2017

Spiritual Leadership: Achieving Positive Health Outcomes in African-American Christian Churches

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This is to certify that the doctoral dissertation by

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Abstract

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MS, Regis University, 2006

MPH, Tulane University, 1986

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Dissertation Submitted in Partial Fulfillment

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Abstract

In the United States, African-American residents are an underserved population with evidence of higher health disparities than those associated with any other race, contributing to escalating health care costs. Despite the absence of health promotion and wellness training, pastors in predominately Black churches accept the responsibility for addressing more than the spiritual needs of their church members. The purpose of this qualitative grounded theory research study was to explore the perspectives of African-American Christian pastors on giving health guidance and their lived experiences as health promotion advocates. A total of 10 African-American Christian pastors were voluntarily recruited from 3 southern U.S. states using both purposeful and theoretical sampling strategies. Interviewing was the main data collection method. Social cognitive theory along with grounded theory were used to examine the interactions based on participants' points of view, and inductive analysis was also used. The results indicated that pastors have knowledge of their congregational members' health challenges and goals and have achieved positive health outcomes. The pastors also agreed that seminary should incorporate more information on health and wellness into the curriculum. These findings suggest that pastors, who are faith-based resources outside of health care systems, need to be educated, equipped, guided, and groomed as health leaders to assist efforts to reduce or eliminate health care disparities. Members of the clergy, their church members, and surrounding community residents would all benefit from the knowledge, understanding, and development of skills to change their unhealthy lifestyle habits and effective self- management of chronic diseases to achieve positive health outcomes.

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Dedication

I dedicate this dissertation with a heart full of love for the person who fostered the desire to serve others, my late grandfather, Reverend Henry Bracey and the person who had the faith I could reach this goal, my late mother, Sarah Ann Bracey. My deepest regret is that they are not here physically to celebrate this achievement; however, I am grateful for the presence of their spirit and cherished memories.

I also dedicate this dissertation to all faith leaders and their faith-based organizations that are working hard to lead their members and surrounding community residents to health. May God continue to give you the strength, resources, and wisdom to sustain your efforts to build healthier communities.

Acknowledgments

I first give thanks to our Heavenly Father, source of strength and help who orders my steps. I was so honored to meet and work with all the pastors who participated in this study and the opportunity to praise God with their church family. I truly appreciate the loving support, guidance, and prayers of my pastor, Reverend Dr. Taijuan O. Fuller, and Beauty Spot Missionary Baptist Church family.

Completion of this educational journey would not have been possible without the patience, time, guidance, support, and commitment of my doctoral committee, Dr. Naa-Solo Tettey, Dr. Magdeline Aagard, and Dr. Egondu Onyejekwe. This committee, along with other faculty members and Dr. Elisabeth Johnson-Kallos, editor, demonstrated that teaching comes from the heart and they utilized every opportunity to increase my level of knowledge and understanding of this process.

I am most grateful for the love, support, encouragement, and prayers from family, friends, and community. My brother, Reverend Dr. John Duckworth, assisted my efforts to understand seminary preparation and the multiple roles of a pastor. My two sons, K. Martai and Bracey, grandsons Jordan and Noah, niece and nephews Gabrielle, John Jr, and Nicholas provide the daily motivation and drive to build healthier communities. Lastly, I must recognize the constant support and love my father, Eddie Bracey, provided from the beginning to the end of this process.

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Chapter 1: Introduction to the Study

African Americans are an underserved population experiencing health disparities, inequalities, and higher rates of mortality and morbidity than any other race (Centers for Disease Control and Prevention [CDC], 2014a). Heron (2013) reported, "Total 2010 deaths from all causes are 2,114,749 for Whites, 286,959 for Blacks, 15,565 American Indians and Alaska Natives, and 51,162 Asian and Pacific Islanders." (p. 11). The Health Disparities and Inequalities Report completed by the CDC (2014b) showed that in 2013 African Americans suffered the highest rates of heart disease and stroke, high blood pressure, excess weight, diabetes, disabilities related to chronic conditions, periodontitis, infant deaths, human immunodeficiency virus (HIV), colorectal cancer, lower vaccine rates for influenza, and premature death than any other race. This report also provided the following details for inequalities: higher rates than all other minorities for homicides, unemployment, poverty, uninsured for health, lower high school completion, and life expectancy rates. The research indicated that African-American churches using faith-based health-promotion activities in collaboration with universities, medical health centers, and public health organizations could offer remedies for these health disparities, as well as remedies for social and economic concerns (Harmon, Blake, Armstead, & Hebert, 2013).

Churches have a long history of addressing the needs of the African-American community with regard to health, social, commercial, legal, and governmental issues (Harmon et al., 2013). African Americans tend to seek the support of their faith and their

churches, as well as the assistance of their faith leaders to obtain social justice and achieve social change (Chatters et al., 2011). When people diligently practice their faith to deal with health concerns and life issues, they feel better and live longer (Wachholtz & Sambamoorthi, 2011). According to the Pew Research Center (2014), the religion most practiced in the United States is Christianity, and attendance is higher than all other races for African Americans in Black churches. Levin (1984) wrote, "Historically, the black church has been the preserver and the perpetuator of the black ethos . . . and the autonomous social institution that has provided order and meaning to the black experience in the U.S." (p. 477).

Black Christian churches are cherished places in the community to worship and to seek solace and help for healing and perseverance during crises (Lewis & Trulear, 2008). Some of the specific types of crises experienced by African Americans were mental, economic, political, educational, physical, and social injustice, pain, humiliation, cruel treatment, and early deaths (Lewis & Trulear, 2008). African Americans have found black churches to be a supportive resource from "slavery, . . . through emancipation, . . . the era of Jim Crow discrimination and lynching . . . to modern day challenges of health disparities and mass incarceration" (Lewis & Trulear, 2008, pp. 343–344). African-American pastors are the leaders in these faith-based organizations (FBOs) to ensure forward progression of achieving social justice, protection, financial stability, health equality, and freedom from discrimination for Black communities (Levin, 1986).

FBOs are deeply embedded in communities and easily identifiable by residents around the world as places for organized religion (Asomugha, Derose, & Lurie, 2011).

Asomugha et al. (2011) noted for centuries, faith leaders were recognized as the authority and experts on religion and religious practices. FBOs provide educational opportunities for learning about spirituality, community service, coping skills with life experiences, governing laws and policies, relationships, parenting, comfort and healing for medical conditions and traumatic events (Asomugha et al., 2011). These institutions have been counted on to embrace and meet the needs of the poor, disenfranchised, and unwanted (Ferris, 2005).

Because FBOs embrace the mission to uplift people in their circumstances; to feed, clothe, and minister to the needs of residents inside and outside of their facilities; and to speak up for growth and development of their members and communities, these institutions demonstrate evidence for being health-promotion advocates (Asomugha et al., 2011).FBOs and their leaders are tasked with the responsibility to open the doors to groups of people who are ignored, forgotten, or invisible for social, economic, and health services (DeHaven, Hunter, Wilder, Walton, & Berry, 2004).

The Black experience in the United States is one of higher levels of health disparities, unemployment, poverty, involvement in the criminal system, and educational disparities (CDC, 2014b). This experience is also a familiar story among African-American pastors who are predominantly male (Jenkins, 2006; Lummis, 2006). Black men in colleges are few, which results in lower completion rates for undergraduate degrees when compared with Black women and both white men and white women (Valburn, 2009). According to Harper (2012), who listed completed postsecondary degrees by level and gender in 2009, the numbers for Black men were lower in

comparison to the same groups for undergraduate degrees. Although more African-American pastors are earning graduate degrees, the numbers are still too low, especially in the southern states (Lummis, 2006). Black clergy have encouraged each other to become more educated through seminaries to effectively empower their congregations to cope with all 21st-century problems facing them (Lummis, 2006). Holistic salvation, which "involves nurturing not only our souls but [also] our bodies" (Maddox, 2011, p. 23), has its roots in Black churches.

African-American pastors readily acknowledge the positive influence of religion on healing and how they themselves are health messengers from the pulpit and individual advisors to affect the health behaviors of their members (Lumpkins, Greiner, Daley, Mabachi, & Neuhaus, 2013). African Americans are more likely to request the support of their pastors and church during personal or family health crises than other Americans (Allen, Davey, & Davey 2010). However, members of the clergy are not trained in seminaries to provide individual and group health guidance to change unhealthy lifestyle behaviors, and a gap in literature exists regarding self-assessment of their skills to do this type of counseling (Bopp, Baruth, Peterson, & Webb, 2013).

In my study, therefore, I explored how African-American pastors feel about their ability to give health advice within their FBOs and what positive health outcomes of their members they have been able to achieve. Lumpkins et al. (2013) indicated, "On the intra-personal level, the beliefs that an individual has in God affect how health information is processed" (p. 1094). The next step in this process is the involvement of the Black church and its pastor to reveal why this health information can change an individual's life and

what needs to be done (Lumpkins et al., 2013). Black pastors are in a unique position to become powerful "agents of change" for their congregational members and their families, themselves and their personal families, and the community at large (Levin, 1986, p. 96). When these members of the clergy effectively help significant numbers of these audiences to change their unhealthy lifestyle habits resulting in positive health outcomes that would reduce the health disparities (Harmon et al., 2013).

In this chapter, I address the research topic by providing a background of the problem, a problem statement, and research questions. I explain the purpose and the nature of the study and provide a conceptual framework. I also discuss assumptions, scope and delimitations, limitations, and the significance of the study. I provide definitions of terms as used in this study and end with a chapter summary and overview of the study. To establish the relevancy of this study, the background discussion must be centered on church leaders, hard-to-reach communities, and health promotion.

Background

The literature review indicated how essential the clergy is with respect to the health of its church members, and it also communicated the need to establish a more prominent presence of the pastor in health program activities (Bopp et al., 2013). Pastors are members of a helping profession, and they commit themselves to social justice and social change through service. This commitment has occasionally proved to be detrimental to their own health and resulted in unhealthy eating and reduction of exercise (Baruth, Wilcox, & Evans, 2014). Yet, in African-American churches, pastors are

leaders, and they are expected to guide their members to holistic health (Baruth et al., 2014).

According to Levin (1984), Black pastors play multiple roles, and one of these roles is as health-promotion advocate. Levin also stated that, in additional research studies, this pulpit leader is a significant health communicator who, "in the broader sense, [has] to effect health-related behavioral change" (p. 96). Research studies undertaken by Levin demonstrated that African-American pastors can advocate for health promotion in FBOs. These faith-based institutions were found to be ideal establishments for health-behavior research opportunities that showed changes in the statistics of disabilities and deaths related to cardiac diseases (Lasater, Wells, Carleton, & Elder, 1986).

In a span of 10 years, researchers were unable to identify quantifiable data to demonstrate conclusively the success of health promotion activities within FBOs, but the data did reveal health benefits for the congregational members (DeHaven et al., 2004). A strong rationale was provided in the research, which showed that African-American churches were able to form effective working relationships with universities and public health agencies because of their access to this underserved population (Asomugha et al. 2011; Goldmon & Roberson, 2004). Because members of the clergy are in a position of authority, the research indicated that their approval is required before health promotion activities can be provided in FBOs to change unhealthy lifestyle habits (Carter-Edwards et al., 2012).

Researchers were able to conclude through measurable data that Black churches were ready to assist efforts to address health disparities among their members and

surrounding communities (De Marco et al., 2011). Some of the barriers and challenges for pastors, included their own unhealthy lifestyle habits, time constraints, and lack of formal training to do effective behavioral health-change guidance (Baruth et al., 2014; Bopp et al., 2013; Lumpkins et al., 2013). A gap exists in research regarding the perspectives of African-American pastors on how they give health advice and health outcomes of this intervention (Bopp et al., 2013). In this study, I intended to take that first step in obtaining that data to support future efforts of addressing health disparities using the contributions of these designated community leaders who promote social justice and social change.

Problem Statement

According to the CDC (2014a), African Americans have the greatest incidence of health disparities and inequalities, at risk for the top 10 leading causes of death and categorize as a vulnerable population and a hard-to-reach community. These situations or concerns have been found by CDC (2014a) to be a direct result of high unemployment, poverty, discrimination, race and ethnicity, poor nutrition, high-risk sexual behaviors, lack of health insurance, low educational levels, and unhealthy lifestyle behaviors.

African Americans, one of the largest minority populations in the United States, are frequently reported by CDC (2014a) in the national health statistics of this country for experiencing preventable medical conditions and for developing chronic diseases that lead to disability and premature death. The health care system in the United States has delivered inadequate care, blocked access to care, and provided poor quality of care to

Black people (U.S. Department of Health and Human Services [DHHS], Agency for Healthcare Research and Quality [AHRQ], 2013).

During the past several decades, several multiple local, state, and national initiatives have sought to resolve health care disparities and inequalities to achieve social change and justice (Healthy People 2020, 2015). Despite these interventions, African Americans are still experiencing these health-related concerns (CDC, 2014a). The U.S. health care system, with its finite number of resources, requires help to meet the needs of all community residents, a group that is growing older, more diverse, and geographically dispersed (U.S. DHHS, Health Resource and Services Administration [HRSA], Bureau of Health Professions, & National Center for Health Workforce Analysis, 2013). The knowledge of this situation is familiar within private and public health care systems, public health and community agencies, and academic institutions, and among corporate and political leaders and FBOs. Primary care "providers generally have only 15-20 minutes with each patient," an inadequate amount of time to help patients make permanent lifestyle changes (Elder, Ayala, & Harris, 1999, p. 281).

