education. Finally, I explored the pastors' perceived levels of control of health information provided during potential alliances. Chapter 2 contains a detailed explanation of the TPB and its use in the current study.

Nature of the Study

In this study, I used an inductive, qualitative approach to assess the views of rural AA pastors regarding their roles in promoting health education in their churches. Given that the lived experiences of AA pastors in their role as health promoters were considered in the current study, I used individual, semistructured interviews to collect data. Conducting semistructured interviews allowed me to observe the participants' mannerisms, such as body posture, facial expression, and body movements. The participants' physical reactions to questions determined the need for follow-up questions. I noted when and why any follow-up questions were necessary. Lastly, I was able to guide the interview conversation by reacting to the participants' answers.

Pastors control much of the information their congregations receive (Harmon, 2018). The purpose of this phenomenological study was to discover how rural AA pastors perceive collaborating with health agencies to promote health education in their churches

and communities. Because pastors are gatekeepers of data, their opinions regarding health promotion in the rural AA church were essential for this research. The data source for this project was a participant pool of AA pastors from rural Person County, North Carolina. The tool for data collection was face-to-face, semistructured interviews. I audio recorded the conversations for transcription and analysis. The data from the transcripts were thematically coded and analyzed via the Nvivo 14 data analysis program.

Definition of Terms

Church-based health promotion programs: Health-promoting initiatives that originate in the church (Lumpkins et al., 2013).

Faith-based organizations: Groups or organizations that provide access to resources, such as food, health care, and informal support (Asomugha et al., 2011).

Health disparities: Differences in preventable diseases and the opportunity to reach optimal health between socially disadvantaged groups and other populations (CDC, 2019).

PHAs: Any local, state, or federal organization that provides vital health services to the public. These organizations may be public, private, or voluntary (CDC, n.d.).

SDOH: The conditions in which people are born, grow, work, live, and age. These conditions are nonmedical factors that affect health (CDC, 2022).

Assumptions

In this qualitative, phenomenological study, I focused on the perceptions of rural pastors regarding their views of promoting health education in their churches through collaboration with PHAs. I made four significant assumptions. The first assumption was

that AA pastors were aware of the concept of health education. Given that this study focused on the pastors' perceptions of promoting health education, they had to be familiar with the concept of health education. Another assumption was that the pastors would see the value in and be willing to participate in this research. I also assumed that the pastors would answer the interview questions honestly. Since this study was about the pastors' perceptions regarding health education and public health collaborations, this assumption was essential. My final assumption was that pastors were actively leading a congregation in Person County.

Scope and Delimitations

There is a health disparity in the AA community of Person County. Because health education effectively decreases such inequality, there is a need to identify ways to promote health education in the AA community. One conceivable way to promote healthy behaviors is by involving pastors as conduits who share health education and encourage behavior changes that promote health in the community. I conducted this study to discover the perceptions of AA pastors regarding promoting health education in their churches and communities. Additionally, this study highlighted the participants' views regarding health promotion collaborations with PHAs. I chose the participants in this study from a pool of AA pastors who have congregations in rural Person County. I excluded pastors of churches outside of rural Person County from this research. I have attended church in Person County for many years; however, I have not had the opportunity to meet many pastors in the area. To eliminate bias in data collection and analysis, I only interviewed pastors with whom I was unfamiliar.

Limitations

Participants for this study came from a pool of pastors who self-identified as AAA. Since the participants were AA, the opinions gathered during this study may not reflect the views of pastors who do not identify as AA. The churches chosen for this study were in Person County, North Carolina, a rural location; therefore, the collected opinions, perceptions, and data may not transfer to urban communities. The method of data collection for this study was face-to-face interviews. The COVID-19 social distancing protocols required wearing a face covering when individuals were less than 6 feet apart. However, wearing face coverings decreases the ability to appreciate facial expressions during the interviews; therefore, I encouraged participants to feel comfortable wearing or not wearing a mask while maintaining a 6 feet distance between us. As an alternative to face-to-face meetings, I offered a form of virtual meeting, such as Zoom; however, no participants requested virtual meetings.

Significance

Person County has exceeded the statewide rate for 8 of the 15 leading causes of death (PCHD, 2019). The 2018 Person County Health Assessment data illustrated a significant disparity in the death rate of AAs in Person County due to preventable diseases (PCHD, 2019). Because of this disparity, there was a need to seek additional ways to improve the health of Person County's AA community. Preventable diseases also substantially affect health care costs in North Carolina. For example, the financial burden of diabetes in North Carolina is around $10.6 billion dollars (ADA, n.d.).

Brand (2019) suggested that decreasing health disparities in the rural AA community could be accomplished by partnering with churches and other faith-based organizations to promote and deliver health education. Given that the pastor is the gatekeeper of information disbursed in the church, it was essential to discover their perceptions of promoting and delivering health education through collaboration with PHAs. This study may be significant because I used the TPB to address the pastors' perceived attitudes and subjective norms toward public health partnerships and perceived levels of control when collaborating with PHAs. By addressing the pastors' concerns, PHAs may be able to form more mutually beneficial partnerships with churches to provide needed health education to address health disparities. The results of this study may encourage positive social change by providing PHAs with suggestions to build trust with and improve communication between AA pastors, PHAs, and the AA community. Additionally, the findings of this study may also provide PHAs with suggestions on building coalitions between pastors and PHAs, such as local health departments, to promote and deliver health education.

Summary

Chapter 1 was a brief overview of the study. I introduced the research and presented the problem statement, purpose of the study, and research questions. I also briefly explained the TPB used as the theoretical framework for this study. To further illustrate the aim of the study, I discussed the nature of the study, definitions used, assumptions, scope and delimitations, limitations, and significance.

In Chapter 2, I will provide a detailed review of the current literature focusing on AA pastors' perceptions of promoting health education through collaboration with PHAs. I will describe the TPB and how I used it to answer the research questions in this study. Chapter 2 also includes a discussion of previous studies that used the TPB as their theoretical framework to determine intent to participate in health behavior initiatives.

Chapter 2: Literature Review

The health disparities of the AA residents of Person County are significant. Person County, North Carolina exceeded the statewide rate for 8 of the 15 leading causes of death (PCHD, 2019). The 2018 Person County Health Assessment indicated that the county's AA residents were 13% more likely to die of cancer, 18% more likely of heart disease, 11% more of cerebrovascular disease, and 70% more of diabetes than their White counterparts (PCHD, 2019). This data established the need to address ways to decrease health disparities in the AA community. Brand (2019) suggested that promoting health education could reduce health disparities in AA communities. Recent literature highlighted the importance of PHAs in promoting healthier behaviors in the AA community through health education. For example, the TIPS program, an HIV education and testing initiative, significantly increased the rate of HIV testing in an AA community (Berkley-Patton et al., 2019). A similar program, the WSA project, provided health screenings to the AA community on the West Side of Chicago that were used to determine the health and social needs of the target community (Lynch et al., 2020). I conducted this qualitative study to determine how rural pastors in Person County, North Carolina perceive their ability to promote health education in the AA church through collaboration with PHAs.

Williams and Cousin (2021) stated that the AA church had been a source of leadership in their community. Current research confirmed that using the church to promote health was influential in encouraging healthier behaviors in AA communities (Howard et al., 2018; Lynch et al., 2020; Wright et al., 2020). Lynch et al. (2020) and

Berkley-Patton et al. (2019) reported that collaborations between PHAs and pastors have effectively delivered health education to the AA community and encouraged positive health behaviors. Although previous studies revealed that providing health education via the church could improve health behaviors, many existing studies did not address the pastors' perceptions of promoting health education through partnerships with PHAs. In addition, previous studies focused on participants from urban communities. Being that recent research did not address rural communities, a gap in the literature existed.

I begin this chapter by describing the search strategy used to locate current literature on how rural AA pastors perceive promoting health education in their churches through collaboration with PHAs. Following the description of the literature search strategy, I provide a review of the TPB, which was the theoretical foundation of the current study. A detailed overview of AA pastors partnering with PHAs to promote health education is presented and included the topics of church attendance and pastors as gatekeepers. I then provide a detailed overview of AA pastors partnering with PHAs to promote health education, including discussions of church attendance, pastors as gatekeepers, pastors' understanding of health education and promotion, and pastors' perceptions of their ability to incorporate health education. In addition, this chapter includes an explanation of the PHAs' role in health education in communities, PHAs' role in health education in the AA community, and the historical background of collaborations between PHAs and churches.

Literature Search Strategy

The literature search strategy for this dissertation consisted of multiple steps. Initially, I performed a broad search of health education and promotion articles using Thoreau, Walden University Library's multidatabase search tool. As expected, this initial search yielded thousands of items related to health promotion. I repeated the search cycle multiple times, placing more limiters in the search criteria with each new search, such as a publication date range of 5 years; peer-reviewed, scholarly journals only; and books. Using this search strategy, I decreased the search results to a manageable number. When there was limited research on the topic, I searched the bibliography of previous studies to find related research articles.

After completing the general database searches, I further decreased the number of related articles by adding keywords to the search criteria. The keywords and phrases used in the subsequent queries were *health education, health disparities, public health agencies, collaborations, health promotion, church, African Americans, Blacks, rural areas, rural communities, theory of planned behavior, pastors, faith leaders, barriers, impedances,* and *facilitators.* I used the keywords in various combinations to achieve a more thorough search. The significant databases searched were Cumulative Index to Nursing & Allied Health Literature Plus with Full Text, MEDLINE with Full Text, Academic Search Complete, Google Scholar, and PsycINFO.

Theoretical Foundation

As an extension of the theory of reasoned action, the TPB was developed in 1980 by the psychologists, Icek Ajzen and Martin Fishbein, as a social change theory (Glanz et

al., 2015; Khani Jeihooni et al., 2022). Ajzen and Fishbein suggested that a person's intention determines their actions and that perceived behavioral beliefs and attitudes toward the behavior, perceived subjective norms, and perceived control of the behavior influence their intentions (Glanz et al., 2015; Khani Jeihooni et al., 2022).

The TPB has been successfully used to predict and encourage healthy behaviors. Le and Holt (2018) used the TPB to assess the effectiveness of using text messaging to encourage AA women to test for cervical cancer via Pap smear. Using the TPB, Le and Holt investigated the participants' attitudes about testing for cervical cancer, the subjective norms associated with testing, and the perceived amount of control over getting tested. The researchers used the results of their investigation to develop and provide text messages to participants, mainly women who attended church, that provided spiritual references and encouraged cervical cancer testing. Their study results demonstrated that providing health education through electronic media was an effective way to promote behavior change. Le and Holt also implied that text messages needed to be culturally appropriate.