In the past decade, the numbers of assigned primary care providers had to be increased to meet the overwhelming patient demand (U.S. DHHS, HRSA, Bureau of Health Professions, & National Center for Health Workforce Analysis, 2013). In the United States, primary care providers are the lead coordinators of medical care. Owing to increases in patient demand, medical students are not choosing primary care because of the heavy workload, lower levels of income in comparison with specialty providers, and underutilization of complex medical skills (Smith & Sabino, 2012). As a result, limited

time is available to spend with a patient and his or her family members to change health behaviors; thus, allied health professionals, medical specialists, registered and licensed practical nurses, health educators, public health leaders, and clergy have had to lend a helping hand (Lumpkins et al., 2013).

Medical providers with all of their professional training and knowledge do not have the power to change everyone's health-related lifestyles (Elder et al., 1999). It is essential to introduce and implement effective health-behavioral change strategies into clinical practice, public health policy, daily personal health regimens, and faith-based practices. Research has provided evidence of models and theories that help to deliver information to people who need to change their high-risk behaviors at the time they are willing to make healthier decisions (Elder et al., 1999). Designated health care and public health professionals who provide health educational teaching, counseling, and health monitoring must also use these strategies to support the efforts of primary care providers (Elder et al., 1999).

In the United States, health statistics vary regarding the number of people who seek health care advice from a medical provider because of factors such as (a) the numbers of uninsured for health care fluctuates; (b) gender (women tend to have more contact with health care systems than men do); (c) race (whites have more designated medical providers than minorities do); (d) age (equal access for both men and women by age 65 years or older); and (e) use of the Internet, friends, and families as alternative resources for health information (Sandman, Simantov, & An, 2000). Although 100% of the residents do not seek health advice counseling from their medical providers, it is

essential that professionals outside of health care organizations are trained to assist them. Therefore, it takes all leaders who advocate for better health to deliver appropriate health information (Elder et al., 1999, p. 275).

Faith-based institutions are partnering with medical communities to address the health problems of their members, but it is unclear if these institutions are able to sustain these programs (Bopp et al., 2013). African-American churches have a history of working with the medical community, academic institutions, and governmental agencies for health screenings and health education programs (Ayton, Carey, Joss, Keleher, & Smith, 2012). Once these partnerships and funding moves to another FBO or community have been made, the literature is not clear about the longevity of these health promotion programs and the health outcomes for the members of these faith-based institutions (Carter-Edwards, Johnson, Whitt-Glover, Bruce, & Goldmon, 2011). Community-centered health activities may have met some of the health needs of the membership body, but researchers have not been able to uncover evidence that adequately demonstrated that these activities were effective and sustainable (Lumpkins et al., 2013).

Pastors can influence the congregational members to achieve better health results (De Marco et al., 2011). Pastors interact with their congregational members where they are on the health continuum, from sickness to well-being. If pastors could assess their members' readiness to change unhealthy behaviors and then give the right health guidance to the member, the result could be a positive health outcome (Elder et al., 1999). The literature is replete with overwhelming information about theories and

interventions to change health behaviors that rely on a basic assessment of the person and a targeted discussion for change (Elder et al., 1999).

I found, however, a gap in the literature exists regarding any targeted effort to improve the skills of the clergy for providing health-behavior guidance (Bopp et al., 2013). Members of the clergy find themselves at the bedside in hospitals, in homes, and at the place of worship, where their church members and families may discuss their health-related concerns. For the Black community, churches are institutions that the members believe in, and they seek guidance from their pastors in every facet of their lives (Lumpkins et al., 2013). These faith-based institutions have a significant history of disseminating medical information and providing caring services to their members and communities (Baruth et al., 2014).

Purpose of the Study

Human behaviors of tobacco use, diets rich in fat, absence of exercise, unprotected sex with multiple partners, and excessive weight gain must change to reduce the risks to longevity (Loef, 2012). The clergy is trained to provide guidance, which requires the study of human behavior. One of those behaviors may be negative health behavior, which leads to chronic medical problems. It was evident in the literature that African-American pastors and Black churches are capable, interested, and actively involved in health-promotion activities (Lasater et al., 1986). These churches have a deep pool of knowledge and expertise in meeting the needs of their congregational members, families, and communities (De Marco et al., 2011). Goldmon and Roberson (2004) indicated that Black churches are thought to be ideal partners in advocating health

promotion for the following reasons: (a) they share the same objectives as public health agencies trying to achieve population health and improvement of socioeconomic conditions; (b) their goal of spirituality is restoring individuals, families, and communities to total health; (c) they offer hope, healing, love, and guidance; (d) they have members from all professions who can contribute their expertise; and (e) they touch the lives of underserved populations.

The purpose of this study was to shine the spotlight on the efforts, experiences, and concerns, as seen from the perspective of African-American Christian pastors, regarding the position as a leader who gives health advice to the congregational and community members they serve. This study was prompted by my desire to close a gap existing in the literature regarding these pastors' self-assessment of a specific type of guidance they were not formally trained to provide, but for the dispensing of which they are uniquely well placed. Bopp et al. (2013) noted that these pastors are perfectly positioned to be strategic assets in addressing health care disparities in Black communities. FBOs and their pastors have built trusting relationship; they can speak across generations, and they have become, through their mission of volunteering, social support, and outreach, highly competent in changing behaviors (Lasater et al., 1986). Levin (1984) wrote:

- The historical agency of the black church as a social institution concerned with the social welfare of black Americans suggests that the black church, in general, and the black clergy, in particular, could serve as agents of

> medical decontrol because of the church's unique status as the seat of both worship and healing. (p. 479)

Besides training physicians, nurses, mental health counselors, and public health leaders in behavioral health guidance for the prevention and management of chronic diseases, clergy, too, may need to be trained. Ministerial staff in faith institutions across this country is a barely touched resource to assist public health leaders and primary care providers in managing chronic diseases (Levin, 2014).

Members of the clergy, by virtue of their position, ability to communicate, and access to hard-to-reach populations, can facilitate efforts to enhance health outcomes (Levin, 1986). The heavy demands on their time and multiple roles, tasks, and priorities can become barriers to their participation; however, members of the "clergy, willing or not are often presented with the challenge of addressing health within their organization" (Bopp et al., 2013, p. 184). Changing health behavior is all about understanding the *how*, *when*, and *what* of health information that needs to be given (Elder et al., 1999). People have to be ready to make profound changes in their lives, especially when it comes to improving their health. The aim of this research was to capture the critical moments and show how these pastors faced up to, met the challenges, and addressed the issues so that future interventions can be tailored to augment their efforts for social justice and social change.

Research Questions

Two research questions guided this study:

RQ1: How do members of the African-American clergy feel about their ability to conduct health-advice guidance within their faith-based institutions to achieve positive health outcomes of their members?

RQ2: What are the African-American pastors lived experiences as members of the clergy and health-promotion advocates?

Conceptual Framework

The focus of this study was trained on the behavior of African-American pastors who were giving health-advice guidance to their congregational members. Social cognitive theory (SCT) was used as the conceptual framework in this study because it illustrates how the individual and the environment engage and transform each other. Glanz, Rimmer, and Viswanath (2008) spoke of "reciprocal determinism—resulting in individual and social change" (p. 168). Pastors who participate in opportunities to assist their members to improve their unhealthy lifestyles may experience a beneficial influence on their own health behaviors and the environment of their churches as they increase their health-promotion activities due their reciprocal effects (Asomugha et al., 2011).

The SCT is widely used to support health promotion because of several key constructs that include, but are not limited to, "reciprocal determinism, modeling, observational learning, self-efficacy, and collective efficacy" (McAlister, Perry, & Parcel, 2008). Pastors can serve as the model for health promotion or appoint a peer to assist the efforts of targeted individuals or groups to achieve effective self-management and improvement of their unhealthy lifestyle behaviors to achieve healthy outcomes (Bandura, 2005). Observational learning can be accomplished through active listening

and physical presence during the pulpit health communication and through church sponsored health education programs that teach how to develop healthy lifestyle behaviors (McAlister et al., 2008). Individuals must be empowered to manage their health for life. Glanz et al. (2008) stated "Interpersonal communication, it is widely agreed, is an important source of influence in health behavior change and maintenance" (p.168).

Pastors are motivational and influential in developing the belief within individuals and groups that they can achieve better health (Goldmon & Roberson, 2004). Members within Black churches must believe that they have the ability to change their unhealthy lifestyle behaviors. Bandura (1998) noted "Whatever else may serve as motivators, they must be founded on the belief that one has the power to produce desired changes by one's actions" (p. 625). History acknowledged during the civil rights movement that the African-American clergy was able to motivate, empower, and lead its members to achieve social change and improve their communities (Moore, 1991).

These spiritual leaders instruct their members to have faith in God, who will give them the ability to overcome obstacles, to achieve their goals, and to work for change (Ellison & Sherkat, 1995). Churches are part of the well-known social institutions in Black communities that play an important role in addressing the political, social, economic, and health concerns of their members (Lewis & Trulear, 2008). The clergy motivates not only individuals but also groups and communities to realize their collective power to choose the appropriate behavior (Ellison & Sherkat, 1995). It is essential that

communities of color combine their efforts to recognize, address, and change the behaviors necessary to resolve health disparities (Ellison & Sherkat, 1995).

Health knowledge, paired with African-American pastors' skills of community mobilization and collective empowerment, has the potential of resolving health disparities for at-risk populations (Ellison & Sherkat, 1995). Bandura (1998) noted "SCT addresses the sociostructural determinants of health as well as the personal determinants" (p.623). With this conceptual framework and grounded theory methodology as the approach to inquiry, I sought to expand the utilization of African-American pastors to augment health promotion activities and new practices within Black churches to change health habits for generations to come.

Because this research study involved the examination of pastors' perceptions regarding their abilities to provide health-behavior counseling, theoretical sampling supported a "grounded theoretical approach" (Marshall, 1996, p. 523). The focus was on obtaining a sample size that was right for this study and sufficiently large to generate the required data, rich in detail, to achieve saturation (O'Reilly & Parker, 2012). Creswell (2009) explained that "grounded theory is a strategy of inquiry in which the researcher derives a general, abstract theory of a process, action or interaction grounded in the views of participants" (p. 13).

Considering the research questions and the number of variables and themes likely to emerge during data collection, a sample size of 10 participants was judged sufficient to demonstrate patterns and categories and to arrive at a description of their connection based on the data (O'Reilly & Parker, 2012). The SCT and grounded theory methodology

were ways that allowed the data to come directly from the pastors and their self-assessment of their skills and abilities in regard to health-behavior guidance.

Spiritual leaders may have common life experiences, values, and goals so that grounded theory methodology was used to obtain the data for analysis and "building theory" (Rudestam & Newton, 2007, p. 43). This method allowed flexibility during the investigation, permitted the African-American clergy to share their perspectives, and facilitated the acceptance of information as it emerged without preformed ideas (Rudestam & Newton, 2007).

Bowen (2006) stated "Grounded theory is a qualitative research approach that uses inductive analysis as a principal technique" (p. 12). This technique allows for the evaluation of the data collected through observation and interviews (Bowen, 2006). The data will provide "the patterns, themes, and categories of analysis . . . emerg[ing] out of the data rather than being imposed on them prior to data collection and analysis" (Patton, 1980, p. 306).

The conceptual framework of this qualitative research design, based on the SCT, allowed for the examination of the spiritual leaders' skills, influence, resources, and beliefs regarding the effect of their health-advice guidance on the members of their churches while evaluating their assessment of why, when, and how they provided health advice. Grounded theory as the strategy of inquiry permitted me as the researcher a deep look into the pastors' life experiences, and the use of open-ended interviews questions produced a rich and varied collection of data for recorded word analysis, emerging methods, and interpretation of themes (Creswell, 2009; Fallon, Bopp, & Webb, 2013;

Greene, 1993). These methods, strategies, and approaches were essential in addressing the research problem and answering the research questions to increase the knowledge base regarding this topic. The SCT provided me with the flexibility to observe the value the study participants placed on their relationship with their congregational members and to understand the participants lived experience of giving health-advice guidance to achieve positive health outcomes among these members (Fallon et al., 2013).

Nature of the Study

This study was qualitative in nature. It gave African-American pastors the opportunity to tell their stories, to share their viewpoints, and to discuss how their health advice has resulted in positive health behaviors among their members. Lumpkins et al. (2013) noted "Semi-structured interviews with African-American clergy revealed that pastors . . . believe that discussing health screening and other health issues more frequently from the pulpit and their own personal experiences will ultimately impact health behaviors among congregants" (p. 1).

The qualitative methods involved in the collected data, were the pastors' words that addressed the difficult task of improving the health status of African-American individuals, families, and communities. The literature review revealed a large gap where effective measures of health promotion programs should have been identified that used evidence-based practices on the foundation of faith (Carter-Edwards et al., 2012). The clergy has demonstrated the ability to provide effective guidance on spiritual health, socioeconomic concerns, and couples and marital guidance, but the literature indicated that "they may lack self-efficacy for health counseling" (Bopp et al., 2013, p. 188). The

research clearly communicated that African-American pastors practice health-related guidance within their FBOs and that they understood their own importance as leaders who made a difference in their community and congregational health (Lumpkins et al., 2013).

Pastors are engaged in a calling that requires a diverse set of roles and responsibilities, which touches the lives of their members, handles the feelings and concerns of individuals and families, and requires dedication to their spiritual practice. This topic elicits personal reflections, emotions, and attitudes while discussing how guidance is given to the members. Qualitative methods were well-suited to address the open-ended research questions necessary to increase the knowledge and understanding of this problem (Creswell, 2007).

Definition of Terms

African American and Black: In this study, these terms will be used interchangeably because "some North American people of African ancestry prefer Black and others prefer African American; both terms currently are acceptable" (American Psychological Association [APA], 2009, p. 75).

Behavioral health guidance: Used in this study "to describe the range of personal advice and related behavior-change interventions that are effectively employed" in faith institutions to aid their members to change health-related behaviors (Whitlock, Orleans, Pender, & Allan, 2002, p. 270).

Faith-based organizations and faith-based institutions (*FBOs*): In this study, the terms refer to places of worship for organized religion (Asomugha et al., 2011).

Health disparity: "A particular type of health difference that is closely linked with social or economic disadvantage" (U.S. DHHS, 2011, para 2).

Health inequity: "A difference or disparity in health outcome that is systematic, avoidable, and unjust" (CDC, 2014c, para 9).

Holistic salvation: This "involves nurturing not only our souls but also our bodies, and addressing both of these dimensions in church outreach ministry" (Maddox, 2011, p. 23).

Assumptions

A general assumption was that African-American pastors would not be forthcoming in sharing information about their health-advice guidance. The literature suggested that pastors who may not practice healthy lifestyle behaviors themselves may be reluctant to discuss giving advice to those who practice unhealthy lifestyle behaviors (Baruth et al., 2014). Also, there could be barriers to the use of health-advice counseling because of legal concerns some pastors may have as they are not licensed or trained in health care (Stansbury, Harley, King, Nelson, & Speight, 2010). There was also literature that provides evidence that African-American pastors do engage in health counseling and that Black churches are willing to accept this advice (Bopp et al., 2013; Levin, 1986; Lumpkins et al., 2013).

These assumptions were taken into consideration in developing a trusting relationship and supportive environment to obtain these pastors' perspectives. People of faith count on their spiritual leaders to provide them with answers to many concerns that they face, regardless of the training or lack of training these members of the clergy may

have (Bopp et al., 2013). All of the interviewing techniques, data collection and analysis procedures, and feedback had to be transparent, honest, and respectful. "By virtue of their apostolic authority" (Levin, 1986, p. 96) and their common goal to uplift their members and the surrounding communities, I carefully dealt with these assumptions throughout this study.

Scope and Delimitations

The number of studies on health-promotion activities in Black churches is growing. In this study, I endeavored specifically to address the perspective of African-American pastors on how they give health-advice guidance and the health outcomes of their interventions. This area of research was missing in the literature about the performance of clergy regarding health-behavioral guidance. As Whitlock, Orleans, Pender, and Allan (2002) noted, this valuable tool is "underutilized in healthcare settings" (p. 267). African-American pastors and their churches are all unique in their own way; so, this study was further delimited by focusing on Christian churches with active memberships of at least 50-100 members and pastors who held undergraduate or advanced degrees in theology or ministry. Their advanced degrees may have been taken in any discipline, but I sought participants with at least one degree in theology or ministry. The pastors also had to hold a full-time position. Church size, location, denomination, and educational level of the pastors are all factors that will influence the existence of health-promotion activities within FBOs, according to Bopp and Fallon (2011).

These delimitations were based on the following considerations: The literature stated that the majority of African Americans support the Christian faith, larger faith-based institutions are more likely than small ones to have members with preventable and chronic medical conditions, and pastors (primary and secondary) with college degrees have formal training in human behavior and guidance. Pastors with advanced degrees are more likely to support health promotion activities and accept behavioral health change (Bopp & Fallon, 2011).

The research methods used in this qualitative study were recorded interviews with pastors; these interviews did not identify the congregational or community member who received health advice or provide any personal biographical information. These pastors were engaged in discussions about specific unhealthy lifestyle behavior they had been addressing and the how, when, and what outcomes they were achieving. I identified the written information for referrals, educational information, and resources the clergy used to support their intervention. I also undertook a biographical survey of the pastors and the faith-based institutions chosen for this study.

SCT, the conceptual framework used in this study was appropriate for supporting the research questions and the overall goals of this study. As a result, this framework allowed for the focus on the individual pastors' perceptions, their health-guidance skills, and their outcome expectations (Bandura, 2004). My expectation for this study was to provide evidence for the type of health-advice guidance being given by the Christian Black clergy and the results achieved by these interventions.

Limitations

Validity and reliability are the limitations to consider in this qualitative research study. I used a variety of methods to validate the data in accordance with Creswell's (2009, pp. 191-192) guidance:

- Investigate, review, and coordinate all data available to be constructive and supportive for themes.
- Have each interviewee check the accuracy of segments of the data collected during follow-up interviews.
- Full details are to be given to communicate the results.
- Provide a clear explanation of this researcher's bias.
- Discuss problematic and erroneous data.
- Spend extended amounts of time in the field.
- Conduct a presentation with classmates.
- Plan to use an external auditor.

To ensure the reliability of this study, I used the following procedures: Every interview was recorded to ensure precise documentation, maintain uniform coding of data with marginal notes based upon the codebook,-and provide complete and consistent coding for data analysis (Creswell, 2009).

African-American pastors are not formally trained to give health advice, and data obtained from them were limited to their knowledge and experience with medical conditions and health management. I also relied on these pastors' ability to recall events and to overcome their personal resistance to sharing exactly what health advice they were

giving to their members. The majority of these pastors were male, which is consistent with the male dominance in this career field (Harmon et al., 2013). To adjust for these limitations, I gave a brief presentation highlighting their valuable contributions, grounded in their spiritual influence, and placing special emphasis on what they know. I also enlisted all available female pastors. I introduced proven recall strategies during formal interviews and provided assurances that the data collected for this research was solely to support learning and not to pass judgment.

Significance of this Study

The results of this study have the potential to provide a rationale for seminaries, health care providers, public health personnel, health-promotion advocates, and researchers to develop educational opportunities to increase the effectiveness and competencies of these pastors as health advisors. Results of this study could also initiate efforts to explore opportunities for developing this group of professionals with targeted, effective resources to assist the national initiatives to reduce or eliminate health disparities. These pastors and their churches are trusted resources with access to entire families of hard-to-reach populations; they are caring, diverse volunteers with a direct link to outside communities with the potential to move people towards better health

Building healthier communities through the enlistment of clergy, who have the essential tools to assist the efforts of people to change their unhealthy habits and gain greater control of their chronic medical conditions, can create positive social change. Data collected on these pastors' perspectives may lead to additional inquiries to increase the understanding, knowledge, and development of successful strategies to reach minority

populations experiencing health care disparities. These data may also reflect interventions that are based upon faith and culture-specific considerations. These pastors, who perform their responsibilities inside FBOs, must support their faith and deliver messages that are culturally relevant (Harmon et al., 2013; Lummis, 2006).

Summary

The aim of this chapter was to introduce the research problem and its characteristics and expound on the nature and purpose of the study. I discussed the research design, the conceptual framework undergirding the study, the assumptions, limitations, scope and delimitations, as well as the significance of this research. I also provided a definition of terms used in this study.

In Chapter 2, I first describe the content, organization, and literature search strategies used. Chapter 2 contains a comprehensive review of the literature with regard the issues under consideration; it also exposes gaps in the existing literature related to this body of knowledge. I examine previous findings related to the topic and provide a conceptual framework for the exploration of the pastors' own perceptions about their health-related activities. I also explain the choice of the most suitable research method for this study. Chapter 2 ends with a comprehensive summary of the information gained through the literature review. Chapter 3 contains a description of the research methods used, including the research design and rationale, the research questions guiding the study, and details regarding recruitment, participants, and the steps of data collection. I describe the data analysis plan, discuss issues of trustworthiness, and present the steps taken to ensure ethical procedures in research. Chapter 4 presents the results of the study,

and Chapter 5 contains a discussion of these results and conclusions drawn based on the findings. Recommendations are offered for practical application and further research on this topic.

Chapter 2: Literature Review

Introduction

Existing literature does not address the pastors' perspectives regarding their skills to conduct health-advice guidance, which is essential to change unhealthy lifestyle behaviors and to improve the effectiveness of chronic disease management (Bopp et al., 2013). Evidence suggests that the clergy does participate in health guidance, but little is known about whether the pastors consider their health-related advice helpful. "Yet, health counseling is the most commonly reported form of faith-based health interventions by faith leaders, nationwide," reported Fallon et al. (2013, p. 3). In FBOs, members of the clergy were found by Fallon et al. (2013) to be important in the successful outcome of health-promotion activities. If the clergy were formally trained and supported, their health-advice guidance could result in positive health outcomes of their members and surrounding communities. Fallon et al. (2013) advocated that formal training of these faith leaders to build their self-efficacy to deliver health-advice guidance, which would result in their members' changing their high-risk health behaviors. In African-American churches, these pastors could make a critical difference in the health of the people they serve. The research clearly indicates that FBOs are capable and resourceful, and they have demonstrated effective working relationships to advocate and deliver health-promotion activities to at-risk communities (DeHaven et al., 2004).

Tangenberg (2005) discussed how FBOs have historically empowered underserved communities to demand social change and social justice. Since the 17th

century, religious organizations in the United States have promoted the importance of human life through the delivery of services to relieve poverty, meet the needs of people suffering from physical or mental illnesses, and care for orphans. However, during the 19th and 20th centuries, professional social workers arose, and they distanced themselves from FBOs to take on the responsibilities for social welfare of populations at risk. Social workers, mental health professionals, and clergy learned to share resources to deliver effective programs for substance abuse, domestic violence, at-risk youth, and assistance for people with mental health concerns, during the late 20th and early 21st century. Communities organized by FBOs and in partnerships with secular establishments have successfully fed the hungry, clothed the naked, built shelters for the homeless, provided jobs for the unemployed, and identified unfair and unethical practices.

Lewis and Trulear (2008) challenged African-American churches to take on the role as social-service providers so they could fully adopt the task of creating social policy. The social needs of the Black community continue to grow as a result of increased numbers of men in prison, jobless, or without higher levels of education, and for African-American families with ongoing physical and mental health issues. Balancing the expertise of social workers and Black churches to fully address the social needs of marginalized people remains an acute need today. Dual degrees in theology and social work is offered in colleges to increase the numbers of clergy who are trained professionally as certified counselors. Since slavery, Black churches were the institutions to address the social welfare needs of the Black community, and today they are still

relevant in assisting in the elimination of health disparities, wrongful deaths, and the reduction of incarcerations.

CDC (2014a) reports provide evidence that Black people are considered an at-risk population for health disparities. The numbers for the top-10 leading causes of death are higher in Blacks than in any other race. In the course of several decades, a large number of health-promotion and chronic-disease-management interventions have been implemented, but they have failed to generate a noticeable reduction in deaths and disabilities for this population. Researchers have advocated a more targeted focus to improve population health for minorities through partnerships with community leaders who can reach them. According to Valente and Pumpuang (2007), members of the clergy, by virtue of their position, are opinion leaders who can motivate communities to change their unhealthy lifestyle behaviors. Throughout history and even today, the Black church and its pastors remain the caretakers and the first-line resource for meeting community and mental-health-care needs (Allen et al., 2010). Documented evidence exists of these leaders' influence on the people they serve in areas of religious beliefs, ideas, desires, and community mobilization.

Carter-Edwards et al. (2011) adequately described how the elderly Black population is at the greatest risk for illness, premature death, and disabilities, which has placed a burden on the health care system: "More than 50% of black elderly in America are in poor health" (p. 141). Black churches are in a position to interact with this specific audience through outreach ministries that visit the sick and shut-ins. Although African-American pastors are educated to minister and tend to religious concerns, they are not

trained “in physical wellness and health promotion” (p. 140). The higher rates of morbidity and mortality are the direct result of the inadequacy of health care organizations to manage their health care needs (U.S. DHHS, AHRQ, 2013). This situation has led to distrust and lack of reliance on health care organizations. Levin (1984) provided evidence that Black churches are considered historical institutions in the community where African-American Christian pastors have been tasked for decades to meet their concerns. A large body of evidence shows that Blacks have been ignored, misdiagnosed, and mistreated by the medical community. The literature also provides evidence that African-American pastors have demonstrated their ability to influence health-related changes at the “tertiary level of prevention (rehabilitation); secondary level (screening and treatment); and primary level (health advice, counseling, and training)” (Levin 1984, p. 97). Churches are trusted institutions that are community centered and valuable to Black people who practice their faith and obtain assistance with the demands of daily life. These churches and their pastors can offer a hard-to-reach population a place to pray, to keep their faith, and to become healthy.

I put the focus of this study, as suggested by Harmon et al. (2013), on the need for African-American pastors and Black churches to examine the relationship between their delivery of health-advice guidance with the potential to effectuate health-behavior changes and the importance accorded to such advice in the faith-based literature and the high attendance rates of African Americans in FBOs. These pastors and their churches are prepared, are active, are involved. They are willing, and they do matter with respect to the development of interventions to address the health disparities of Black people.

They have professional and personal knowledge of how physical health and wellness are of how physical health and wellness are related to religion and spirituality; thus, their leadership is essential to success. Pastors have the skills to help their congregants believe in themselves to adopt a healthy lifestyle behavior (Elder et al., 1999).

Harper (2012), Jenkins (2006), Lummis (2006), and Valburn (2009) provided information regarding the educational experience and college degree completion for these African-American pastors to assist their congregational members' and community residents' efforts to achieve health awareness and health outcomes as they relate to religion. Maddox (2011) discussed the importance of holistic salvation, where God intends for his people to be healthy spiritually and physically, and how its origins are found in the Black church.

Bopp et al. (2013), De Marco et al. (2011), Goldmon and Roberson (2004), Lasater et al. (1986), and Lumpkins et al. (2013) discussed the role of Black clergy and their churches and validated them as valuable assets in addressing preventive health and chronic-disease management. There exists an historical pattern of addressing social concerns and, then, lending support for mental-health and, more recently, health-related behavioral-change agents to address health disparities. African-American pastors and their members can reach communities and get them involved in managing their health problems, and they can build partnerships with other health agencies, academic institutions, and social organizations. Whitlock et al. (2002) made it clear that doctors' offices, clinics, and hospitals were not the only places to assist people in changing their unhealthy lifestyle habits. Asomugha et al. (2011) provided evidence that FBOs can,

indeed, advocate for better health and contribute to the research in achieving positive health outcomes for their members and the communities they serve.