In a similar study, Berkley-Patton et al. (2019) sought to determine the feasibility of using church sermons to encourage HIV testing. The researchers selected subjects from Latino and AA churches. Using the TPB, the researchers addressed the participants' attitudes towards HIV testing, normative and subjective beliefs about HIV testing, and perceived control of HIV testing. Berkley-Patton et al. developed sermon guides that provided accurate information, encouraged testing for HIV, and addressed the myths surrounding HIV and HIV testing. The researchers concluded that church-based HIV

interventions that used pastoral sermons were effective in increasing HIV testing and reducing HIV stigma. The researchers also determined it is essential that the pastors have control over messages, that the communications are tailored by the pastor, and that the communications respect the beliefs and the cultures of the target population.

I conducted the current study to determine rural AA pastors' perceptions regarding their abilities to promote health education through partnerships with PHAs. Using the constructs of the TPB, I addressed the pastors' perceived beliefs and attitudes, perceived subjective norms, and perceived control regarding collaborations with PHAs (see Glanz et al., 2015; Khani Jeihooni et al., 2022). Considering that the purpose of the current study was to explore pastors' perceptions and the TPB's constructs are focused on perceptions, I was able to fulfill the purpose of the study and use the TPB to guide answering the research questions.

Church Attendance

For many years, the church has been a source of information and guidance for the AA community (Brewer & Williams, 2019; Williams & Cousin, 2021). According to Mohamed et al. (2021), there are four main reasons why AAs attend church: spiritual comfort, fellowship, financial help, and civil rights. The most recent pre-COVID-19 survey of AA religiosity performed by the Pew Research Center (n.d.) indicated that in 2014, 47% of AAs attended church at least once weekly, more than any other ethnic group in the United States.

In January 2020, researchers reported that the highly virulent novel coronavirus caused COVID-19 disease (National Institute of Health, 2020). COVID-19 began to

spread rapidly, and in March 2020, the World Health Organization announced that COVID-19, a potentially deadly disease, had become a pandemic (*American Journal of Managed Care*, 2020). Researchers also noted that the coronavirus was highly transmissible through airborne particles, and in response to the coronavirus' virulent nature, the CDC (2020b) suggested banning large public gatherings of people. This restriction of public gatherings prevented AA churches from participating in religious practices, such as weekly meetings and services, conventions, weddings, and funerals. Since the church members could not assemble in person, disseminating sermons and exchanging information between the pastors and parishioners became challenging. To address this challenge, many churches began delivering sermons via other methods, such as the internet, television, radio, and telephone. Researchers estimated that post-COVID-19, 38% of historically AA Protestants attend church monthly; however, approximately 10% participate in remote services (Nortey, 2022). Despite the challenges presented by the COVID-19 pandemic, the church remains a significant source of information for the AA community (Williams & Cousin, 2021).

Pastors as Gatekeepers

Perhaps, the pastor is the most influential person in the AA church hierarchy. One of the AA pastor's roles is the gatekeeper of information (Brand, 2019; Harmon et al., 2018). The pastor's sermons are a critical resource for disseminating various information to empower the congregates (Williams & Cousin, 2021). The pastors could use their sermons to provide vital health information and promote healthier behaviors. For example, Bellamy et al. (2021) sought to discover ways to deliver opioid-related

information to an AA and Latino community and found that the community required information from a trusted community member. Being that the target group needed information delivered by someone trustworthy, the researchers appointed the community's church pastors to provide the education. Their study presents an example of how pastors can provide health information that promotes healthier behaviors.

In another study, Howard et al. (2018) described a project designed to increase prostate education among Black men through a focus on the shared decision-making process of seeking prostate examinations. To improve prostate education and prostate screenings among Black men, project facilitators formed a community partnership that included ministers; local hospital staff, such as doctors and nurses; prostate cancer survivors; and other prostate cancer advocates. The participants of the Howard et al. study were 438 Black men from 12 churches who received educational materials and lectures about prostate cancer. The study participants also had the opportunity to participate in question-and-answer sessions with cancer survivors. According to pre- and postintervention surveys, the participants' knowledge level increased by 48%. Postintervention survey results also demonstrated a 17% increase in participants who intended to engage in shared decision making in the future. Their study presents an example of how pastors have been instrumental in disseminating valuable information.

Although pastors are known to provide religious guidance through their sermons, many pastors have used their platforms to offer advice on other topics, such as health and social issues (Bellamy et al., 2021; Howard et al., 2018; Williams & Cousin, 2021).

Given that pastors are trusted gatekeepers, they could form valuable collaborations with PHAs to promote health behavior changes in the AA community (Howard et al., 2018).

Pastors' Understanding of Health Education and Promotion

Harmon et al. (2018) and Brand (2019) stated that pastors are the gatekeepers of information. Pastors have played a role in disseminating health information to promote healthier behaviors to congregates (Williams & Cousin, 2021). Williams and Cousin (2021) interviewed 12 urban AA pastors to discover their views on health education and found that participants were knowledgeable about promoting health education and felt the need to promote it in their churches. In a related study, Gross et al. (2018) interviewed 11 urban AA pastors to determine their opinions of promoting health education. All study participants were aware of health education and expressed the need to promote it. Williams and Cousin and Gross et al. agreed that many urban AA pastors were aware of health education and favored promoting it in their churches.

Pastors' Perceptions of Their Ability to Incorporate Health Education

Williams and Cousin (2021) and Gross et al. (2018) implied that many urban AA pastors were aware of the health education concept and favored promoting it in their churches. In comparison, Wright et al. (2020) identified factors that could hinder the pastor's delivery of health education through interviewing 31 urban AA pastors regarding their views on providing sex education for teens to prevent teen pregnancy. All study participants agreed that providing sex education would be beneficial in preventing teen pregnancy; however, the pastors did not feel comfortable with delivering the instruction. The pastors believed that parents should provide information about sexuality to their

children and implied that they would receive opposition from the teens' parents (Wright et al., 2020).

In addition to the hindrances to health promotion found by Wright et al. (2020), Williams and Cousin (2021) found that some pastors felt that the pastor's health status reflects in their followers. The study participants believed they were examples for their parishioners and could not preach about healthy behaviors if they were not healthy (Wright et al., 2020). In a related study, Haughton et al. (2020) interviewed 22 pastors and church leaders in urban San Diego County to discover their views on their ability to promote an exercise program in their churches. The study participants, pastors of catholic and protestant churches with large Latino populations, implied that there were barriers to incorporating health education in their churches. Some of the obstacles cited by Haughton et al. were a lack of knowledge of the subject matter, a lack of denominational support from senior leadership, and conflicting cultural behaviors of the church members. The pastors also implied that it would be difficult to promote healthy behaviors in the parishioners if the pastors were in poor health. Although Haughton et al. studied pastors of Latino-populated churches, the findings may help highlight barriers to and develop strategies for implementing health programs in AA churches.

PHAs' Role in Health Education in Communities

In 1798, the United States established the Marine Hospital Service (MHS; CDC, 2021). The MHS consisted of hospitals designed to provide medical services for U.S. seamen and was considered the first PHAs (CDC, 2021). Over the next 114 years, the MHS scope of practice grew to include preventing contagious diseases in the United

States. As a result of their expanded roles, the MHS became known as the U.S. Public Health Service (USPHS; CDC, 2021).

Although the USPHS's primary focus was to prevent contagious diseases, it became necessary to create agencies to focus on other health concerns such as chronic diseases, injuries, and SDOH. Therefore, the USPHS provided communities with PHAs to address those health problems (CDC, 2020a). An example of a public health agency is the Local Health Department (LHD). The LHD provides many services to the communities they serve, including disease and injury prevention, disaster response, and assuring access to health services. The roles of the LHD include but are not limited to providing information and education and empowering people to improve the health of their communities (CDC, 2020a). LHDs have played significant roles in preventing the prevalence of disease through community health education programs. For example, during the COVID-19 pandemic, LHDs educated communities and schools on how to prevent the spread of COVID-19 and techniques in quarantine and isolation (CDC, 2022). LHDs also helped decrease preventable disease incidences through educational initiatives such as the Life in 24 Diabetes Prevention Program provided by the PCHD (n.d.).

In addition to preventing the spread of contagious diseases, PHAs work to prevent chronic diseases. In 2018, 27.2% of U.S. adults had multiple chronic conditions (Boersma et al., 2020). Coronary heart disease is one of many chronic conditions that burden U.S. communities (Boersma et al., 2020). To address these chronic conditions and reduce their prevalence in communities, the CDC partners with state and local PHAs to provide preventative programs. One such program is the Million Hearts program. The

Million Hearts program, a collaboration between the CDC and the American Heart Association (2018), aims to prevent 1 million heart attacks and strokes over the next 5 years. The program provides communities with education and assistance in managing heart attack and stroke risk factors. The Well-Integrated Screening and Evaluation for Women Across the Nation is a similar CDC-sponsored program addressing cardiovascular disease (CDC, 2020c). The Well-Integrated Screening and Evaluation for Women Across the Nation program provides screenings for heart disease and stroke risk factors and services that promote positive health behaviors (2020c).

Another example of PHAs outreach is The Real Cost, a tobacco prevention campaign designed to deter youth from smoking (U.S. Food & Drug Administration [FDA], 2022). The FDA initiated this campaign in 2014, intending to educate U.S. youth between 12-17 years old about the dangers of smoking cigarettes. The campaign utilizes digital advertising, social media, and influencers to reach the targeted population. According to the FDA (2022), cigarette smoking among U.S. youth is at an all-time low, and the campaign will save the United States over $53 billion. The Real Cost initiative may help prevent the prevalence of other chronic conditions, such as cardiovascular and lung disease, caused by smoking cigarettes.

PHAs' Role in Health Education in AA Communities

One of PHAs goals is to prevent disease spread in all communities (CDC, 2020). However, some communities, such as the AA community, experience health disparities due to SDOH and require more focused outreach to address these disparities (Ozturk & Kilic, 2019). PHAs have successfully addressed these health disparities by promoting

health education in the AA community. According to the ADA (2020), health literacy is a critical SDOH contributing to health disparities in the AA community. To address health literacy, some PHAs have developed outreach programs to provide education for diabetes prevention and management. The PCHD, for example, provides a diabetes education program, Life in 24, to assist with lowering the diabetes disparity in Person County's AA population (PCHD, n.d.). Health educators from the PCHD provide an extensive 16-week educational program that informs participants about proper diet and exercise activities to help lower their risk of diabetes (PCHD, n.d.). In a similar diabetes prevention initiative, the YMCA of the Triangle provides a 12-month education program focusing on proper diet and exercise to prevent and manage diabetes. This program is open to anyone at risk of developing diabetes (YMCA, n.d.).