I begin this literature review chapter by focusing on members of clergy, FBOs, and health promotion initiatives. I first searched for evidence related to the topic of interest and potential illustrations of the importance of the research problem and its characteristics. I also review the conceptual framework, literature search strategy, key search terms, and I end the chapter with conclusions drawn from the literature reviewed.

Literature Search Strategy

In the past 2 decades, there has been a veritable explosion of research interest for this area of study, that is, the intersection of religion, health and wellness, and FBOs. My search of the literature depended largely on the use of Google Scholar and PubMed search engines through the Walden University library of Systemic Reviews, SAGE Premier, SAGE Research Methods Online, and by specifying the subjects of counseling, religion, health, social work, and psychology. Some of the specific databases used within this university's online site were Medline with full text, Academic Search Complete, Psych Articles, Cochrane Database of Systemic Reviews, SAGE Premier, SAGE Research Methods Online, and by specifying the subjects of counseling, religion, health, social work, and psychology. I searched and reviewed peer-reviewed articles and journals, from 1984 to the date of this writing, to gain a better understanding of the topic, to develop research questions, and to obtain proper research methods to evaluate this area of concern. The key terms used for this search were health-advice guidance, health promotion and wellness, religion and health, faith-based health promotion programs, faith

and wellness, clergy and health, Black churches and African-American pastors, medical and religious partnerships, and health disparities.

I spared no effort to select articles published in English within the last 10 years; however, I discovered large gaps in the existing literature regarding my specific topic of interest. I, therefore, had to look for relevant information beyond the 10-year time frame. Some research efforts have been made to obtain data directly from the perspective of the clergy to examine their own health and the health of their congregants (Bopp et al., 2013; Catanzaro, Meador, Koenig, Kuchibhatla, & Clipp, 2006; DeHaven et al. 2004). The biggest gap in the existing literature concerns how African-American pastors themselves view their health-advice guidance and how they think they are meeting the health needs and concerns of their members. This lacking evidence of self-reflection on the part of the clergy prompted my research efforts. Research opportunities are seemingly unlimited in the area of faith and physical wellness, and the FBOs are interested in health-promotion activities that build on the foundation of faith.

Conceptual Framework

SCT is uniquely suited for investigating health promotion activities because of its central focus on unhealthy lifestyle behaviors, the pastor's belief in his or her self-efficacy in promoting change through health-advice guidance, anticipated health outcomes, the interventions and abilities to achieve healthy life-style habits, and the possible obstacles of achieving the changes that need to be put into effect (Bandura, 2004). The SCT was able to guide this study regarding the assessment of these faith leaders' understanding of health risks, their ability to give health-advice guidance how

their guidance connected with positive health outcomes, their roles and the church's influence on this health outcome, and the possible barriers to success

The SCT embraces all of the factors that could positively or negatively influence the pastors' ability to achieve healthy lifestyle behaviors among their members through health-advice guidance. As Bandura (2002) explained, "this theory posits a multifaceted causal structure in which self-efficacy beliefs operate in concert with cognized goals, outcome expectations, and perceived environmental impediments and facilitators in the regulation of human motivation, action, and well-being" (p. 596). The present study required African-American pastors to examine their self-efficacy in providing health-advice guidance to their congregants, to assess their ability to motivate themselves and others to change unhealthy behaviors, to reflect upon the outcome expectations for their efforts, and to determine the role played by their institution as a barrier or as an enabler in promoting the desired goals. The conceptual framework of the study is supported by the research method of grounded theory.

In accordance with Corbin and Strauss (1990, p. 422), I established the following key research considerations for my research methods:

- Joint exercise of data collection and analysis for effectiveness.
- The concepts are to be the result of these joint efforts; they are consistently to evolve, be compared, and lay a foundation for an emerging theory.
- Some concepts can become categories and, once connected, may form a theory.

- The target audience is related to the phenomenon under study, but the why, when, how, and what they do must be analyzed to move forward on a theoretical basis.
- Analysis is dependent upon ongoing comparisons; Regular forms and discrepancies must be explained.
- Regular forms and discrepancies must be explained; Process must be built into the theory.
- Documentation is an essential part of doing grounded theory research.
- Hypotheses about relationships among categories are developed and verified as much as possible during the research process.
- Analyses will be shared and verified with clergy and public health professionals.
- Broader structural conditions must be brought into the analysis; the research focus, however, is microscopic in nature.

In a research study conducted by Laws et al. (2009), grounded theory was used to study primary-care clinicians' beliefs and commitment to changing the high-risk behaviors of their patients. The evidence showed that, during the short period of time spent with a health care provider, the latter employed the "5As principle of brief intervention (ask, assess, advise, assist, and arrange)" (p. 2) to good advantage to change some unhealthy lifestyle behaviors in the patients. Pastors are familiar with beliefs, commitments, sacrifice, and change. Pastors could ask their member about the high-risk behavior, determine that it contributes to unhealthy medical conditions, recommend that

the person change that behavior, support him or her in getting professional assistance, and designate a volunteer to ensure that follow-up support is given to bring about the necessary behavioral change (Laws et al., 2009).

Use of the SCT as the conceptual framework for this study illustrates the importance of African-American pastors in providing health-advice guidance and the importance of maximizing this resource. Use of the SCT also helped to demonstrate compatibility in the data. Study results mirrored some of the challenges encounter by the pastors in providing this type of guidance. Overall, this study provides uniformity; it can be replicated by other researchers and, thus, checked for accuracy and validation of the results (Corbin & Strauss, 1990; Fallon et al., 2012).

Some of the key concepts found in the literature are germane to the topic under study such as health-advice guidance, health-information processing, perceptions of health benefits, reciprocal determinism, observational learning, modeling, self-efficacy, collective efficacy, outcome expectations, external cues, self-management, stages of change, behavioral modification, and traditional distribution of health information (Elder et al., 1999). In the following sections, I discuss in greater detail these concepts found through the literature review and pertaining to my study.

Key Variables and Concepts Discussed in the Literature

The behaviors of tobacco use, unhealthy eating, and extreme use of alcohol, as well as the lack of physical exercise "are a major cause of preventable mortality, morbidity, and impaired functioning" (Laws et al., 2009, p. 2). Strategies to change unhealthy lifestyle habits and reduce health care disparities involve the variables and

concepts of holistic health, health-advice guidance, wellness and health promotion, significance of religious beliefs on healing, health and religion, spirituality and aging, health communication, faith-based health-promotion interventions, and agents of health-related change. Although primary care settings and their providers are ideally set up to recognize and address high-risk behaviors of community residents, they are not routinely used; premature deaths and disabilities occur daily, and health disparities are still prevalent in hard-to-reach populations (Laws et al., 2009).

Fallon et al. (2012) utilized a national, Internet-based, opt-in, cross-sectional study of faith leaders to identify large churches with postgraduate pastors who were confident in providing health advice at least once a week. This study also revealed that pastors with less formal education in smaller churches were less likely to provide health-advice guidance. The overall result, however, showed that the majority of faith leaders did engage in some health counseling. African-American pastors were not represented in this survey and health counseling was not clearly defined. The study was dependent on technology and self-reporting, and the measures used needed improvement. The authors reached the conclusion that the use of both qualitative and quantitative methods would increase the understanding of these faith leaders' specific health-advice guidance techniques, beliefs, motivation, and perceptions.

Bandura (2004) explored the use of SCT to achieve health promotion and disease prevention. This article describes the importance of individuals' empowerment to change their unhealthy behaviors through the understanding of health risks; the ability to describe the rewards and expenditures of unhealthy habits; achievement of desired goals for

behavioral change through planned actions; and the use of enablers to overcome obstacles. This theory also encompasses group effort to change health habits as a socially oriented approach to health. FBOs are social systems that can assist members and communities to improve and manage their health concerns.

Campbell et al. (2007) provided strong evidence of church-based health promotion (CBHP) interventions succeeding in addressing unhealthy lifestyle habits within black churches. This qualitative study was based on published studies that used interviews with church leaders and members. Although this comprehensive study outlines specific steps to set up CBHP activities it fails to identify pastors' perspectives regarding the health advice guidance they give to their members. These authors do support this research with evidence that congregational members believe the health-related messages from their pastors and pastors do participate in health-related communications through sermons and prayers.

Catanzaro et al. (2006) used "a quantitative, cross-sectional survey design to obtain pastors' views on their congregational health ministries" (p. 6). This study indicated that pastors in Christian churches, with and without such health ministries, found these activities nevertheless to be essential. Although this study focused on the pastors' views regarding this type of health promotion activity, it failed to provide the pastors' perspective on giving health-advice guidance to their members. These researchers emphasized that "it is important that community and public health nurses understand the views of pastors" (p. 16). To augment the understanding of the pastors' own views regarding their health promotion activities was the main goal for my study.

An outcome-based literature review identified that "the key elements to promote success in church-based health promotion programs are partnerships, positive health values, availability of services, access to facilities, community-focused intervention, health behavior change and supportive relationships" (Peterson, Atwood, and Yates, 2002, p. 409). This research supported the present study in that it highlighted the influence of spirituality upon the success of changing unhealthy lifestyle behaviors. There is no reference to how the pastors directly changed any health behavior, but these leaders were noted for being an essential requirement in the success of these programs (Peterson et al., 2002).

Hale and Bennett (2003) were able to identify, in a qualitative study, the clergy and their members as allies to assist the medical professionals in managing chronic diseases in the elderly population. This study indicated that "clergy were less likely to say they would encourage their members to modify health-compromising behaviors" (Hale, p. 930). The only information provided about these pastors and members was their religious denomination; lacking was information regarding diversity or specific information about the pastors' views on giving health advice and the reasons why they avoided addressing unhealthy behaviors.

A qualitative study with 40 pastors and 96 members of a rural church compared church leaders' and members' perceptions on health promotion (Williams, Glanz, Kegler, & Davis, 2012). Health messages increased from the pulpit when pastors associated them with biblical scriptures, and acceptance by the members increased simultaneously

(Williams et al., 2012). The strength of this study was the examination of church leaders' and members' perceptions regarding the health-promotion activities and the findings supporting the pastors' role of giving health-advice guidance. The limitations of the study were many, but the major problem was that the researchers did not fully examine all the factors within a church setting that facilitated effective health programs and policies (Williams et al., 2012). I tried to remedy this lack with the present study.

Leeman and Sandelowski's (2012) study demonstrated the usefulness of "qualitative inquiry to obtain practice-based evidence" (p. 171). The employment of a qualitative research design in the present study was particularly suited to answer the research questions regarding the actual practice of African-American pastors who provide health-advice guidance and to explore their feelings and experience in performing this task. As a trained nurse, I endeavored to follow up on recommendations of previous researchers with this study and expand the pool of knowledge by seizing the opportunity to enlist faith leaders in this study and train them, at the same time, in health-advice guidance that would improve the health outcomes of their members and communities. "Qualitative research contributes . . . to identifying promising implementation strategies . . . and practice-based interventions" (Leeman & Sandelowski, 2012, p. 174).

Black churches have a documented history of participating in health programs, and the literature pointed out that they are in a position to contribute significantly "within four areas of community medicine: primary care delivery, community mental health, health promotion and disease prevention, and health policy" (Levin, 1984, p. 477).

According to Goldmon and Roberson (2004), community residents, academic facilities, and government organizations "see churches as institutions that should be included in public health partnerships" (p. 368). Pastors, due to their influence and authority, can positively affect their members' participation, desire, and motivation "in health promotion and research" (De Marco et al., 2011, p. 961

"Churches have many characteristics that are compatible with behavior change programming for primary prevention of chronic diseases" (Lasater et al., 1986, p. 125). According to DeHaven et al. (2004), churches are great supporters of health promotion programs and effective advocates for reaching all populations. There are documented patterns of Black churches and their leaders in meeting the health care needs of their elderly residents (Carter-Edwards et al., 2011). As faith-based health promotion in Black churches expands in popularity, researchers are delving into the nuances that characterize program success. The critical element appears to be the active involvement of the pastor (Harmon et al., 2013). FBOs engage in health communication to improve the health of their members (Bopp et al., 2013). They offer an environment for delivering health promotion messages and conduct health promotion activities with African Americans (Baruth et al., 2014). The health communication from the pulpit of Black churches have effectively supported "national prevention program initiatives such as the National Cancer Institute and American Cancer Society's Body and Soul: A Celebration of National Eating and Living and the American Heart Association's Power Sunday" (Lumpkins et al., 2013, p. 1095).

Summary and Conclusions

During the past 2 decades, Black churches and their pastors seem to have attracted considerable research attention as special resources for improving health care disparities of African Americans because of their distinction in the community and the potential of improving the health for generations to come (Harmon et al., 2013). Considering this evidence in the literature, I was able to formulate the research questions and a plan to obtain the answers. The literature review helped me to identify the health concerns of African Americans, the evolving role of Black churches and their pastors in health promotion, and the assessment of the readiness of these institutions to support efforts to reduce health disparities. The literature review also revealed gaps in the knowledge, and primary among these gaps was a lack of information about the African-American pastors' own perspective about how they were providing health-advice guidance and how these efforts led to positive health outcomes. The review also led to the SCT as a useful conceptual framework for this study and provided guidance for obtaining the needed data to expand the area of knowledge through doctoral research.

This chapter contained a description of the literature search techniques and key search terms, a conceptual framework, a review of pertinent publications, a specification of some key variables and concepts, and conclusions based on existing research. In Chapter 3, I describe the research design and its rationale, data collection techniques, and interview questions. I discussed criteria for participant selection and the role of the researcher. I specify the data analysis plan and discuss issues of trustworthiness and

ethical procedures in research, as well as measures taken for the protection of the participants' rights and anonymity.

It is important to note that the literature clearly indicated that Black churches and their pastors are capable of improving the health of their congregations and the surrounding communities. These institutions and their clergy were considered essential components in the successful implementation of health promotion programs because health and religion seemed to be connected in a vital way (Lasater et al., 1986). Health-advice counseling can change unhealthy lifestyle behaviors, and pastors do provide this counseling, argued Bopp et al. (2013). However, neither exact measures were available nor any solid information on how often members of the clergy provided health-advice guidance or what positive health outcomes were obtained when they did provide such guidance (Bopp et al., 2013). It is this gap in the existing literature that the present study sought to close.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore, from their own perspectives, the recent and past experiences of African-American Christian pastors who have engaged in giving health-advice guidance to their congregational and community members. With this study, I attempted to close a gap in the professional literature regarding these pastors' self-assessments of providing this specific type of guidance as health-promotion advocates (Bopp et al., 2013).

In the past 20 years, research has provided evidence for reduced morbidity and mortality among African Americans who fully supported their religious faith and engaged in their church activities on a regular basis (Levin, Chatters, & Taylor, 2005). African-American pastors have created an environment within Black churches were community residents feel respected and can obtain encouragement to cope with life's stressors; it is a place that offers guidance to achieve social justice and aides in participating in health-promotion activities (Levin et al., 2005). The research clearly articulated the value of partnering relationships with FBOs for the delivery of health-promotion programs that are culturally sensitive and faith based to address the large problem of health disparities in hard-to-reach populations (Bopp & Fallon, 2011).

The clergy readily provides guidance on spiritual concerns and in the areas of parenting issues, marital problems, and financial barriers (Bopp et al., 2013). Even

though members of the clergy may feel inadequately prepared to provide health-advice guidance, they "are most likely to report involvement in individual-level health counseling" (p. 188).

In this chapter, I provide a rationale for choosing this qualitative research design. I describe the role of the researcher and details of the research methods employed. I lay out a comprehensive data collection and data analysis plan and address issues of trustworthiness, ethical procedures in research, and the protection of the participants' rights and anonymity

Research Design and Rationale

Research Questions

RQ1: How do members of the African-American clergy feel about their ability to conduct health-advice guidance within their faith-based institutions to achieve positive health outcomes of their members?

RQ2: What are the African-American pastors lived experiences as members of the clergy and health-promotion advocates?

Rationale

The central phenomenon under study was how African-American Christian pastors view their abilities to provide health-advice guidance, what is their intent in performing this type of counseling, and what do they see as the outcome of their intervention. Participating pastors in this study were given the time to reflect on their experiences, both positive and negative; their internal and external motivation,

confidence, and competence levels; available resources and tools used or desired; obstacles and aids; and past life experience and educational training related to this task.

The pastors had the opportunity to provide, in their own words, their thoughts and feelings regarding their performance in giving health-advice guidance and their experiences with this activity. The data obtained was considered useful for faculty members at seminaries, public health agencies, health care organizations, researchers, and other interested parties seeking to reduce or eliminate health disparities with the help of the clergy. Health disparities for African Americans, health-behavioral change and health promotion, faith and wellness, faith-based health-promotion activities, as well as Black churches and their pastors are reviewed in theses sections as they relate to the phenomenon under study.

The qualitative research tradition employed in this study was grounded theory. This method of inquiry was selected to explore the African American pastors' perceptions regarding health-advice guidance. I sought to determine how the pastors viewed the how, the why, and the when of this health-promotion activity and relied on my familiarity with the environment (i.e., the church), as well as my education and training as a nurse and my professional experience in the health field, which included interviewing people on health-related matters. Grounded theory methodology started with the pastors' stories. Next came data management and its classification with the emergence of themes and concepts, which finally allowed "formulating them into a logical, systematic, and explanatory scheme" (Patton, 2002, p. 490).

During the interviews with these pastors, the discussion could involve their personal health, their family's health, and the health of the congregation and the surrounding community members. I attempted to keep the focus of the conversation on the health-advice guidance these pastors provided towards positive health-behavior change among their advisees. Based on the conceptual framework of the SCT, grounded theory methodology was an ideal approach to managing a large volume of data and conduct a systematic data analysis through coding and identification of patterns and, finally, theory development.

The SCT allowed highlighting data related to health-advice guidance and the role of health-promotion advocacy, and grounded theory methodology assisted with efforts to collect, evaluate, and group data into themes and patterns (Bandura, 2002; Rudestam & Newton, 2007). Rudestam & Newton (2007) stated "Grounded theory offers perhaps the most structured and unified procedure for developing categories of information . . . to construct a narrative to connect them and generate a set of theoretical propositions" (p. 185). In addition to conducting the interviews, I engaged in observations of the interactions between pastor and church members, interactions of the members with each other, church programs, the church environment, as well as a review of applicable documents such as previously recorded sermons.

Role of the Researcher

Participant-Observer

This qualitative study sought to expand, from the perspective of African-American pastors, the knowledge and understanding regarding the health-advice

guidance these pastors are providing to congregation members of Black churches and surrounding community residents. As the researcher, I assumed the role of observer-participant. I collected a large volume of data during face-to-face interviews with open-ended questions that I conducted with a sample of pastors at their respective churches, through a review of designated health promotion materials, and through activities and observations of the interaction between pastors and congregants or family members in the church, observations of the pastors during community events, and the analysis of recorded or online health communications conducted by the pastors, as well as by my own participation in church services (Polkinghorne, 2005).

African-American pastors of Black churches were targeted for participation in this research. From them, I sought to obtain information regarding their process of delivering health-advice guidance. I also conducted observations and participated in church services and church-sponsored health-promotion events to collect additional information for an examination of the ways these pastors sought to improve and support their health advice counseling. I retrieved other valuable data sources like church bulletins, visible presentations, church Websites, and taped sermons.

The pastors chose where, in their churches, the interviews were to be conducted with use of recording devices. I asked their permission to attend their church programs and conduct observations for the purposes of this study. I kept field notes at all these events. The primary data collection instrument in this study was the researcher, and the retrieval of quality data was dependent on my competencies as well as the participants' ability to recall their experiences (Polkinghorne, 2005). As explained by Chenail (2011),

the researcher must develop a trusting relationship with the interviewee and create an environment that is conducive to freedom of expression and rich in detail. Completed 30 years of training and conducting interviews, analyses, and observations with more than 1,000 people of diverse backgrounds and in a variety of settings have prepared me well to play this particular role of the researcher. The research design used a number of valid strategies for data collection, and the roles played by the researcher in this study demonstrated "adoption of the characteristics of naturalist paradigm, . . . level of skill appropriate for a human instrument through which data will be collected and interpreted, . . . [and planning for a] research design that utilizes accepted strategies for naturalistic inquiry" (Hoepfl, 1997, p. 3).

Guarding Against Researcher Bias

During this qualitative inquiry, I made every effort to ensure that the perspectives of these participants' life stories were recorded. I was fully aware and took every precaution not to interject personal interpretations or medical language, while collecting and analyzing these participants' experiences. Whenever clarification and deeper understanding were required, I used the language of the pastors to restate what I had heard, and I followed up with open-ended questions. I gave both verbal and nonverbal cues to obtain more details (Polkinghorne, 2005).

None of the pastors interviewed had any personal relationship with me. However, some of my family members are pastors, and I have participated in church activities for most of my life. I also count several pastors among my friends, and I have been active in a number of different religious institutions in and outside of the United States. Because of

these circumstances, I had to consider the possibility that our paths might have crossed along the way. In actuality, I visited one out-of-town church and discovered that I had served with its pastor in the Army 27 years ago, but we had not had any contact since that time. The remaining sample acknowledged that we had not met prior to this study.

Interviewing the Investigator

Interviewing the investigator and peer debriefing were two strategies used to guard against researcher bias. I decided to conduct a pre-pilot study for this purpose to avoid losing the small pool of available pastors, conserve and support their valuable time, and avoid the need for approval by the institutional review board (IRB) of the university under the auspices of which this research was to be conducted (Chenail, 2011). For this pre-pilot study, I planned for my pastor to interview me, the eventual investigator in this research, with the same open-ended questions, recording devices, and rigor that I intended to use in the study. The location (i.e., the pastor's office inside his church) mirrored the actual interview site for all participants to ensure privacy and maintain confidentiality. I recorded explanations about the research, signing of the consent forms, and all interactions and discussions during and after the interviews. I used two recording devices: One was recording continuously to capture all discussions and include reflections and interruptions throughout the interview process, the other was stopped and started to capture only the interview data.

These strategies recorded input from a pastor and the investigator regarding the entire process and the actual interview. The recording was shared with the chair of my dissertation committee for additional feedback. I also asked a peer to conduct debriefing

for additional feedback. I kept a journal before and after this interview technique "to examine thoughts and impressions that surfaced during the interview which might bias the collection and analysis of the 'real' interviews of the study" (Chenail, 2011, p. 239). Without the requirement of an IRB approval, I was able to gain valuable insights about conducting this research, which, in the words of Chenail (2011), "can lead to more ethical and responsible research" (p. 261). In addition to developing an ethical and responsible research study, I also ensured easy replicability of the study.

Methodology

Participant Selection Logic

The target population for this study was African-American pastors of Black Christian churches. The inclusion criteria specified that the pastors (primary or secondary), both male and female, in full-time positions had to have undergraduate or graduate degrees, preferably in theology or ministry, or an advanced degree in another discipline that required formal training in human behavior and guidance. The churches had to have an active membership of at least 50-100 members; FBOs of this size usually have both primary and secondary pastors. The literature stated that the majority of African Americans support the Christian faith, that many African Americans are considered to be a hard-to-reach population with large health disparities, that larger churches have members with a diverse set of health conditions, and that the pastor's educational level contributes to the likelihood of valuing health promotion (Catanzaro et al., 2006; CDC, 2014a; Pew Center Research Center, 2014; Thomas et al., 1994). To ensure the quality of this research, these inclusion criteria aimed at selecting a sample of

participants ideally suited and likely more forthcoming and willing to share their experiences to build data quantity (Abrams, 2010; Coyne, 1997).

I requested a copy of graduate degree certificates, a recent curriculum vitae or resume, and a statement of church membership levels and demographics, as well as a discussion with key administrative leaders of designated FBOs to make sure that the selection criteria would be met. I conducted participant selection at the church and "at the participant level" (Creswell, 2007, p. 126). From the start of sample selection, I applied these criteria to enlist pastors who indicated a desire to participate in this research and were actively engaged in health-promotion activities in their churches and surrounding communities to fulfill "the qualitative principle of appropriateness that requires purposeful sampling and a good informant" (Coyne, 1997, p. 623).

This sampling strategy was used to gain a better understanding of these pastors' perspectives on their health-advice guidance in regards to how, when, why, or why not they do what they do. Data obtained in the initial stages were useful for providing a direct and forthright communication about the study's goals, rationale, limitations of the sample size, and improvement in the utility of the findings (Patton, 2002). Some writers advocated that purposeful sampling be used in all types of qualitative research to achieve fullness in the data with a reduced sample size, when compared to quantitative studies (Coyne, 1997). Although theoretical sampling was the prevailing strategy for this study, purposeful sampling was essential in the beginning for identification of who can give the best information (Coyne, 1997). Once the data started coming in, theoretical sampling was used to analyze, collect, code, and back again in this order until category saturation

was complete (Coyne, 1997). A number of sampling or selection strategies were used, including "theoretical sampling that is associated more specifically with grounded theory" (Abrams, 2010, p. 538), which was one of the methods used in conjunction with the conceptual framework, based on the SCT.

Several sampling or selection strategies were implemented to obtain a sample size that was appropriate for this study and sufficient enough to generate the required data rich in detail to achieve saturation (O'Reilly & Parker, 2012). Pastors were provided with flyers to give to other pastors, so that other interested pastors could contact me as the researcher of this study. After the initial contact with interested pastors, I gave them a brief overview of the study and determined if they met the inclusion criteria. In this manner, an initial pool of potential study participants was created.

The phenomenon under study is the perspective of African-American pastors who preside over Black Christian churches regarding their giving health-advice guidance to their congregants and residents in the surrounding community. The sample of pastors represented different age brackets, years of pastoral and living experience, and a variety of communities to "deepen the understanding of the investigated experience" (Polkinghorne, 2005, p. 140). Selection of participants was ongoing to ensure obtaining an appropriate and adequate amount of details for analysis (Polkinghorne, 2005).

In consideration of the research questions and the number of variables and themes emerging during data collection, the proper sample size was 10 participants. These 10 pastors demonstrated the patterns of categories to describe their connection within the data to generate the themes (O'Reilly & Parker, 2012). The size of this sample adequately

reflected the historic pattern of educational disparity for this specific group of people, the pattern of their appointment and ordination as pastors, the labor involved in data collection and analysis, and the use of multiple techniques to justify fewer participants (Bopp & Fallon, 2011; Jones, 2000; Mason, 2010). Mason 2010 stated "Qualitative samples must be large enough to assure that most or all of the perceptions that might be important are uncovered, but at the same time if the sample is too large data becomes repetitive and, eventually, superfluous" (pp. 1-2). Sampling is the key factor in data collection and is based upon the research topic, inquiries, and goals; it is important to the truthfulness of the study, to obtaining vibrant amounts of data, and to saturation, which is related to a meaningful analysis (Abrams, 2010).

Goals of the research were clearly presented to potential participants, and they had ample opportunity to express their thoughts and ask questions. If these pastors expressed a desire to participate in the study and met the inclusion criteria, they were accepted as participants under the condition that they would continue freely to share their thoughts, ask questions, and examine documents. They also were informed that they could withdraw from the study at any time without adverse consequences. All the participants were responding to the same research questions.