Another way for PHAs to provide health education to the AA community is to develop health campaigns such as the Truth Initiative. The Truth Initiative is a public health organization that focuses on deterring smoking, vaping, and nicotine use among young people (Truth Initiative, n.d.). Due to Truth Initiative's campaign efforts, the smoking rate of U.S. youth has decreased from 23% in 2000 to 2.3% in 2021 (Truth Initiative, n.d.). To reduce tobacco and nicotine use in the AA community, the American Heart Association has partnered with Truth Initiative to educate the AA community about the impact of tobacco use. This collaboration seeks to deter tobacco use and secondhand smoke exposure on Historically Black Colleges and Universities campuses (Truth Initiative, n.d.).

Research has shown that recruiting community members to provide health education can effectively help decrease and manage chronic diseases in the AA community (Victor et al., 2019). For example, Victor et al. (2019) conducted a clinical trial using AA barbers to link clients with hypertension to pharmacists for treatment. The study participants, 319 AA male clients with hypertension, were separated into intervention and control groups. The intervention group received blood pressure (BP) checks from their barbers, who referred them to pharmacists for BP follow-up. The control group received BP checks from their barbers, who referred them to primary care physicians for follow-up. The study results demonstrated that over 12 months, the average baseline systolic BP of the intervention group decreased from 152.4 mm Hg to 123.8 mm Hg compared to the control group's BP decrease from 154.6 mm Hg to 147.4 mm Hg (Victor et al., 2019). The study results demonstrated that using members of the AA community to provide health education was influential in decreasing and managing hypertension in the AA community.

Background of Collaborations Between PHAs and Churches

Although researchers have agreed that the church has been a source of leadership and health information for the AA community, the authors did not suggest when collaborations between PHAs and AA churches began (Howard et al., 2018; Lynch et al., 2020; Williams & Cousins, 2021; Wright et al., 2020). Although existing literature revealed little about the origins of collaborations between PHAs and AA churches, there were references to some earlier collaborations, such as the Health and Human Services Project of the General Baptist State Convention (Idler et al., 2019). This project, the first

in the United States, was established in 1989 and encouraged churches and communities to serve as patient advocates (Idler et al., 2019).

Recent literature has shown the significance of PHAs in promoting healthier behaviors in the AA community and church. For example, the TIPS program, an HIV education, and testing initiative, significantly increased the rate of HIV testing in an AA community (Berkley-Patton et al., 2019). A similar program, the WSA project, provided health screenings to the West Side of Chicago AA community. These health screenings were instrumental in determining the health and social needs of the target community (Lynch et al., 2020). Another community outreach initiative, The Faithful Families Thriving Communities program, exemplifies PHAs collaboration with churches. This program focuses on expanding PHAs' reach in the community by allowing faith leaders to become health ambassadors. According to Hardison-Moody and Yao (2019), this program's success is partly due to encouraging faith leaders to focus on health issues of most concern to the faith community. Berkley-Patton et al. (2019), Lynch et al. (2020), and Hardison-Moody and Yao stressed the importance of church participation in delivering successful community health programs.

There are other examples of collaborations between PHAs and churches, such as Think Well: Healthy Living to Improve Cognitive Function, an educational program for AA breast cancer survivors (BCSs). The program aimed to educate the community through collaboration with church leaders to improve AA BCS's cognitive health (Bail et al., 2018). According to Bail et al. (2018), having the church involved in planning and

promoting the Think Well program was essential to providing culturally competent education to the AA BCS community.

During the COVID-19 pandemic, PHAs needed ways to disseminate COVID-19 related information to the AA community. Previously church gatherings had been a resource for the distribution of information, but now there were restrictions that limited in-person gatherings. These restrictions forced many churches to discontinue in-person meetings and use alternative communication methods, such as social media, to reach the AA community. PHAs partnered with churches in the San Francisco Bay area to address this concern by forming Project Trust (PT; Thompkins Jr. et al., 2020). The results of PT were a collection of 15-minute culturally specific videos that addressed the physical, mental, and spiritual concerns of the AA community (Thompkins Jr. et al., 2020). According to Thompkins Jr. et al. (2020), PT reached 951 churches, and 206,450 congregates.

Collaborations Between AA Pastors and PHAs

The reviewed literature indicated AA pastors controlled the information disseminated to their parishioners (Brand, 2019; Harmon et al., 2018). Previous researchers suggested that the church has been a valuable source of information regarding health and social issues for the AA community and that collaborations between pastors and PHAs could provide more significant public health outreach (Bellamy et al., 2021; Howard et al., 2018; Williams & Cousin, 2021). This literature review addressed the TPB constructs, and research questions related to AA pastors' perceptions of collaborating with PHAs.

AA Pastors' Beliefs and Attitudes Toward Collaboration

The first construct of the TPB is that an individual's beliefs and attitudes toward a behavior influence their intention to perform the behavior (Glanz et al., 2015; Khani Jeihooni et al., 2022). Previous authors have explored this construct to determine how AA pastors felt about promoting health education through collaborations with PHAs. For example, Williams and Cousin (2021) sought to discover how black pastors viewed their health, the health of their congregates, and their influence on their health behavior. The participants in this qualitative phenomenological study were 12 AA pastors from various Christian denominations. Williams and Cousin informed that the pastors considered themselves gatekeepers of information and shepherds of their congregates; they also suggested that AA pastors did not always have sufficient health information to help the members remain healthy. The pastors implied a need to collaborate with health experts from the community to ensure that the AA church had access to current health information (Williams & Cousin, 2021).

In a similar study, Gross et al. (2018) used qualitative interviews with 11 urban AA pastors to discover their perceptions of promoting health education in their churches. The researchers also sought the pastors' views on partnerships with health agencies not part of the church to improve the community's health. Gross et al. found that the study participants agreed that pastors could improve the congregants' health by encouraging visits to their medical professionals. In addition to promoting the practice of healthier behaviors, the study participants also implied that forming partnerships with outside health agencies could keep the church aware of current health issues in the community.

In addition to the research done by Williams and Cousin (2021) and Gross et al. (2018), Adimora et al. (2019) presented a study that showed that some pastors held a different view of public health collaborations. In their study, researchers interviewed 39 AA pastors in North Carolina to discover their opinions on providing sermons related to heterosexual activity. The study results suggested that many pastors disagreed on the extent of sex-related information incorporated in their speeches. Although there were disagreements on subjects such as condom use, most pastors agreed to discuss marriage, fidelity, abstinence, and monogamy. Adimora et al. suggested that pastors agree to partner with public health professionals to introduce health topics; however, the pastors need to approve the messaging to ensure agreement with church convictions. The Adimora et al. study added credence to the research done by Williams and Cousin and Gross et al. It suggested that many pastors believe collaborating with PHAs benefits their churches' health status. The study's data helped to address the TPB's first construct and this dissertation's first research question focused on pastors' perceptions about collaborating with PHAs to provide health education to their congregations.

AA Pastors' Perceived Subjective Norms Towards Collaboration

The second construct of the TPB is that a person's subjective norms about a specific behavior also help to dictate the intent of performing the behavior (Glanz et al., 2015; Khani Jeihooni et al., 2022). Bellamy et al. (2021) conducted a participatory action research study to address the opioid crisis in the AA and Latino communities through a partnership with churches. Preliminary research revealed that the target groups would benefit from opioid-focused education (Bellamy et al., 2021). After conducting focus

groups, the researchers discovered that the participants felt the need for a trusting environment to receive information regarding opioid addiction. Believing that these communities trusted the pastor and the church, the researchers appointed the church pastors to provide the education. In addition to conducting the training, the church pastors collaborated with psychologists and psychiatrists to develop the curriculum. This study's results suggested the need for trust between the church, pastor, and PHAs. In contrast, the study results may not be the same with a different population that does not have a trusting relationship between PHAs, pastors, and churches.

The reviewed literature also indicated that, as a norm, the AA community historically distrusts PHAs—for example, Bolger et al. (2018) conducted focus groups and interviews with AA church members to discover their concerns with partnering with health professionals. Although Bolger et al. found that most church members participated in health initiatives, there remained a distrust in collaborating with PHAs. Participants frequently mentioned the Tuskegee Syphilis Study, in which researchers denied treatment to poor AAs suffering from syphilis, as a cause for lack of trust in public health. They also noted that the health care community would need to build an elevated level of trust with church pastors (Bolger et al., 2018). In another study, Nguyen et al. (2021) surveyed 140 AAs admitted to the hospital with a COVID-19 diagnosis. Of the 140 participants, 37 said they did not trust the health care system. The study participants referred to the Tuskegee Syphilis Study for their distrust. The participants in the Nguyen et al. study and the Bolger et al. study noted the Tuskegee Syphilis Study as a factor in their distrust of doctors and the health care system. These studies illustrated that distrust in public health

is a norm in the AA community. The data from these studies helped address the TPB's second construct and this dissertation's second research question relating to the perceived subjective norms towards collaborating with PHAs to promote health education in rural Person County.

AA Pastors' Perceived Control During Collaborations

The third construct of the TPB is that a person's perceived control of behavior influences their intent to perform the behavior (Glanz et al., 2015; Khani Jeihooni et al., 2022). AA pastors play many essential roles in their churches. As mentioned earlier in this literature review, the gatekeeper role is one of the critical services pastors provide (Ransome et al., 2018). Adimora et al. (2019) informed that most pastors agree to promote health education in their churches; however, the pastors may not always agree on the subject matter of the proposed education. For example, in the Adimora et al. study, the researchers interviewed AA pastors in North Carolina to discover their opinions on providing sermons related to heterosexual activity. The study participants said they would incorporate the information in their sermons about marriage, fidelity, abstinence, and monogamy, but most participants said they would not discuss birth control and condom use. Adimora et al. presented evidence that AA pastors need to control the content of the proposed education.

In a similar study, Wright et al. (2020) conducted semistructured interviews with 31 AA pastors to determine their perceptions on incorporating teen pregnancy prevention in their sermons. Most pastors agreed that there was a need to address teen pregnancy; however, there was disagreement as to the extent of the information provided. Some

participants felt that it was not their place to discuss topics such as birth control and condoms and that teens should discuss such issues with their parents. Wright et al. concluded that all participants agreed to partner with PHAs to address teen pregnancy; however, many had strict limits on the subjects they would incorporate in their sermons such as pre-marital sex and abstinence.