Instrumentation

To ensure that the appropriate questions were asked to obtain sufficient data, while compliance with all applicable policies of the IRB of Walden University, I designed the following data collection instruments: interview questions and observation sheet as well as field notes and journaling. Researcher-produced data collection

instruments are commonly used and are appropriate for learning more about a phenomenon under study (Chenail, 2011)— in this case, health-advice guidance described from the perspective of a sample of African-American pastors. To ensure the validity of the content, I took great care and ample time to prepare the formal interview protocol. I also used triangulation, peer evaluation, and a thorough data analysis. I maintained a journal for self-reflection to describe values, biases, and thoughts and to preserve flexibility and alternative plans to deal with changes and problems. I strove to maintain transparency of methods, challenges, researcher bias, and bias management (Chenail, 2011; Jacob, 2012; National Center for Postsecondary Improvement Headquarters [NCPI], 2003; Tracy, 2010).

I adapted the presentation checklist protocol (Appendix A) from the National Center for Postsecondary Improvement Headquarters (NCPI, 2003) to support the semi structured format with the application of standardized procedures for each interview. This presentation checklist protocol included talking points accompanied by a power point presentation (Appendix B) and open-ended interview questions with prompts to address informed consent and audiotaping (Appendix C) to guide this "qualitative researcher through the interview process" (Jacob, 2012, p. 2). The face-to-face meetings were designed to introduce the research topic and its purpose, to develop a trusting relationship, to obtain voluntary participation, and to begin the recall of memories and reflections by each participant regarding his or her experiences with health-advice guidance, as directed by Jacob (2012). Data from this initial face-to-face contact did not address the research questions but provided biographical information about the pastor, his

or her church, and congregational members (Appendix D). These data are not transcribed or coded; they are reported verbatim with the results of the study.

The purpose of the formal interviews was to capture each participant's recollections of providing health-advice guidance and his or her perspective on the effectiveness of this intervention. During these discussions, I explored the pastors' thoughts about health risks, health promotion, the church, and their own role in regards to influence, obstruct, or support the church body's ability to achieve healthy outcomes. In addition to the introductory presentation and formal interview, I spent time during church services and church-sponsored health-promotion events to conduct observations, which are described in my field notes, journal entries, and participant-observation form (See Appendix E) . I used journaling for reflections throughout the data collection process. I also reviewed documents, which included active numbers of church attendance, church Websites, church bulletins, and taped sermons to verify health-promotion events and health-advice guidance.

The accurate documentation of all data required equipment and software products such as a laptop, a digital voice recorder for transcription, and NVivo Mac for coding. I used the following methods for security and confidentiality of collected data: a locked office, locked filing cabinet, and own computers. I used duplicate recording devices, flash drives, and extensive notes to avoid the loss of data.

Multiple face-to-face contacts, several field trips to the selected churches, and extensive notes from observations and journaling provided a sufficient amount of data to

answer the research questions. One face-to-face contact would make it impossible to achieve the vast amount of data to fully describe these pastors' experiences of providing health-advice guidance (Polkinghorne, 2005).

Procedures for Recruitment, Participation, and Data Collection

Recruitment

All of the interviews were conducted at the participants' churches; the pastors decided which specific room was to be used. I collected the majority of data during site visits, which were scheduled with the participant and did not exceed two visits in the same week. The initial face-to-face visit and presentation of research goals lasted 40 minutes; the actual interview lasted 1 hour. Other visits included attendance at worship service and church-sponsored health- promotion events; duration was not to exceed 3 hours. I made telephone calls and emails instead of follow-up visits to obtain clarification or additional information from study participants. I used a digital recorder, laptop, flash drives, biographical forms, observations, field notes, and journaling to collect the data. I obtained additional data through the review of designated documents, Websites, and audiotaped sermons.

A combination of recruitment strategies such as passing out flyers to pastors in person or site visits to FBOs, telephone calls, and written communications were used initially. As described in greater detail in Chapter 4, I had to make changes to the recruitment strategies as time went by because a number of interested pastors did not meet the inclusion criteria, and some of those who did meet the criteria declined to

participate in the study. Journaling helped to determine effective and ineffective recruitment strategies.

Participation

Goals of the research were clearly communicated to potential participants, and emphasis was placed on the voluntary nature of participation. If the pastors expressed a desire to participate in the study and they met the inclusion criteria, they were accepted as study participants with the understanding that they would continue freely to share their thoughts, ask questions, and examine documents. They were informed that they could change their mind and discontinue their participation without any negative consequences. All the participants were presented with the same open-ended interview questions (Appendix C).

At the conclusion of the interview, I thanked the participant for his or her participation and offered to answer any questions they might have and provide clarification as needed. I provided the pastors with the opportunity to add additional thoughts that may have occurred to them after the conclusion of the formal interview. I emphasized once more the goals of the study and its voluntary nature, which allowed them to withdraw from participation at any point in the research process.

I assured them again that their information would be kept private and noted how much it was supporting this study. I provided them with the opportunity to review the transcript of their interview and told them how I would disseminate the results of the study. I briefly discussed the researcher's role in obtaining their perspectives while keeping researcher bias in check. We reached an agreement on setting up additional

visits, and I made sure that the participant had my contact information (Tracy, 2010; UMass Amherst, 2010-2014).

Twelve Steps of Data Collection

These 12 specific steps of data collection were undertaken in accordance with IRB approval.

1. Community pastor awareness: Pastors are provided with flyers to give to other pastors, and interested pastors will contact the researcher.
2. Initial contact with potential participants serves to give a brief overview of the study, determine if the pastor meets the inclusion criteria, and whether he or she is interested in participating
3. During scheduling of the presentation with potential study participants, I request that the following documents be made available for review if the pastor desires to participate in the study: copies of the average church attendance record, copies of diplomas, and a curriculum vitae (CV) or resume.
4. Semiformal presentation to include informed consent, request for the pastor's decision to participate or to decline the offer to participate. If consent is signed, proceed to collect the documents requested in Step 3. Schedule the formal interview and request completion of the biographical form. Regardless of the pastor's decision, a copy of the presentation and contact information are provided.

5. Review of all collected documents. Cross-check the information of the CV or resume with the pastor's bio provided on church Website and postgraduate education with the named school Website to ensure degree offering.
6. Initial interview, collection of biological form, and scheduling of follow-up visit to review the transcript.
7. Review all data collected in Step 6 and the taped interviews; complete transcriptions.
8. Follow-up visits to review transcripts and schedule field visits for observations.
9. Field visits to church service or church-sponsored health-promotion event to capture data for pastor-directed health-advice counseling, pastor-approved health-promotion activities, and the pastor's role as health-promotion advocate. Data collections are to be both observational and based on the retrieval of designated taped sermons and available church program materials.
10. Review of previously taped sermons and printed church programs and materials that demonstrate the pastor's role as health-promotion advocate.
11. Schedule visit for dissemination of study results.
12. Disseminate the study results using a one- or two-page summary

Data Analysis Plan

The collected data were analyzed to answer the following research questions guiding the study:

RQ1: How do members of the African-American clergy feel about their ability to conduct health-advice guidance within their faith-based institutions to achieve positive health outcomes of their members?

This question was answered based on the data obtained during the formal interviews and follow-up visits with the participating pastors during which they had the opportunity to describe their thoughts and actions more fully, if desired, and engage in self-analysis of their performance in giving health-advice guidance to their congregational members or other community residents. I also used my field notes taken during observations and of nonverbal communications during interaction with the participants to answer this question.

RQ2: What are the African-American pastors lived experiences as members of the clergy and health-promotion advocates?

This research question was also answered with data generated during interviews, follow-up visits, observation of events and nonverbal communications, the review of church Websites and related documents, and field notes pertaining to attendance at church services and health-promotion events. I was able to ask the appropriate probes to encourage in-depth discussions to answer this question. I had to depend on transcribed data, rich in detail to ask this question.

This research study involves the discovery of the pastors' perspectives regarding their health-advice guidance, and as the researcher, it behooved me to provide explanations of their stories and tie an inductive content analysis to the research questions (Elo & Kyngäs, 2007). A reflexive approach was also used to examine the researcher's participation in the data analysis process. According to Welsh (2002), "the reflexive approach attempts to focus attention on the researcher and her or his contribution to the data creation and analysis process" (p. 55). These two analytic processes were ongoing throughout data collection, data analysis, open coding, categorizing, and the development of themes (Welsh, 2002). Both manual and digital means (with the use of NVivo software) were used to organize data, apply open coding, take marginal notes or memos, and endeavor to maintain transparency. I read the data obtained through formal interviews, follow-up visits, and field visits multiple times and took notes to achieve a comprehensive understanding of what the participants had expressed individually and collectively.

Frequent data comparisons and analysis, one encounter at a time, must be done to recognize patterns and help the researcher in developing themes based on these lived experiences, advised Thorne (2000). NVivo computer software and digital recording for transcription were the tools I used in combination with the manual efforts to manage the data from collection to analysis to reporting the final results, and, in the words of Welsh (2002), all efforts had to demonstrate rigor, validity, and reliability. Because humans are prone to making mistakes, the use of digital equipment and computer software helped to establish an audit trail to substantiate what was understood (Welsh, 2002). I, then,

examined the product of this data process to write a detailed summary to facilitate the understanding and relevancy of the data (Welsh, 2002). I also had to considered the possibility that some pastors might state that they did not engage in health-advice counseling or consider themselves health-promotion advocates, instead they delegated this responsibility to their congregational nurses or the health ministry, or they referred their health care providers. Anderson (2010) noted "Contradictory evidence, often known as deviant cases, must be sought out, examined, and accounted for in the analysis to ensure that researcher bias does not interfere with or alter their perception of the data and any insights offered" (p. 143). This situation did, however, not arise. As explained in Chapter 4, these pastors were comfortable with providing health-advice guidance and they were fully aware of their professional limitations

Issues of Trustworthiness

It is important to deliver a completed study that is acknowledged for its integrity and transparency about the realities of what took place regarding the methods used for data collection, data analysis, potential researcher bias, and how the study might have been affected by mistakes, decisions, and strategies (Tracy, 2010). Therefore, I included an honest assessment of myself as the researcher and a trained nurse and of the research process and the participants. This self-assessment, according to Tracy, must include both successful and unsuccessful moments, adjustments, motivations, feelings, thoughts, and concerns. An audit trail and notes provide clear details on the decisions, challenges, and corrective actions to describe how the research unfolded from preplanning to the completion of the research study (Tracy, 2010).

Credibility is established through profound descriptions that are culturally sensitive and culturally relevant (Tracy, 2010). Adequate data were obtained as a result of multiple contacts and extended periods of time devoted to field visits. Triangulation and peer review was applied to manage researcher bias and to evaluate different types of data such as observations, field notes, written materials, taped sermons, and church Websites. The use of multiple methods led to emerging themes that supported similar findings from dissimilar sources (Tracy, 2010). Ten participants with varied backgrounds and circumstances told their stories in their own words and expressed what these experiences meant to them. Transcriptions of the recorded interviews allowed this process of multivocality (Tracy, 2010). All participants were given the "opportunity for collaboration and reflexive elaboration" with respect to the research findings, but they were not allowed to invalidate the study's results (Morse, Barrett, Mayan, Olson, & Spiers, 2002, p. 16). Participants were given the completed transcriptions for member checking, before I started the formal data analysis, so that they could verify the accuracy of their recorded words (Houghton, Shaw, & Murphy, 2013).

When the research is written up, the intent is to promote understanding, provide an emotional connection with the reader, and foster the ability to walk in someone else's story; in other words, there should be transferability of the results (Tracy, 2010). The results of this study, I hoped, would affect the reader and the findings would be useful in other situations. The findings of this study have expanded the pool of available information on how pastors viewed their health-advice guidance and their roles as health-promotion advocates. They are contributing to the understanding of the phenomenon

under study and assist other researchers to build future research studies, to direct new discoveries, and to obtain useful information for training and curriculum development (Tracy, 2010).

Each research method was matched to the specific research question then "matched to the data and the analytic procedures" (Morse et al., 2002, p. 18). This required the researcher to be flexible and to make changes to the methods or numbers of participants to adjust to the needs of the data (Morse et al., 2002). The number of participants had to be adequate, and they had to be knowledgeable; they also had to have had first-hand experience with respect to the research topic. The participants in this study had a variety of experiences and were able to describe them in rich and colorful detail. The entire process of data collection and data analysis kept going back and forth to promote understanding of what is known and what is needed, as described by Morse et al.: "By definition, saturating data ensures replication in categories, replication verifies, and ensures comprehension and completeness" (p. 18).

Ethical Procedures

In accordance with the policies and procedures of the IRB of Walden University, all participants must clearly understand the goals of the research study, the benefits and risks, that their participation is voluntary at all times, and that they are free to terminate their participation at any point during the process. The use of audio recorders had to be approved, and computer programs, accurate contact information for the researcher and the dissertation chair, and all consent forms had to be understood and signed by the

participants before any interviews could be initiated. All participants were treated with respect and courtesy and were protected from harm.

All written and recorded data were secured, participants were assigned codes to protect their identity, all study products were and continue to be kept in a locked cabinet; these materials will be kept on file for 5 years after completion of the study. Access to the data was and is restricted to the researcher and designated faculty at Walden University. At no time was information provided by the participants discussed with members of a participant's staff, congregational members, or other participants in the study or other pastors. Specific information about the participants could be discussed only with designated faculty of Walden University. Findings of the study are published in aggregate form, which does not allow identification of participants or their churches. I endeavored at all times to safeguard the anonymity of the participants and their churches.

Summary

In this chapter I presented the research methods used in this study, including the research design and rationale. I described the role of the researcher, participant selection, recruitment, data collection and data analysis instruments, and the data analysis plan. I discussed issues of trustworthiness, ethical procedures in research, and measures taken to protect the anonymity of the participants and their churches.

In Chapter 4, I present the results of the study, including the use of a pre-pilot study, description of the research setting, demographics of study participants and their FBOs, methods to collect and analyze the data and evidence of trustworthiness. I discuss changes in procedures, unusual responses, and adaptations to selection criteria. I

summarized all of the participants' responses to both research questions and all additional follow-up questions.

Chapter 4: Results

Introduction

The intention of this qualitative research study was to document the voices of 10 African-American pastors providing their perspectives on delivering health guidance for which they were not formally trained. I also examined pastors' perspectives on fulfilling their role as health advocates for their congregational members and the community residents they serve. Bopp et al. (2013) remarked that these pastors are capable partners of hosting health promotion activities for their congregational members through virtue of their authority. Although Bopp et al. (2013) and Goldmon and Roberson (2004) also documented that pastors give health guidance, no evidence suggests what type of information is provided. However, evidence does suggest that pastors may be uncomfortable in providing health advice because the seminary does not train them in this area. Studies clearly indicate that these pastors must address both physical and mental health concerns of congregational members in Black churches regardless of their lack of training or their desire to do so (Allen et al., 2010; Bopp et al., 2013).

A gap in the literature exists regarding the perspective of African-American pastors on how they feel about giving health advice. Also, missing from literature are the positive health outcomes of health-advice guidance these pastors provide to address health disparities that lead to disability and deaths in the African-American population (Bopp et al., 2013; CDC, 2014). In addition to the absence of these pastors' viewpoints, studies suggest that pastors should hold a more prominent position concerning health and wellness (Bopp et al., 2013). Yet, no evidence indicates that pastors accept the leadership

role of health promotion advocacy in sustaining initiatives (Bopp, et. al; 2013). Investigation into the lived experiences of African-American pastors meeting the health concerns of the communities they serve requires extensive time in the field and recognition of influences between members' behavior health changes and environments.

Grounded theory was integral in this qualitative study to acquire information about this phenomenon and to use inductive analysis (Bowen, 2006; Creswell, 2009). Interviewing was the main data collection method used in this study and inductive analysis aided in recognition of patterns generated (Rudestam & Newton, 2001). The use of grounded theory facilitated the interpretation of the data collected about these pastors lived experiences (Laws et al., 2009).

SCT worked well with grounded theory to examine the influence and interactions of pastors giving health guidance, pastors and members' behavioral health changes, and the church environment hosting health promotion activities (Fallon et al., 2012; Glanz & Bishop, 2010). African-American pastors work within their FBOs to encourage their members to have faith and trust in God that they can overcome health obstacles (Levin et al., 2005). Because the concentration of this research was on the behavior of giving health advice and experience of acting as health promotion advocates, the conceptual framework of the SCT was used to explore the interactions between the pastors and congregational members to achieve positive health outcomes (Glanz et al., 2008).

This qualitative data was collected from a variety of sources to include: in-depth face to face interviews; telephonic contacts; extended field visits; written communications; church programs, and websites. Data was also collected from visual

screens during worship services, health promotion displays, online attendance of church services, interactions with congregational members, and listening to taped sermons. Each secondary data source provided different characteristics such as supportive descriptive details, explanatory clauses, past and present records of events, and opportunities to obtain different perspectives from the interviews. I used all of these data sources to examine these pastors lived experiences with health advice guidance and health promotion advocacy.

In response to the following two research questions pastors were able to reflect on their years in their profession and then describe in their words those experiences related to:

RQ1: How do African American clergy feel about their ability to conduct health advice guidance within their faith-based institutions to achieve positive health outcomes of their members?

RQ2: What are their lived experiences as clergy and health promotion advocates? These research questions, combined with follow-up interview questions and probes, were designed to validate their acceptance of the roles and responsibilities to lead their congregational members and community residents to health (Baruth et al., 2014).

The purpose of all interview questions and probes was to address the predominant research questions, yet it was also intended to encourage self-reflection and recognition of lifelong endeavors to tackle health challenges. The semi-structured interview questions provided to each study participant, it resembled a professional conversation that led

pastors to share from their perspective what health issues exist for their congregational members and community residents. After discussion of health challenges these pastors challenges these pastors provided their thoughts and beliefs about the possible causes, how they responded to these concerns, identified the results of their interventions, and articulated a self-evaluation of their efforts.

I will discuss in this chapter, the use the of a pre-pilot study, changes in research settings and its influence on the interpretation of the results, introduction of the participants through demographic data, the process of data collection and data analysis to include discussion about discrepant responses and the evidence of trustworthiness. I will discuss the themes derived from data collected for each research question will be provided to support findings. Summarize answers for both research questions offered in this chapter from all ten participants. In chapter 5, I will reveal the interpretation of the study results.

Interview the Investigator

Due to the limited number of available research participants, the time restraints of the participants for this study, and to prevent the loss of data, a pilot study was not conducted (Chenail, 2011). The conditions that limited the sample size were: the historical patterns of educational disparities; the procedures to become licensed as pastors without educational requirements; the time restraints; and the selection criteria further reduced the pool of potential research participants (Jones, 2000, Mason, 2010, Bopp & Fallon, 2011). Strategies were implemented to protect this potential study population to

achieve data saturation, to maintain thoroughness and management of researcher bias (Chenail, 2011; Mason, 2010)

Since the researcher is the data collection instrument, information was needed to manage bias; to determine the quality of the interview questions; to experience what the participants go through in this process; to identify areas to improve; and employ efforts that will obtained adequate data (Chenail, 2011). A trial run was essential for this investigator to use the interview plan to test this procedural guidance, retrieve useful information, identify, and develop a plan to control bias (Chenail, 2011; Jacob & Furgerson, 2012). "To remedy these problems, investigators can turn to a pre-pilot study inquiry known as interviewing the investigator" (Chenail, 2011, p. 258).

Following the interview protocol, the pastor at the church I attend was familiar with the study, agreed to be the interviewer and utilized the researcher's interview questions. This pastor was selected because of access, his recent appointment to this position, the congregational size of 500, the absence of a health ministry, and his Doctorate in Theology. As the interviewee in preparation for the role of pastor reflected on the lifetime experiences of being a congregational member and partner with FBOs for health promotion activities.

I recorded the interview on laptop and digital recorder in the pastor's office. The recording continued after the dialogue to secure pastor's feedback, to share thoughts, and concerns regarding this meeting. I used the laptop to record all conversations, and digital recorder was just used to capture the interview. Journal notes reflected the thoughts and

feelings before and after this practice interview and to recognize any researcher biases. Dissertation chair and peer were sent a copy of this audiotape to review, provide feedback, and assist efforts to manage researcher bias.

This interviewee had feelings of nervousness, anxiety, and doubts about the ability to portray a pastor and to provide adequate responses to the questions. Some of these feelings were also related to possible impressions this interviewer would develop about the interviewee. During the interview, I became lost in self-reflection and how best to provide examples to explain the answers. All of the research questions appeared to encourage self-reflection, challenged to determine the best response, and stimulated the choice of storytelling to provide details (Polkinghorne, 2005). After the interview, the interviewer stated he would have had similar responses, and the questions tested his ability to remember all of those moments he had to provide health guidance to promote a healthy Christian lifestyle.

I felt a sense of relief after the interview was over and decisions were made to re-examine the delivery of each interview question to avoid overwhelming the participants, initiate conversation to restate instructions on this process before recording, and create a relaxed, open setting. Participation in this process helped to: identify personal and potential study participants' feelings; strength and weakness of the questions; and how to manage interview time (Chenail, 2011; Polkinghorne, 2005). Other insights gained were the researcher's essential role as the data collection instrument; recognition of how valued participants' time and support is to this study (Chenail, 2011; Polkinghorne, 2005). I was the primary instrument to collect data, and the highest risk to the integrity of

this research design, so time intensive efforts in preparation and planning were dedicated (Chenail, 2011).

Interviewing is a skill that requires empathy, practice, listening, and patience. The data is dependent upon the interviewer's skill to gain worthy evidence and the interviewee's ability to provide quality information (Chenail, 2011; Jacob & Furgerson, 2012). Feedback from the Chair and peer debriefing helped to manage researcher bias through the recommendation of slowing the pace of the interview; accepting the manner in which the data flowed; and maintenance of scholar-practitioner posture.

Research Setting

Although the plan was to have the study participants designate where the introductory presentation and formal interview would take place inside their churches, several of the participants changed this research setting and the planned separate visits for these interactions. The initial presentation was held at a restaurant over breakfast due to the request of two study participants. The purpose of this face-to-face visit was to give in-depth information about the study, address their questions, provide informed consent, and to obtain their decision regarding participation with a refusal or signed consent. We sat apart from the other customers in restaurant, for privacy. This change in setting provided a more informal environment, which supported relationship building and development of trust. This alternative setting allowed a safe atmosphere for meeting a female stranger. Two other study participants did not change the research setting or the planned separate visits for initial presentation and formal interview.

The six remaining study participants, to include two females requested that the first presentation be sent to them via email then follow-up telephonic contacts provided to answer their questions and obtain more information. This change in procedure resulted in their ability to adjust their schedules to spend more time in the interview, allowed them more time to consider their decision for participation, and facilitated the combination of consent procedure and the formal interview.

Altogether these changes resulted in a positive influence on the interpretation of the study results because of the triple exposure to introductory presentation, provided the participants more control over this process, and effective time management. The changes also decreased the level of anxiety for both the interviewer and interviewee and allowed the participants to share their story with extensive details. All interviews held in a private place where confidential information discussed and allowed more time to become familiar with the contributors, so these changes did not negatively influence the interpretation of the results. All field visits were conducted inside of the participants' churches during regular scheduled services and designated events.

Demographics

Participants completed a form to provide demographics about themselves, congregational members and community residents, and the FBO they serve (Appendix D). The confidential information such as participant's name, church name, and contact information for both were kept secured. The specific demographic data not confidential provided within the study were the pastors' race, age range, gender, marital status,

educational level, number of years serving in current FBO and as a pastor, personal health ratings, the state of residence, and the number of chronic medical conditions.

All ten of the research participants were African American pastors who presided over predominately Black Christian churches. Three of these pastors were women, and the remaining seven were men. At the beginning of the study eight pastors were married, one was a widow, and one was divorced. During the data analysis, another pastor became a widow. These pastors resided in the following three states: North Carolina (NC), South Carolina (SC), and Virginia (VA).

Nine selected pastors held a full-time primary position, and the remaining pastor had a full-time secondary position; the pastors achieved graduate degrees, verified congregational sizes of more than 50 active members, and actively participated in their communities, and three pastors resided and led congregations in different geographic areas. One of the female pastors held the position of secondary whose daily duties included all the responsibilities of the primary in his absence, the progression of regularly scheduled church with management of the part-time associate pastors and deacons. She also conducts weekly Bible studies, community partnerships that have supported outreach ministries, after-school and summer youth programs, community-based research, and clinical site management of the social work students.

All pastors were asked the number of chronic conditions diagnosed by their health care provider and to rate their personal health as poor, fair, good, very good, and excellent. Five pastors indicated they each had one chronic medical condition, and the other pastors had none. Pastors without chronic medical conditions, three rated their

personal health as excellent and remaining two rated it as very good and no one reported their health as fair or poor. According to Bopp and Fallon (2011) wellness activities are reported more frequently with pastors rating their health as excellent and very good, in this study it remains the same compared to the remaining five pastors who rated their health as good.

In consideration of documented educational disparities for African Americans, and Black pastors residing in southern states with lower graduate degrees, I did not confine recruitment efforts to one geographical location (Harper, 2012; Jenkins, 2006; Lummis, 2006; Valburn, 2009). A total of five pastors resided in NC, four in VA, and one in SC and no other pastors expressed interest in participating in this study after achieving data saturation. The evidence and data obtained in this study do support increased presence of health promotion activities in FBOs with pastors who completed a master's degree or higher (Bopp & Fallon, 2011). Doctor of Ministry (D. Min), Doctor of Theology (Th. D), Doctor of Divinity (DD), Doctorate of Health Administration(DHA), Masters of Divinity (M. Div.), and Applied Masters degree in Ministry (MA) and additional characteristics found in Table 1:

Table 1

Participant Demographics

Identifier	Age (y)	Educational level	Number of years as pastor	Number of years in current FBO	Personal health rating
Pastor A	40–49	D. Min	31	3	Excellent
Pastor B	60–69	M. Div	27	6	Excellent
Pastor C	50–59	Th. D	15	20	Very Good
Pastor D	40–49	D. Min	17	10	Good
Pastor E	50–59	DD	24	24	Very Good
Pastor F	60–69	D. Min	36	17	Very Good
Pastor G	60–69	MA	35	3	Excellent
Pastor H	60–69	M. Div	12	30	Good
Pastor I	60–69	DHA	23	11	Good
Pastor J	50–59	D. Min	14	3	Very Good

The youngest pastor who participated in this study was 44 years old, and the oldest pastor was 66 years old. There were nine pastors who had a difference in number of years as pastors versus number of years serving in current FBO. Seven pastors served in another FBO and the remaining two pastors were members who served in other positions in their current FBO before becoming the pastor. All of the differences and similarities in the participants' demographic characteristics provided a context for their thoughts, beliefs, and lived experiences.

In regards to the church demographics, slaves and free men together founded and built nine churches from 1756-1889. Inside the stained-glass windows of the sanctuary, the historical evolution of one church building was present from the beginning and through renovations. Another church is a storefront that has occupied this building for the

purpose of worship for past three years. Two churches located downtown, two in rural areas, two within walking distance of a major interstate, one in a commercial district, and three inside a residential community. Six of these FBOs were found in dominant black communities.

Every pastor took the opportunity to complete demographic information about his or her FBO and congregation members (Appendix D). This form completed in its entirety by eight pastors; one pastor gave the answers for completion, and one pastor provided an incomplete form because he had an emergency. In addition to demographic information, this form instructs pastors to list some of the medical challenges and health goals; list positions of his or her staff; list professional committees and community organizations; community sponsored events; and identification of ministries that support health.