Payán et al. (2019) researched to evaluate incorporating HIV messaging in pastoral sermons. The study participants were pastors who served primarily minority populations living in Los Angeles' high HIV prevalent areas. Payán et al. provided the pastors with sermon guides that included suggestions for writing sermons that addressed HIV-related information such as public health data, cues to reducing HIV stigma, and HIV testing. After performing a process and thematic analysis of the pastors' sermons, the researchers discovered significant variations in the pastors' messages. Payán et al. informed that all pastors were favorable to the idea of providing HIV education via their sermons; however, fewer included cues to reduce HIV-related stigma. Although this research indicated pastors' willingness to work with organizations outside the church to address health issues, it showed that pastors control message fidelity. The data from these studies helped address the TPB's third construct and this dissertation's third research question that explored AA pastors' perceived levels of control when collaborating with PHAs to promote health education in rural Person County churches.

Summary

Researchers have informed that the AA church has been a source of leadership for the AA community and that the church could be instrumental in encouraging healthier

behaviors (Howard et al., 2018; Lynch et al., 2020; Williams & Cousin, 2021; Wright et al., 2020). Although current studies revealed that providing health education via the church could improve health behaviors, many existing studies did not address how the pastors perceived promoting health education through partnerships with PHAs. In addition, these studies focused on participants from urban communities. Being that recent research did not address these issues, gaps in the literature existed. To address how rural AA pastors perceived promoting health education through partnerships with PHAs, I used the concepts of the TPB to guide this literature review.

The reviewed literature suggested that because AA church pastors considered themselves gatekeepers of the information given to their congregates, they felt a responsibility to ensure the accuracy of information (Brand, 2019; Harmon et al., 2018). Gross et al. (2018) found that pastors could improve the congregants' health by encouraging visits to their medical professionals and that forming partnerships with outside health agencies could keep the church aware of current health issues in the community. Williams and Cousin (2021), Gross et al., and Adimora et al. (2019) suggested that many pastors believe collaborating with PHAs benefits their churches' health status. These authors helped address the TPB's concept that a person's belief in a behavior helped to determine that person's intent to perform that behavior.

A common theme in the reviewed literature indicated a need for trust between the church, pastor, and PHAs (Bellamy et al., 2021; Bolger et al., 2018). However, historical events in the AA community have caused AA to distrust PHAs. Nguyen et al. (2021) and Bolger et al. (2018) noted the Tuskegee Syphilis Study as a primary factor in AA’s

distrust of doctors and the health care system. These studies illustrated that distrust in public health is a norm in the AA community and helped to address the TPB's construct that a person's subjective norms about a behavior dictate that person's intent to perform that behavior.

Adimora et al. (2019) suggested that most pastors agree to partner with public health professionals to introduce health topics; however, the pastors need to control the messaging to ensure agreement with church convictions. Wright et al. (2020) and Payán et al. (2019) concluded that all participants agreed to partner with PHAs to address teen pregnancy; however, many had strict limits on the subjects they would incorporate in their sermons such as premarital sex and abstinence. Although this research indicated pastors’ willingness to work with organizations outside the church to address health issues, it showed that pastors always exercised their option to edit the educational material. The previous authors addressed the TPB’s third construct that control of behavior influenced a person's intent to engage in that behavior.

In Chapter 3, I will discuss the research design and rationale, role of the researcher, methodology, and instrumentation. I will also cover the data collection and analysis process and trustworthiness issues. Ethical procedures, including obtaining IRB approval, informed consent, and confidentiality, will also be addressed.

Chapter 3: Research Methods

Brand (2019) and Harmon et al. (2018) suggested that AA pastors are the gatekeepers of information distributed to their church members. Recent literature has shown that collaborations between PHAs and pastors have effectively delivered health information to the AA community and encouraged positive health behaviors (Berkley-Patton et al., 2019; Lynch et al., 2020). Because the pastor plays a significant role in providing information to their congregation, addressing pastors' perceptions regarding health education and partnerships with PHAs is essential. Recent studies addressed urban AA pastors' opinions regarding their ability to promote health education in their churches; however, little is known about the perceptions of AA pastors who lead churches in rural communities. Therefore, I conducted this qualitative, phenomenological study to determine the rural AA pastors' perceptions of promoting health education through collaborations with PHAs. In the first two sections of this chapter, I discuss the research design and rationale of the study and my role as the researcher. Next, I describe the methodology and issues of trustworthiness sections. The chapter concludes with a summary.

Research Design and Rationale

The research questions that dictated the focus of the current study were:

RQ1: What are AA pastors' attitudes towards collaborating with PHAs to improve the health status of their congregations in rural Person County, North Carolina?

RQ2: What are AA pastors' perceived subjective norms towards collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

RQ3: What are AA pastors' perceived levels of control when collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

Central Concepts of the Study

Previous research has shown that pastors are gatekeepers of information provided to their congregations and are an excellent resource for distributing and promoting health education in the AA community (Brewer & Williams, 2019; Harmon et al., 2018; Williams & Cousin, 2021). In addition to pastors promoting health education, researchers have found that PHAs are essential sources for promoting health education in the AA community (CDC, 2020, 2022). Augustin et al. (2019), Tucker et al. (2019), Payán et al. (2019), Berkley-Patton et al. (2019), and Lynch et al. (2020) demonstrated that using AA churches, pastors, and PHAs to promote health education was an excellent way to improve the health outcomes of the AA community. One concept under study was that AA pastors and PHAs are essential to health promotion in AA communities. Another concept, taken from the TPB, was that an individual's perceived attitudes about a behavior, perceived subjective norms about the behavior, and perceived control of performing the behavior influence their level of intent to perform the behavior (see Glanz et al., 2015). Collaborations between pastors and PHAs are vital in providing health

education in AA communities; therefore, exploring the phenomenon of rural AA pastors collaborating with PHAs to promote health education was warranted.

Research Tradition

In this study, I explored the phenomenon of AA pastors collaborating with PHAs to promote health education in their churches. Traditionally, researchers have used qualitative methods to describe phenomena such as lived experiences (Burkholder et al., 2016). Given that I investigated the pastors' lived experiences when collaborating with PHAs, a qualitative, phenomenological design was employed in this study.

Creswell and Creswell (2017) implied that phenomenological research uses storytelling to elicit the lived experiences of individuals within a group who share similar experiences. Traditionally, researchers have used individual interviews to collect data for phenomenological studies (Burkholder et al., 2016). Because I sought to discover individuals' perceptions within a group of AA pastors, I conducted individual interviews. During the interviews, I was able to ask follow-up questions as needed to draw richer responses from the participants.

Role of the Researcher

Considering that I conducted the interviews, I was the primary instrument of data collection (see Burkholder, 2016). Although I attend church regularly, I do not have a relationship with the pastors I interviewed. Even though I do not have a personal relationship with the study participants, some attributes about my background may have increased the participants' comfort level during the interviews. For example, I am an AA male, born and raised in Person County, and I have lived in Person County for the past 60

years. Since I was presented as an AA Person County resident, and the study participants were AA pastors, they may have been more comfortable speaking with me on issues concerning Person County's AA community. Given that I presented as male, the male interviewees may have felt more comfortable discussing topics, such as sexual health, than their female counterparts. Additionally, I attempted to build rapport with the participants by informing them that I have been affiliated with Person County churches for many years. Being that I have a history of church attendance, the interviewees may have felt more comfortable using words, such as God, sin, and atonement, when speaking of church-related issues.

Constructing an interview guide (see Appendix A) is an essential part of qualitative inquiry. When creating an interview guide, the researcher should develop questions that allow participants to provide answers in their own words (Patton, 2014). As such, I constructed an interview guide by formulating queries that addressed the study's research questions and the TPB's components as they related to the study. I lessened researcher biases by providing a carefully constructed interview guide containing the same questions to all study participants.

Methodology

Participant Selection Logic

Previous researchers collecting qualitative data have used purposive sampling (Burkholder et al., 2016; Creswell & Creswell, 2017). Patton (2014) defined purposive sampling as selecting participants with the purpose of exploring a particular phenomenon. Because I sought to explore the lived experiences of individual rural AA pastors, I used a

purposive sampling strategy. The potential study participants were taken from a pool of African American pastors who oversaw rural Person County churches (*N* = 20). Google searches did not provide the number of AA churches in Person County; however, I obtained a list of 20 AA churches from local AA funeral homes. The participants were required to be at least 18 years old and have at least 2 years of pastoral experience with their respective churches. The invitation to participate in this study had these criteria included.

Creswell and Creswell (2017) stated that there is no specific number of recruits for qualitative studies when using a purposive sampling strategy. Although I reached data saturation after four interviews, this study had a total of seven participants. Although no new data were introduced after the fourth interview, data saturation was not achieved until the research questions were answered (see Burkholder et al., 2016; Creswell & Creswell, 2017).

I collected a list of Person County AA churches (*N* = 20) along with their physical addresses. Person County is a small rural community with two funeral homes providing services to AAs. Since these two funeral homes serve the AA churches of Person County, I obtained lists of church pastors from the two African American funeral homes. I compared the lists from these two sources to avoid duplication of participants. To establish rapport, I hand delivered an invitation to participate to 10 of the prospective pastors. A 2-week response period was given for recruits to respond to their invitation to participate in this study. After 2 weeks of no participant responses, I hand delivered a second set of invitations to 10 different pastors from the list of potential participants.

Although it was not needed, I reserved the option to use the snowball method of recruitment. Patton (2014) wrote that the snowball method of sampling included allowing study participants to recruit others to become participants.

Instrumentation

Patton (2014) stated that semistructured interviews are often used to capture the lived experiences of participants during qualitative phenomenological research. Being that the purpose of this study was to discover the lived experiences and perceptions of rural AA pastors regarding collaborations with PHAs, I developed and used an interview guide as the data collection instrument for this study. The guide contained components, such as an introduction to the discussion, the participants' demographic information, informed consent, and interview questions with spaces for taking notes after each question (see Creswell & Creswell, 2017).

I based the current study's research questions on the concepts of the TPB. The interview guide contained the interview questions that addressed the study's three research questions. To help ensure the validity of the interview questions, I piloted the questions by asking a church attendee who had worked with PHAs on various health outreach projects and was unaffiliated with the study to review the questions and offer suggestions. Given that the interview questions were semistructured, I was able to use the interview guide to redirect the focus of the interview to the research questions as needed. Burkholder et al. (2016) suggested that using prompts during an interview could help ensure that the research questions are answered. I used the interview guide with each research participant to ensure a consistent discussion.

Data Collection

Using the interview guide, I collected data from AA pastors who served churches in rural Person County. I collected data from semistructured interviews with study participants until I had interviewed them all. The interviews were scheduled for 30–45 minutes each, and I audio recorded all data via the Philips Voice Tracer DVT2000 digital recording device and made notes on the interview guide. After each interview, I debriefed the participants by reassuring them that the collected data would remain anonymous and confidential. I also informed the participants of the next steps in the research procedure and offered to answer any relevant questions; however, I received no inquiries.

Data Analysis Plan

The data collected from the interview sessions answered the three research questions. The interview guide consisted of 17 interview questions. Interview Questions 1–6 addressed general demographic information (such as age, years of experience, church size, and church denomination), Questions 7–10 addressed Research Question 1, Questions 11–12 addressed Research Question 2, and Questions 13–17 addressed Research Question 3. After each interview session, I transferred the digital voice recording of the interview to the Nvivo 14 qualitative data analysis program. The Nvivo 14 analysis program's transcription feature automatically transcribed the digital recording into text. This transcription feature allowed me to review the program-generated text manually and make corrections, as needed, to the transcript. Manually checking the text helped eliminate errors in transcription. After ensuring that there were no transcription errors, I provided copies of the completed transcripts to the study participants via email

with an attached read receipt (see Appendix B). If necessary, I hand delivered the transcript. I asked the study participants to respond within 7 days of receiving their if any changes to the transcript were needed. If the study participants responded and suggested changes to the transcripts, I made changes as appropriate.

When there were no further changes to the transcribed interviews, I read each transcribed conversation and employed inductive coding to generate codes, categories, and themes from the transcripts. I repeated the coding process multiple times until there were no new codes in the document. After identifying the codes, I sorted them into categories and then performed a thematic analysis. After the first round of analysis, I emailed a copy of the interview interpretation with an attached read receipt to the study participants. If necessary, I hand delivered a copy of the interview interpretation to the participants for approval. This served as a form of member checking. I asked the study participants to respond within 7 days if there were any disagreements with the interpretation of the interviews. If I found discrepant cases, I contacted the participants to ensure that I had captured their intended sentiments.

Evidence of Trustworthiness

In qualitative research, the trustworthiness of a study is determined by four essential components: credibility, transferability, dependability, and confirmability (Burkholder et al., 2016; Creswell & Creswell, 2017). The qualitative researcher must show that the research data are believable. Researchers can establish credibility in several ways, such as triangulation and peer debriefing (Burkholder et al., 2016). I established credibility by keeping a reflective data collection and analysis journal, reviewing

interview notes, and performing frequent member checks for data accuracy. Transferability is how relevant the study results are to other situations (Burkholder et al., 2016). I demonstrated the study's transferability through detailed descriptions of the participants' demographic information and the geographic setting of the study. Burkholder et al. (2016) suggested that dependability shows consistent data collection, analysis, and reporting. In this study, I addressed dependability by developing an interview guide, and this protocol guided the interviews and ensured that each participant was asked the same interview questions. I recorded the interviews using a digital audio recording device and transcribed them into written form to minimize data collection errors. By using the Nvivo 14 data analysis system, I ensured consistency in analysis. The final component of trustworthiness is confirmability. Burkholder et al. defined confirmability as the aim to provide objectivity by removing researcher bias from the study findings. To ensure confirmability, I provided an audit trail that included careful review of the data collection and analysis of each interview. I also reviewed my notes to confirm that I had followed the steps detailed in this study's methodology.

Ethical Procedures

The participants in this study were not at risk for physical harm. To ensure minimal risks for psychological damage, I followed the ethical guidelines dictated by the Walden University Institutional Review Board (IRB). After receiving IRB approval (No. 07-25-23-0608131) to conduct the research study, I recruited the participants. The study participants received an informational packet containing a combined consent form and confidentiality agreement. I asked the study participants to sign a copy of the consent

form and confidentiality agreement as well as retain copies for personal records. Because this study was voluntary, I advised the participants of their right to decline to answer questions and that they may withdraw from the study at any time. Although study participation was voluntary, I offered a $20.00 Visa gift card as a show of appreciation. The participants were advised that the data collected during this study, including audio and transcriptions, would be kept in a locked file cabinet in my home for a period of 5 years, as required by Walden University. Any participant demographic data will be stored separately from the study data. Additionally, I informed the participants that copies of their research data will be stored on a password-protected cloud drive and a removable storage drive that will be kept in a locked file cabinet in my home. Except for the Walden University IRB and the dissertation committee, I had exclusive access to the collected research data.

Summary

Chapter 3 included a discussion of the research design and rationale, role of the researcher, methodology, and instrumentation. In this chapter, I also highlighted the data collection and analysis process and issues of trustworthiness. Ethical procedures, including obtaining IRB approval, informed consent, and confidentiality, were also described. Chapter 4 will include the results of the study, while in Chapter 5, I will provide an interpretation of the findings, discuss social change implications, and offer recommendations for future research.

Chapter 4: Results

Recent literature has shown that PHAs have formed collaborations with AA pastors to effectively deliver health information to the AA community and encourage positive health behaviors (Berkley-Patton et al., 2019; Lynch et al., 2020). The pastor acts as the gatekeeper of information, and they play a significant role in providing this information to their congregation (Brand, 2019; Harmon et al., 2018). Because the pastor acts as the gatekeeper of information, addressing their perceptions regarding health education and partnerships with PHAs was essential. Therefore, the purpose of this qualitative, phenomenological study was to understand the rural AA pastors' perceptions of promoting health education through collaborations with PHAs. I used the current study to address the following research questions:

RQ1: What are AA pastors' attitudes towards collaborating with PHAs to improve the health status of their congregations in rural Person County, North Carolina?

RQ2: What are AA pastors' perceived subjective norms towards collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

RQ3: What are AA pastors' perceived levels of control when collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

In the remainder of this chapter, I describe the pilot study, study setting, participant demographics, data collection, data analysis, and evidence of trustworthiness. This chapter concludes with a discussion of the study results and a chapter summary.

Pilot Study

I asked a church attendee who had worked with PHAs on various health outreach projects and was unaffiliated with this study to assume the role of a pilot study participant. I assembled the required paperwork for the interview, which included the consent form, confidentiality agreement, and the interview guide. Following the steps in the interview guide, I administered the interview questions. I audio recorded the interview using the Philips Voice Tracer DVT2000 and later transcribed the recording to a Microsoft Word document. I used the Nvivo 14 data management software to enter and code the interview data. The interview lasted for 20 minutes. Conducting the pilot study gave me the opportunity to hone my data collection skills as well as determine that the data collection and analysis instruments functioned as expected. All interview questions were validated by the pilot study participant as being nonbiased and nonleading.

Setting

The current study took place in Person County, North Carolina. Located near the Durham-Chapel Hill Metropolitan area, Person County is a small rural county with approximately 39,196 residents (PCHD, 2019). The study participants were AA pastors who oversaw churches located in rural Person County. I hand delivered the study invitations to the perspective participants. The subjects chose the site where their interviews would take place. The interview sites provided privacy for the participants and

safety for me as the interviewer. The interview environment was also quiet, which decreased interruptions due to noise during the recordings.

I offered the participants the option of virtual meetings for their interviews; however, they all chose face-to-face interviews for data collection. Although the COVID-19 pandemic had officially ended, COVID-19 infections remained elevated, and many people were continuing to use safety precautions. As a result, I asked the study participants if I should wear a mask for respiratory precaution purposes. When I was not required to wear a mask, I maintained a 6-foot social distance between the subject and myself. To further decrease the risk of spreading infection, I offered hand sanitizer to the participants after signing the consent forms.

Demographics

The seven participants for this study were all AA pastors who oversaw AA churches located in rural Person County, North Carolina. The ages of the participants ranged from 55–69 years. One participant declined to give their age. All participants had been pastors of their respective churches for at least 2 years. The range of pastoral experience was from 6–45 years. Five of the six participants had Bachelor of Science degrees, and two had Master of Science degrees. Five of the seven participants identified as male, while two identified as female. Three of the seven participants were of the Holiness faith, while three of the seven participants were of the Baptist faith. One participant identified as nondenominational. The congregation size of the participants' churches ranged from 21–1,000 members.

Data Collection

After receiving Walden University IRB approval to conduct the study, I began data collection. Using the interview guide, I collected data from seven AA pastors who served churches in rural Person County, North Carolina. Perspective participants were slow to respond to the study invitations. I had planned to interview two participants each week until all interviews were completed; however, the slow response to the invitations dictated that I was not able to meet this expectation. The interviews took place sporadically from September 16, 2023, through December 12, 2023.

The participants chose the location of their interviews. Three interviews took place in the pastors’ offices with only me and the interviewee present. At the request of the participant, one interview was held in the pastor’s office with the pastor’s spouse present. The pastor’s spouse did not participate in the interview. Per the participant’s request, one interview took place in their church sanctuary with the participant’s assistant present. The assistant did not participate in the interview process. Finally, two interviews were held in the church fellowship hall with only me and the interviewee present.

The durations of the interviews ranged from 6:00–21:54 minutes and varied according to the characteristics of the participant. For example, the shorter interviews were from participants who were direct with their answers, while the longer interviews were from participants who were more conversive. I audio recorded all interviews via the Philips Voice Tracer DVT2000 digital recording device and made notes on the interview guide sheets. At the end of the interview questions, I asked the participants if they wished to revisit any of the previous questions or if they had any additional input that they

wished to provide. After each interview, I debriefed the participants by reassuring them that the collected data would remain anonymous and confidential. I also offered to entertain any questions the participants had about the next steps in the research procedure; however, I received no questions.

Data Analysis

The data collected from the interview sessions answered the three research questions. The interview guide consisted of 17 interview questions. Interview Questions 1–6 addressed general demographic information (such as age, years of experience, church size, and church denomination), Questions 7–10 addressed Research Question 1, Questions 11–12 addressed Research Question 2, and Questions 13–17 addressed Research Question 3. After each interview session, I transferred the digital voice recording of the interviews to the Nvivo 14 data analysis program. I used the Nvivo 14 analysis program's transcription feature to assist in transcribing the longest interview, which lasted 21:54 minutes. For the remaining six interviews, I manually transcribed the digital recording into a Word document. After ensuring that there were no transcription errors, I provided copies of the completed transcript to the study participants via email with an attached read receipt. I asked each study participants to respond within 7 days if changes to the transcript were needed. None of the participants requested changes to the transcripts.

When there were no further changes to the transcribed interviews, I read each transcribed conversation and employed inductive coding to note any similar words or phrases that could be grouped into codes. I repeated the coding process multiple times

until there were no new codes in the documents. To further the analysis, I looked for similarities in the codes and grouped them together to form categories. After categorizing the codes, I performed a thematic analysis that consisted of reviewing the contents of the categories and developing a theme that was representative of the codes and categories. There were no discrepant cases found during the analysis phase.

The coding process yielded 10 themes. There were three themes that addressed Research Question1: negative feelings, positive feelings, and perceived benefits of collaboration. Four themes addressed Research Question 2: negative input from peers, no input from peers, positive input from peers, and reasons to collaborate. Finally, there were three themes that addressed Research Question 3: importance of gatekeeping, topics declined, and topics uncomfortable discussing.

Evidence of Trustworthiness

I conducted the current study as qualitative research; thus, evidence of trustworthiness was required. In qualitative research, the trustworthiness of a study is determined by four essential components: credibility, transferability, dependability, and confirmability (Burkholder et al., 2016; Creswell & Creswell, 2017).

Credibility

The qualitative researcher must show that the research data are believable, and researchers can establish credibility in several ways, such as triangulation and peer debriefing (Burkholder et al., 2016). I established credibility by keeping a reflective data collection and analysis journal, reviewing interview notes, and performing frequent member checks for data accuracy. I provided copies of the completed transcript to the

study participants via email with an attached read receipt. I asked the study participants to respond within 7 days if changes to the transcript were needed. None of the participants requested changes to the transcripts. After the first round of coding, I emailed a copy of the interview interpretation to each participant with an attached read receipt. This served as an additional form of member checking. I asked the study participants to respond within 7 days if there were disagreements with the interpretation of the interviews. None of the participants requested changes to the interview interpretations.

Transferability

Transferability is how relevant the study results are to other situations (Burkholder et al., 2016). I demonstrated the study's transferability through a detailed description of the participants' demographic information as well as the geographic setting of the study. The descriptiveness of the current study's research procedures should allow other researchers to obtain comparable results.

Dependability

Burkholder et al. (2016) suggested that dependability is derived from a researcher showing consistent data collection, analysis, and reporting. In this study, I addressed dependability by using an interview guide to ensure that each participant were asked the same interview questions. I recorded the interviews using a digital audio recording device and transcribed them into written form to minimize data collection errors. By using the Nvivo 14 data analysis system, I ensured consistency in analysis.

Confirmability

The final component of trustworthiness is confirmability. Burkholder et al. (2016) stated that a researcher establishes confirmability by supplying objectivity to remove researcher bias from the study findings. To ensure confirmability, I provided an audit trail that included careful documentation and attention to details of this study's methodology. I also kept a reflective journal of my findings from each interview.

Results

The purpose of this qualitative, phenomenological study was to discover the perceptions of AA pastors who oversaw AA churches in rural Person County, North Carolina regarding collaborations with PHAs to promote health education in their churches. The pastors' interview responses were audio recorded and transcribed into a Word document. I analyzed the transcripts using thematic analysis, which produced emergent themes that were used to answer the study's three research questions. Table 1 displays the research questions and related emergent themes.

Table 1

Research Questions and Emergent Themes

Research questions	Emergent themes
RQ1: What are AA pastors' attitudes towards collaborating with PHAs to improve the health status of their congregations in rural Person County, North Carolina?	Negative feelings Positive feelings Perceived benefits of collaboration
RQ2: What are AA pastors perceived subjective norms towards collaborating with PHAs to promote health education in rural Person County, North Carolina churches?	Negative input from peers Positive input from peers No input from peers Reasons to collaborate
RQ3: What are AA pastors' perceived levels of control when collaborating with PHAs to promote health education in rural Person County, North Carolina churches?	Importance of gatekeeping Topics declined Topics uncomfortable discussing

Research Question 1

There were three themes identified to address Research Question 1: negative feelings, positive feelings, and perceived benefits of collaboration.

Theme 1: Negative Feelings

Theme 1 focused on the negative views of partnering with health agencies. When asked if they felt that partnering with PHAs would be beneficial in addressing the health issues found in their congregations, there were two participants who shared negative views of communicating with PHAs.

P4 stated that there was "broken communication between the health department and the church." P5 stated, "As I was saying earlier, that it's a service that a lot of people don't know what they have to offer for people." P5 also asked, "Why haven't they made an issue to reach out to the Black churches and churches in general, to let us know the services that they have?" Finally, P5 suggested that "The health department should have some type of representative to go around to these churches and let us know what they have available to us. Anyway, they are not visible like they should be to the communities."

Theme 2: Positive Feelings

Although there were some negative feelings towards PHAs, there were more positive feelings associated with partnering with PHAs. When asked if they felt that partnering with PHAs would be beneficial in addressing the health issues found in their congregations, some participants suggested that partnerships are mentioned in the Bible, beneficial to the community, and that PHAs are knowledgeable. Specifically,

P1 suggested that partnering with PHAs are biblical stating, "If we look at it from the scripture point of view, they hold a place in God for us for our benefit. And you ought to want all the benefits that God has for you." P2 and P4 felt that partnering with PHAs was "beneficial." P3 added,

> The word of God tells us that wisdom comes from God. And I think when we chose to use our wisdom, and using what the Lord has provided through whether it be resources, whether it's the health department or whatever.

P5 considered the health department to be “vital for adults.” P6 said, “PHAs are knowledgeable and when they [church members] start talking to me like I am a doctor, I am not qualified, so naturally, I refer them to someone else who is.” P7 suggested, “You cannot give God total praise when your body is wretched with pain, and you’re sick, and you can’t hardly move and get around.”

Theme 3: Perceived Benefits of Collaboration

Theme 3 focused on the perceived benefits of collaborating with PHAs. The participants were asked to give examples of circumstances in which they would reach out to PHAs for addressing health issues in their congregation. All study participants agreed that collaborations with PHAs could be beneficial in disease management, forwarding information, and research. For example,

P1 implied that diseases, such as COVID-19, diabetes, high blood pressure, mental, and sexual health, could be managed with the assistance of PHAs. P2 also stated, “We have the effects of high blood pressure, diabetes, those are the things that we face here today. And stress as well as mental problems and what not.” When referring to disease management P4 stated, “It’s on preventing it versus... you know, reacting to what has already happened.”

Another benefit of PHA collaborations is access to and forwarding of information.

P2 implied that churches could benefit from collaborations by receiving and forwarding information. P2 added that, “Knowing what’s being offered, what the latest laws, the techniques, medicines, treatments, and just the availability” were benefits of collaborating with PHAs. P5 recalled,

> I got a package called the COVID-19. The information for getting the shot and the services they offered and myself, I went up there and I took the COVID shot as well. And I advised the others that had not taken the COVID shot, that they were rendering it at that time.

A final benefit of collaborating with PHA was the ability to participate in research studies. Only two participants referred to participating in research studies. For example, P2 stated, "We also have partnered with UNC Chapel Hill on various studies for black male health." P2 also added, "We recently participated with North Carolina Central University in long term individuals with COVID-19." Finally, P2 added that their church had "participated with the North Carolina Rural Farm Development Study, to have a consensus of reaching out to communities and trying to make the community…the very services that are needed in the community, infrastructure, internet, things of that nature." P6 recalled, "We did do a cancer study with UNC Chapel Hill, maybe 15 years ago. At that time, they said that Person County was one of the leading counties for cancer."

Research Question 2

There were four themes associated with Research Question 2: negative input from peers, no input from peers, positive input from peers, and reasons to collaborate.

Theme 4: Negative Input From Peers

Participants were asked if they had received any input from peers regarding partnering with PHAs to promote health education. There was one participant that had received negative input from fellow pastors regarding partnering with PHAs and pastors

promoting health education. P6 stated that, “I am more discouraged because sometimes other pastors say, “well, that’s a personal thing between the members and their doctors. I don’t get involved in that.” P6 also added, “Some pastors just tend to believe that that is an area that is hands off. They may do a sermon on it. But as far as partnering, they tend to stay away from that.”

Theme 5: No Input From Peers

While some of the study participants had received input from fellow pastors regarding collaborations with PHAs, there were others who had not received input from their peers. When participants were asked if they had received input from fellow pastors regarding PHA partnerships. P1 stated, “I try not to take other people opinions of something or experiences because that could be a particular incidence, or specific to that pastor or congregation.” P2, P4, and P5 stated that they, “had not received input from peers.”

Theme 6: Positive Input From Peers

There were two participants that received positive input from their peers and had been encouraged to collaborate with PHAs. When asked if they had received input from fellow pastors regarding partnering with PHA to promote health education, P3 stated,

> I’ve been encouraged that there is a resource. I have talked to other pastors, and I know that they too have sought out resources for their people…things that were available to them without them having to use their insurance or to spend a lot of money. And it’s all been positive. I haven’t received any negative responses from that.

P3 also added, “I think that they’re all willing, the pastors that I know, to collaborate with health agencies.” P7 stated, “I have been encouraged. I have a minister that keeps us informed and up to date about health issues. He keeps us informed as far as medical stuff.”

Theme 7: Reasons to Collaborate

The participants were asked to describe reasons to collaborate with PHAs. P1 suggested that “We are having people die or go into health great health issues because of lack of understanding about something as simple as an aspirin or vaccination.” P1 also added, “We are trusted or entrusted by our congregation to make sure we look out for their behalf. And that behalf is got to be what benefits them and not benefits us as an individual pastor.” P2 suggested that “Sometimes as a pastor, you would rather have someone come from the outside to the inside of the church to share the information and they receive it better.” P4 alluded to an increase in outreach stating, “But we have had some contact and had a very successful outreach event with the Medical Bus of North Carolina.” P5 noted that, “As far as someone has a mental problem or a mental breakdown, we can refer them to the health department, and they can guide you in the direction that you need to go.” P6 concluded that, “PHAs bring a lot of materials just to get our seniors to start thinking about their health.”

Research Question 3

Research Question 3 focused on how the pastors felt about being able to control the narrative of the information that is presented to their congregations. Three themes

addressed Research Question 3: importance of gatekeeping, topics declined, and topics uncomfortable discussing.

Theme 8: Importance of Gatekeeping

When discussing the importance of gatekeeping, the participants presented various views. The dominant sentiment was that the pastors have authority and a responsibility to control information provided to their congregations. The participants were asked to describe the importance of having control over information provided to their congregations.

P1 answered, “I think the only type of control you should have whether it's with health topics or anything, is that in which people give you as far as when they trust you.” P1 also said, “That is why we must give them all the information. You cannot give them the part that is particular to you. Whatever you decide you like. You have got to give them all the information.” P2 said, “I think any format of instruction and participation for the people, you would need some particular guidelines and you need people on-hand who's knowledgeable of the subject matter.” P3 suggested,

> I think it’s important that you’re able to control. Because, if not, the bible tells us to be aware of the enemy’s tactics. That the enemy sometimes will use what is a very good thing and a very helpful thing in a negative connotation or in a negative kind of way.

P6 added, “On a scale of 1-10 with 10 being the highest control, I’d go with a 10. I prefer to be free to say whatever the Holy Spirit leads me to say.” P7 concluded that, “Control is critical because you do not want it to get out of hand.” P4 disagreed with most

participants stating, "So, I don't think that it should be controlled... I think the holy spirit should lead. But I do think that people should be allowed to ask questions."

Theme 9: Topics Declined

All study participants agreed that forming collaborations with PHAs to promote health education is a good idea. However, there was some disagreement about the topics that would be allowed for discussion. When asked to describe health topics that they would decline to discuss with their congregation, P1 said, "None, because the very thing that you don't discuss is the very thing that come back and cause you problems." P1 also explained that "In order that there are no unaddressed issues, there cannot be any issues that we will not cover." P2 simply stated that there were no issues that they would decline to discuss. P3 and P4 agreed that there were no health topics that they would refuse to discuss. P4 also added, "Everybody doesn't have the same questions. I feel like if that question is important to them, I feel like I should address it." P6 said, "I would discuss pretty much any issue except sex change surgery." P5 had a different view stating,

> Well, it depends on what the topic is that you want to address. Being a shepherd, you have to know what's coming through the church. And so, if it's something that's going to help will help the congregation, I wouldn't have any problem for them to come in and reach out and help.

Theme 10: Topics Uncomfortable Discussing

The final theme of this study focused on the topics that the pastors were uncomfortable discussing, and how they would handle these topics. When asked to describe health topics that they would be uncomfortable discussing, P1 said, "But you

have to cover them the right way. You know, you can't overtly have men cover women issues." P2 answered saying, "None. I've been here 30 years plus. The people pretty well know me, and I know them. And they know I'm straight forward." P3 stated, "I think because we see the changing trends in not just America, but in society today, and so many varied opinions about certain issues when it comes to same sex or gender." P3 also added, "When we attempt to be biblically sound it, it may cause some controversy when you attempt to teach on various sexually transmitted diseases, there may be a difference in opinions." P3 further explained, "It may be difficult not to ignore it, but it may come with some challenges not to address those issues." P4 said, "I think that it would be more appropriate to have a male discuss men's health for as prostate exams and that type of stuff." P5 noted,

> I have pastored for 32 years, so, if you don't feel comfortable talking to your congregation after 32 years, then you have missed something. I certainly feel comfortable in any area far as pregnancies, teen pregnancies, or whatever issue you may have. I don't have any problems discussing same sex marriages. And I am not afraid to discuss with them as well.

Summary

In this chapter, I discussed how I used thematic analysis to code and analyze transcripts of semistructured interviews. I designed the interview questions to capture the feelings of AA pastors who oversaw churches in rural Person County, North Carolina. I also designed the interview question to address the three research questions.

The first research question focused on the pastors' attitudes toward collaborating with PHA to promote health education in their churches. There were a few mentions of negative feeling towards PHAs such as lack of communication and visibility. There were many positive feelings associated with collaborations with PHAs such as they are beneficial, biblical, improved access to health care, provided disease management and information.

The second research question focused on the pastors' perceived norms about collaborating with PHAs. The themes that developed from this question suggested that there was little to no negative input from fellow pastors regarding PHA partnerships. There was a mention that pastors do not like to address health issues in church and felt that health topics should stay between the congregant and their physician. Many of the study participants had received positive input from other pastors encouraging collaborations with PHAs.

The third research question focused on how important it is to have control when collaborating with PHAs. Most of the participants said that having control during collaborations was especially important. Some participants stated that they would discuss any health topic with their congregations, while others stated that it would depend on what the topic was.

In the following chapter, I will provide an interpretation of the study findings, study limitations, recommendations for further study, followed by the study implications, and a conclusion.

Chapter 5: Discussion, Recommendations, and Conclusions

The purpose of this qualitative phenomenological research study was to explore the feelings of AA pastors that oversaw churches in rural Person County, North Carolina. While conducting this study, I used semistructured interviews to guide conversation with the participants about their feelings towards collaborating with PHAs to promote health education in their churches. I designed the interview questions to help answer the three research questions. During the analysis of the data collected during this study, I discovered that many of the pastors had positive views of partnerships with PHAs and few participants had negative views. I also found that pastors would use PHA partnerships for a variety of reasons, including disease prevention and management, health outreach, general information, and research. I also discovered that although the participants all agreed that they had no reservations about PHA partnerships and promoting health education, a few did require the ability to decide which topics could be discussed with congregants. Finally, most of the pastors expressed that they would promote health education; however, they would feel uncomfortable discussing some sexual- and gender-related topics.

Interpretation of the Findings

I used the results of the current study to address the following research questions:

RQ1: What are AA pastors' attitudes towards collaborating with PHAs to improve the health status of their congregations in rural Person County, North Carolina?

RQ2: What are AA pastors' perceived subjective norms towards collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

RQ3: What are AA pastors' perceived levels of control when collaborating with PHAs to promote health education in rural Person County, North Carolina churches?

Attitudes Towards Collaborations

I derived the current study's research questions from the tenants of the TPB. The first construct of the TPB is that an individual's beliefs and attitudes toward a behavior influenced their intention to perform the behavior (Glanz et al., 2015; Khani Jeihooni et al., 2022). The results from the current study revealed that AA pastors of rural churches have positive attitudes towards collaborations with PHAs. For example, the pastors mentioned positive references, such as collaborations being beneficial, collaborations mentioned in the Bible, collaborations improving access to health care, and providing disease management and information. These references were also mentioned in the literature review and extend and support the findings of past researchers, such as Willilams and Cousins (2021) who felt that pastors expressed a need to collaborate with health experts from the community to ensure that the AA church had access to current health information. Bail et al. (2018) added that having the church involved in planning and promoting the Think Well program was essential to providing culturally competent education to the AA BCS community.

Research has shown that recruiting community members to provide health education can effectively help decrease and manage chronic diseases in the AA community (Victor et al., 2019). Another example of the AA church engaging with PHA is the TIPS program, an HIV education and testing initiative, that significantly increased the rate of HIV testing in an AA community (Berkley-Patton et al., 2019). A similar program, the WSA project, provided health screenings to the West Side of Chicago's AA community that were instrumental in determining the health and social needs of the target community (Lynch et al., 2020). Berkley-Patton et al. (2019), Lynch et al. (2020), and Hardison-Moody and Yao (2019) also stressed the importance of church participation in delivering successful community health programs.

While there were positive feelings about PHAs, there were some negative comments made by the participants in this study. Some pastors implied that there was a lack of communication between PHAs and AA pastors and that there should be a liaison between the PHAs and the pastors. The reviewed literature did not highlight the lack of communication as a concern among AA pastors of urban churches.

The findings from the current study suggest that urban and rural AA pastors share positive attitudes towards PHA partnerships and are willing to engage in such collaborations. The findings also imply that urban and rural AA pastors feel that partnerships with PHAs are vital to improving the health of their community. Although the participants in the previous studies were from an urban population, the results from this study add evidence that data from both sources can be applied to rural populations such as Person County's AA pastors.

Perceived Subjective Norms

The second research question addressed the second component of the TPB that a person's subjective norms about a specific behavior also help to dictate the intent of performing the behavior (see Glanz et al., 2015; Khani Jeihooni et al., 2022). The current study results support this component with the following themes: negative input from peers, no input from peers, positive input from peers, and reasons to collaborate. There were a few participants who indicated that they had been discouraged from participating with PHAs in delivering health education, stating that some peers believed that the congregants' health should be between them and their doctor. One participant also suggested that some of their peers felt that health was a "hands off" topic for pastors. While the current study results showed that "hands off" was the major negative sentiment among pastoral peers, the reviewed literature suggested that the lack of trust was the leading concern among AA pastors. For example, Bolger et al. (2018) found that although most church members participated in health initiatives, there remained a distrust in collaborating with PHAs. The participants in the studies of Nguyen et al. (2021) and Bolger et al. also noted the Tuskegee Syphilis Study as a factor in their distrust of doctors and the health care system. These studies illustrated that distrust in public health is a norm in the AA community. The current study results did not indicate that trust in PHAs was a major concern for rural AA pastors.

The current study results suggested that some of the participants had not received input from peers about PHA collaborations. One of the participants said, "I try not to take other people opinion of something or experiences because that could be a particular

incidence, or specific to that pastor or congregation." The reviewed literature did not reveal this sentiment among the study participants from the urban areas.

Other themes in the current study suggested that AA pastors received positive input from pastors highlighting the reasons for partnering with PHAs. For example, one participant said, "I've been encouraged that there is a resource. I have talked to other pastors, and I know that they too have sought out resources for their people." Another participant said, "I have been encouraged. I have a minister that keeps us informed and up to date about health issues. He keeps us informed as far as medical stuff." Other pastors implied that PHA partnerships were beneficial because of increased health outreach, increased access to health care, and the ability to participate in health research. One pastor said, "Sometimes as a pastor, you would rather have someone come from the outside to the inside of the church to share the information and they receive it better." The results from the current study confirmed the sentiments found in the reviewed literature regarding collaborating with PHAs. The current results also confirmed that AA pastors felt that PHA collaborations were accepted in the AA pastoral community.

Perceived Levels of Control

The third construct of the TPB is that a person's perceived control of behavior influences their intent to perform the behavior (Glanz et al., 2015; Khani Jeihooni et al., 2022). The current study results revealed that the participants felt that there should be a level of control over the topics that were addressed while providing health education via PHA partnerships. Some pastors felt that they would discuss all health topics, while other pastors felt that their participation would depend on what the topic was. One of the main

themes in these results was that gender-related health topics made the pastors uncomfortable; however, they would not decline discussing them. Another theme was that the pastors considered themselves to be gatekeepers.

The current study results confirm the sentiments found in the literature review. For example, Wright et al. (2020) concluded that pastors agreed to partner with PHAs to address teen pregnancy; however, many had strict limits on the subjects they would incorporate in their sermons, such as premarital sex and abstinence. Likewise, Adimora et al. (2019) suggested that most pastors agree to partner with public health professionals to introduce health topics; however, the pastors need to control the messaging to ensure agreement with church convictions. Finally, the reviewed literature suggested that because AA church pastors considered themselves gatekeepers of the information given to their congregates, they felt a responsibility to ensure the accuracy of information (Brand, 2019; Harmon et al., 2018). These themes were present in both the results of the current study of rural AA pastors and the previous studies of urban AA pastors. These themes imply that both urban and rural AA pastors consider themselves as gatekeepers with the responsibility of ensuring that incoming information is not harmful to their congregates.

Limitations of the Study

The primary limitation of this study was the participants were all from a specific geographical location: Person County, North Carolina. Because Person County is a small rural area, this limitation could affect the transferability of the study to populations from other larger, urban locations. Another limitation for this study was that the pastors were

either Baptist, Holiness, or nondenominational. This was a limitation because other denominations were not found among the study volunteers. A third limitation to this study was that only AA pastors were asked to participate. However, this limitation was by design due to the focus of the study being AA pastors. The fourth limitation to this study was the lack of previous studies that focused on pastors in rural settings; therefore, some of the literature and results were based on pastors in urban settings. The final limitation was the sample size of seven participants. Creswell and Creswell (2017) stated that there is no required number of participants for qualitative studies; however, having more participants in this study may have provided more variations in the participant pool's demographics. For example, this study's participants identified as Baptist, Holiness, and nondenominational. It is possible that the data collected may have been different if more denominations were represented in the study's sample.

Recommendations

The findings of this study provided insight into how AA pastors of rural churches in Person County, North Carolina felt about collaborating with PHAs to promote health education in their churches and communities. The results of this study showed that the participants generally had positive thoughts of PHA collaborations, and pastors were agreeable to pursuing future partnerships. Although pastors were agreeable to partnerships, they had strong feelings about retaining control over how health topics were presented. The study participants also revealed that they had few reservations about the health topics that were discussed with their churches.

While there were many studies that addressed the views and concerns of urban AA pastors, the current study gave insight into the AA pastors in a rural area. This study focused on only one area in North Carolina. Future research could investigate other rural areas that are like Person County and compare the results. Another limitation of this study was the number of study participants. As such, future researchers should increase the number of participants and recruit pastors from diverse denominations.

While this study focused on the pastors' perceptions of PHA partnerships, future studies could investigate the perceptions of Person County's rural AA church members. For example, researchers could seek to discover how the congregates feel about receiving health-related counseling and education from clergy. Researchers could also assess the comfort level that the parishioners felt when discussing health concerns with clergy. Additionally, rural AA pastors could use this study's data to initiate conversations with church members regarding forming health ministries in their churches.

The current study revealed that there was a lack of communication between PHAs and rural AA pastors. PHAs could use this study's data to help justify the need for additional personnel to serve as liaisons between PHA and pastors. Additionally, pastors could consult with the PHA liaisons for advice in building health ministries within their churches. Finally, PHAs could use this study's data when planning health outreach events. For example, this study revealed that rural AA pastors favor forming partnerships with PHAs and that rural pastors would discuss most health topics with their congregations. Using this information, PHAs and pastors could plan health initiatives that target diseases that are prevalent in rural AA communities.

Implications

In this qualitative, phenomenological study, I explored the perceptions of AA pastors from rural Person County. The research questions were designed to address the components of the TPB, such as the pastors' perceived attitudes regarding PHA partnerships, perceived subjective attitudes of peers, and level of control of collaborations to promote health education. The study results revealed that the AA pastors generally had positive opinions of PHAs, such as being a resource for disease management, information, and health outreach. The results also revealed that pastors were willing to collaborate with PHAs to promote health education; however, pastors needed to have control of information provided to their congregants. Finally, the results showed that pastors needed PHAs to be more visible in their communities and provide liaisons between PHAs and the churches.

Information from this study can be used on an organizational level by PHAs such as local health departments. For example, when developing and implementing health outreach campaigns such as prostate screenings in rural AA communities, local health departments can focus on collaborating with AA pastors to partner in disease prevention, disease management, and outreach. Positive social change could be realized on the societal level when PHAs and churches partner to fulfill health outreach initiatives to decrease health disparities in Person County. For example, partnerships could promote healthier behaviors in rural AA communities such as encouraging physical checkups, taking medications as prescribed, seeking mental health counseling, smoking cessation, and family planning. By participating in the activities mentioned above, Person County's

rural AA community could improve health outcomes by taking a proactive approach to health as opposed to a reactive approach.

Furthermore, rural AA communities could realize positive social change when pastors use their leadership roles to engage their congregation in community activism. Pastors could achieve this change by forming organizations such as health and outreach ministries to gain access to the AA community members who do not attend church. Because the pastor is considered the gatekeeper of information for the church, the pastor could provide a vital link for communicating between PHAs and the AA community in rural areas. Because pastors fill the role of leadership in rural AA communities, they could encourage AA residents to make use of health initiatives offered by local PHAs. Rural AA communities could realize improved health outcomes by participating in health initiatives designed to address their health issues.

This study implies that partnerships between PHAs and rural AA pastors could be instrumental in decreasing health disparities in Person County by providing a conduit for delivering and promoting health education to the AA community. This study also implies that pastors want channels of communication that allow them to relay their congregations' health concerns to PHAs. This conveyance of information could enable PHAs to offer disease prevention initiatives that are most beneficial to rural AA communities. Finally, PHAs could include AA pastors in distributing county health assessments to their churches. By using data from these assessments, PHAs could apply for grants that are specifically for diseases that are most prevalent in rural AA communities; thus, decreasing the community's financial burden. Using data from

community health assessments, PHAs can focus on the most prevalent health issues in the rural AA community and direct funds to programs that specifically address these health issues.

When comparing the perceptions of urban pastors with those of rural pastors, this study revealed no appreciable difference in the views of the two demographics. For example, previous studies, such as Augustin et al. (2019), Berkley-Patton et al. (2019), and Lynch et al. (2020), suggested that urban pastors appreciated PHAs as a resource for health screenings, health education, and disease management. The results of the current study indicated that rural pastors have the same sentiment regarding PHAs as a valuable resource. The current study utilized the TPB to demonstrate that urban and rural pastors felt that forming collaborations with PHAs was an essential and beneficial pastoral responsibility. This study also implied that urban and rural pastors considered themselves gatekeepers and needed a certain level of control over the information forwarded to their churches.

Overall, this study implies little difference between urban and rural AA pastors' perceptions regarding collaborating with PHAs. This study also suggests that urban and rural AA pastors welcome partnerships with PHAs if they are allowed control over the health information forwarded to their congregates. PHAs and research institutions can feel more confident in reaching out to AA pastors to promote health education, conducting community assessments, and aiding with research studies. Finally, this study suggests that AA pastors and the AA community can feel more empowered to improve the health of their community when collaborating with PHAs.

Conclusion

Person County's AA population suffers from significant health disparities as compared with their White counterparts. Research has shown that health disparities can be reduced by providing health education in AA communities. Research has also shown that AA communities respond to health education provided through collaborative efforts between PHAs and AA pastors.

Given that research has shown that health disparities in the AA community can be reduced by promoting health education through partnerships between AA pastors and PHAs, I conducted semistructured interviews with seven AA pastors who oversaw churches in rural Person County, North Carolina to assess their feelings towards collaborations with PHAs to promote health education in their churches. Using the TPB as a guide, I formulated research questions that addressed the participants' perceived attitudes towards collaborating with PHAs, perceived subjective norms about collaborating with PHA, and perceived level of control when collaborating with PHAs.

This study showed that AA pastors have positive attitudes of collaborations with PHAs. The results also showed that pastors have limited conversations with peers regarding PHA partnerships. In addition, this study showed that although pastors are agreeable to PHA collaborations, they still require a level of control of the health topics presented to their congregations. Because this study presented the views of rural pastors, as opposed to the views of urban pastors, it helped to close the gap in the existing literature.

It seems reasonable that collaborations between PHAs and AA pastors could be a viable way to decrease health disparities in Person County's rural AA community by helping PHAs to focus on the health topics that affect the AA community. PHAs could also use partnerships with pastors to promote healthier behaviors, promote health education, conduct health assessments, and collect data to assist in obtaining funding for the prevention and management of diseases that disproportionately affect the AA community.

In addition to PHAs benefiting from partnerships, pastors and their church congregants could benefit as well. For example, if a pastor observed an increase in the number of congregants who developed diabetes or other preventable diseases, the pastor could reach out to a local PHA for information regarding diabetes prevention and management. Pastors could also reach out to PHAs for guidance in forming health ministries in their churches and improve community outreach.

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Appendix A: Interview Guide

Interview Guide

Participant Number _________

Pre-interview Script

My name is Richard Johnson. I am a PHD candidate in the Health Education & Promotion program at Walden University.

Recent research studies have shown that partnerships between public health agencies and African American pastors are effective in promoting health education and healthier behaviors in the African American communities. However, these studies focused on pastors of churches in urban communities. The purpose of this study is to explore the perceptions of rural African American pastors regarding partnering with public health agencies to promote health education.

As a reminder, you may choose to not answer questions that make you uncomfortable answering. You may also end this interview at any time. Are you ready to begin? Starting recording now.

Demographics

1. What is your age?
2. What is your gender?
3. What is your educational background?
4. How many years have you been a pastor?
5. What is the size of your church congregation?
6. What is the denomination of your church?

Attitude towards Collaborating with PHAs (TPB)

7. What are the most common health issues that you find in your congregation?
8. Do you feel that partnering with PHAs would be beneficial in addressing the health issues found in your congregation?

9. What are examples of circumstances in which you would reach out to PHAs for assistance in addressing health issues in your congregation?
10. What are your plans to partner with PHAs such as the Person County Health department?

Perceived Subjective Norms of Collaborating with PHAs (TPB)

11. What are examples of times when you have partnered with PHAs to address a health issue in your community?
12. Have you been encouraged or discouraged to collaborate with PHAs by the experiences of other pastors you know or have spoken with?
    How did this information help you to decide whether to work with or not to work with a PHA?

Perceived Control of Collaborating with PHAs (TPB)

13. What health topics would you feel uncomfortable discussing with your congregation?
14. Why do you feel uncomfortable discussing these topics?
15. What health topics would you refuse to discuss with your congregation?
16. Why would you decline to address these health topics?
17. How important is having the ability to control which health topics that you address in your church?

Post interview Script

This is the end of the interview and the end of the recording.

Thank you for volunteering your time to participate in this research. I will transcribe this interview and I will contact you to see if you would like to review the transcription before I perform data analysis.

If you have further questions or concerns, I can be reached at the phone number and email address provided on the invitation.

Appendix B: Sample Read Receipt

Transcription letter

Dear participant,

Thank you for your participation in my doctoral research study.
Please find attached the transcript from your recent interview on 11/19/2023.

If you would like changes to your transcript, please reply to this email with requested changes within seven days.
If there are no changes needed, do nothing.

Thank you for your participation.

Richard H. Johnson, PHD (c)
Health Education & Promotion
Walden University