During the formal interviews, pastors discussed the health challenges such as diabetes, obesity, unhealthy lifestyle habits, health goals to lose weight, and self-management of medical conditions of congregational members. Seven FBOs had a centralized health ministry coordinated by health care professionals, and the remaining FBOs had integrated management of health promotion activities by designated leaders of several programs. Congregational Health Ministry (CHM) is another name for health ministry that is considered an established program and evident in larger FBOs (Catanzaro et al., 2006). The principal area of concentration was health promotion, disease prevention, and self-care management of chronic health conditions (Catanzaro et al., 2006). However, every pastor reported all other ministries must support health promotion activities to achieve positive behavior health outcomes. Therefore, the discussion

centered on how the health ministry fit inside other programs such as Christian education, senior ministry, kitchen committee, youth ministry, bereavement ministry, and tender loving care (TLC) ministry.

The pastors were also asked to rank in order of priority what their congregational needs were regarding physical, emotional, social, spiritual, environmental, financial, intellectual, and occupational, using 1 for highest priority and 8 for lowest. The majority of the responses ranked spiritual, physical, emotional, and financial in the top four, yet one pastor ranked social number one and spiritual the eighth priority for his congregation. This pastor resides in a community with lowest population size in comparison with the other nine pastors.

In spite of some of the similarities for these FBOs, the differences noted during the field visits. All FBOs have expanded to meet the population growth, went through renovations to meet the needs of elderly and persons with handicap conditions, two FBOs approved as historical sites, and seven more should be considered based on their age, integrity, and significance in the community. FBOs represent a place for healing, comfort, and release from life stressors for African American communities (Allen et al., 2010). The following information provided in Table 2: denominations for FBOs, the number of years in existence, average attendance, congregational members' racial make-up and gender in percentages for Blacks, Hispanics, Whites, Others, and age range for the church body.

Table 2

Church and Congregational Demographics

Denomination	Membership size	Number of years in community	Diversity of congregation	Age range for church body (y)	Gender percentages (females/males)
Baptist	275	144	100% Blacks	0–97	90/10
AME Zion	450–500	220	95% Blacks 4% Whites .5 Hispanics .5 Other	0-97 years	60/40
Baptist	350	143	99% Blacks 1% Whites	2-80 years	60/40
Baptist	2400	140	99% Blacks 1% Whites	0-96 years	75/25
Baptist	700	142	98% Blacks 1% Whites 1% Hispanics	7-98 years	61/39
Baptist	248	260	100% Blacks	0-90 years	60/40
Baptist	300	127	95% Blacks 5% Whites	1-88 years	60/40
Baptist	248	260	100% Blacks	0-98 years	60/40
AME Zion	147	220	100% Blacks	3-94 years	75/25
Nondenominational	120–150	3	94% 4% Whites 1% Hispanics 1% Other	1-82 years	65/35

Data Collection

Time was devoted to examining researcher bias in regards to thoughts, opinions, beliefs, and attitudes about African-American pastors and congregational members before beginning the data collection process. Lifelong experiences with this target audience, familiarity with different types of FBOs developed biases, therefore self-examination was required throughout this entire process (Chenail, 2011; Patton, 1980).

After approval of Walden IRB, the recruitment plan activated in the following manner: 40 Recruitment flyers disseminated to church administrative assistants at various FBOs, 20 flyers sent via email to area FBOs, and 20 given to different congregational members. These efforts identified 20 potential participants. As a result of these efforts, ten pastors called, five pastors emailed, and five pastors contacted the researcher in person using the information on the flyers.

Five pastors did not meet the selection criteria, and five pastors expressed no interest in participating. During the scheduling, ten pastors for initial presentation, two of them decided not to contribute. The researcher contacted four churches found in a local faith-based magazine and obtained permission to send four recruitment flyers to them. This change in the plan helped to identify two interested potential study participants.

At the start of this study, I used the inclusion criteria and purposeful sampling to recruit potential study participants. All of the selected participants met the criteria. However, two potential study participants had a difference in their educational credentials. In regards to Pastor, G researcher conferred with dissertation chair and the

second chair about his Applied Masters in Ministry and honorary Doctorate in Ministry to validate he met the selection criteria. This consultation with both chairs was necessitated because this pastor's educational achievements did not include undergraduate degree completion

I also conferred with both dissertation chairs in regards to compliance with inclusion criteria for Pastor I because this potential study participant held a Bachelor of Science in Nursing, Masters in Public Health Administration, and Doctorate in Health Administration. This pastor attended seminary without the desire to obtain another postgraduate degree and has provided clinical site management for local universities for several graduate nursing students and seminary students. Both pastors followed selection criteria and provided quality data. Doctorate degrees in Theology or Ministry was preferred but not required.

After the presentation of the study and informed consent procedures, if the approved # 03-06-16-0173340 Walden IRB consent form was signed, a copy of this consent form was provided along with researcher's written contact information. All interviews were scheduled based on the availability of the study participants on Tuesdays, Thursdays, and Fridays. Mondays usually considered a day off, and Wednesdays reserved for Bible study.

Using six open-ended questions and probes as needed (Appendix C), data was collected from ten African American full-time pastors leading predominately black

congregations. Vivid details resulted from the responses to these questions and probes. All of these face-face interviews were recorded using a digital recorder, saved into designated folders on this recorder and desktop computer.

The duration of the interviews on average was 30 minutes with an additional 20 minutes upon the request of the pastors to provide a tour and oral history of their church. Since the time planned for the interview was one hour, the excess time afforded the ability to learn more information about the pastor. Opportunity presented by the available time helped to explore the pastors' feelings about their ministry, congregational members, community residents, knowledge of their church, increased familiarity with this institution, and time to make notations regarding observations.

A verbatim transcription of each interview was completed using a digital recorder. Included in these transcripts journal notes regarding the nonverbal behaviors, the research setting, and some characteristics of the interviewee. Handwritten reflective comments completed on the researcher's copies of these transcriptions. Per the participants' request, their respective transcript to include journal notes was sent to the interviewees via email for member checking within five days of the interview, and their response expected within fourteen days (Houghton et al., 2012).

All pastors approved of the content either verbally or in writing, and clarifications requested from the interviewer were added in regards to acronyms or biblical reference for accuracy. All participants declined a follow-up visit to review transcriptions because of their time restraints and the desire to conduct this review at their leisure.

Data Analysis

Data viewed through the lens of a health care provider trained in human behaviors; active listening; self-reflection of bias; critical thinking and analysis; relevant inquiry skills; observations while participating in diverse settings and cultivation of empathy and caring traits (Creswell, 2009; Patton, 1980; Tracy, 2010). This training and educational journey provided the tools to manage this researcher's bias and remain open to receiving and experiencing the data from the perspectives of participants and other data sources.

A record of data collected placed in journal notes, calendars, document files, audiotapes, flash drives, and computer devices. Additional data records located in audio records, completed transcripts, reflective notes, and field visits captured on typed participant-observation sheet imported into Nvivo 11 for Mac software for organization, storage, and data management (Smith & Firth, 2011).

Researcher read each transcript multiple times and notations made in the margins and original codes for organizing and selecting the areas for analysis (Elo & Kyngäs, 2007). Manual coding was repeatedly done on each sentence to find a word or words, apart from the content to describe the responses. Then coded information was used to generate categories, to reduce the list of categories, and recognize patterns for connections through comparisons. To capture direct quotes that supported the interpretation of the data, and to develop themes or concepts (Gioia et al., 2013; Elo & Kyngäs, 2007; Rudestam & Newton, 2001; Saldana, 2008) Transcribed data reformatted according to this software so

For each study participant, poster boards containing transcriptions with coded responses and reflective notes, observations, and field notes was displayed side by side to continue open coding to define the categories. Next this information recoded, highlighted with different colors for categories and subcategories and the constant comparisons of data to capture the meaning for themes were tracked with a code sheet. All other data sources combined with the transcripts were reviewed and analyzed during this manual coding process until no new themes found. This inductive analysis included the codes, designated categories, patterns, and direct quotes from the data, which lead to the themes or concepts (Rudestam & Newton, 2001; Starks & Trinidad, 2007).

Once all efforts were exhausted for manual coding the transcribed data was analyzed using QSR International NVivo 11 for Mac, qualitative data analysis software program (NVivo 11 for Mac, QSR International, 1999-2016). This software was used to maintain data, organize, coded at nodes, and store field notes and journal notes. NVivo allowed all coding of transcribed data with single and multiple codes then placed them into hierarchical coding (NVivo 11 for Mac, QSR International, 1999-2016). Transcribed data reformatted according to this software so coding stripes were used to see the patterns and displayed them in maps for comparisons and additional analysis (NVivo 11 for Mac, QSR International, 1999-2016).

A total of six themes, sixteen categories, and twenty-nine codes identified after data became repetitive. For the first research question, a total of three themes, eight categories, and fifteen codes recognized. In support of this exploration the initial

categories, and fifteen codes recognized. In support of this exploration the initial interview questions to ascertain the pastor's knowledge of the health conditions and follow-up questions were asked to identify the causes related to these medical conditions that necessitated the request for health advice counsel.

Each participant responded with a list of long-lasting diseases and treatable medical conditions with causes or elements to justify their origins. After answering these interview questions, each participant was asked the first research question to share their feelings, their approach, the outcomes, and to provide self-assessment from their perceptive about giving health guidance.

The second research question had a total of three themes, eight categories, and fourteen codes. Before addressing this research question, interview questions were asked to identify internal efforts generated to provide their congregational members and community residents' opportunities to improve their health status and to understand resource utilization. Each pastor identified programs, event, or activities sponsored by their church or as partners with community agencies to assist their members' efforts to achieve healthier lives. Responses to these interview questions supplemented the data gained from asking each participant the second research question regarding their lived experiences as clergy and health promotion advocates.

Discrepant Cases

Two pastors provided data, which was contradictory to all other responses regarding the health challenges their congregational members and residents faced. In addition to providing a list of diseases or conditions, they chose to discuss a problem for

the church administration. Pastor G stated “We have had other people with sickness wearing the bag, the colostomy bag, so that had been a challenge.” Pastor H said in the midst of discussing residents of group homes “We have had individuals from various group homes to walk into the church with colostomy bags breaking on them here in the church people trying to clean them up.” Pastor H further stated, “So there were some liability issues there it was not the fact that church leadership was being cold or cruel . . .because if something would have happened to that individual . . .”

The data was found to be more unusual, episodic, and with the use of probes, the concern is how the church can handle the situation of broken colostomy bags. This data does not reflect the experiences of study for health guidance for congregational health challenges and support for health promotion. It does provide evidence of an administrative issue that may require training and specific procedural guidelines to respond to this situation.

For this study the code for consideration is a health risk since colostomy bags create an alternative release of fecal matter and increases the risks of exposure to infectious disease (Ashbolt, 2004). This code provides information related to the potential of caregivers handling infectious waste and connected to the category environmental hazard and social concerns, and theme precursors to ill health make it inclusive because these pastors are making it concern for not only the church leadership but also for the members.

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Evidence of Trustworthiness

The research study focuses on a valuable issue, the health leadership of African American pastors assisting with the efforts to reduce and eliminate health disparities for an underserved population. Thoroughness was achieved with the use of adequate, diverse, correct, and multifaceted techniques to select study participants with depth of experience related to these phenomena (Tracy, 2010). Other strategies to ensure rigor was to obtain data rich in details, utilization of several lines of evidence, employment of two sampling strategies, and several types of coding methods during the data analysis (Tracy, 2010).

This study is inclusive of the self-assessment regarding the biases of the researcher and the revelation of the methodology and obstacles. Rich details are provided in the words of the participants; triangulation was achieved when more than one data source agreed with the explanation, and member reflection were provided with transcribed interviews. This research can identify with a variety of readers on issues surrounding health promotion and disease management (Tracy, 2010).

This exploration provides inquiries to further research studies, and consideration of empowering a group of leaders to increase their effectiveness in health promotion to build healthier communities. Under the approval of Walden IRB methods were identified to ensure procedural ethics; the practice to cause no harm; to act with integrity and be respectful of the participants, and disseminate the results to all study participants. This study demonstrated achievement of the standards for quality in this qualitative research (Tracy, 2010).

Credibility

In compliance with the stated plan to provide a credible research study, the data reflects the exact words of these pastors detailing experiences that were culturally sensitive and relevant. This data was achieved with more than five contacts with every study participant and from multiple sources that included field visits, interactions with congregational members, written church materials, displays and bulletin boards, local faith-based publications, social media avenues such as church websites and Facebook.

Triangulation is documented with the methods to control researcher bias, the adjustment to widen the opportunities to obtain data, member checking, frequent comparisons of data for each participant, across participants, and with the research questions and goals, and through the manual and software applications employed for analysis to ensure the data produces the themes. The utilization of NVivo software had applications to allow the data generate themes (Welsh, 2002).

Transferability

Exposure to this study does create the shared experience of enlisting the support and assistance of persons who are trusted and influential in managing health challenges and changes for healthier lives. The common methods of storytelling by these pastors allow the reader to visualize, understand, and express feelings for the situation from clear detailed descriptions. The efforts of these faith leaders to recognize health challenges and to assist health behavior changes applicable to individuals, families, any professions or work groups, any institutions, public, private, and business policies, societal and economic concerns.

Dependability

Consistently documented thoughts, feelings, decisions, and changes in methods from the planning to the conclusion of this research process was achieved. The readers can recognize the biases, efforts to manage them, the handling of negative data, and the lens used to apply the methods, and interpretation of the data. There is evidence of the researcher's personal contributions, and responses recorded on the audiotapes. Planned strategies with an adjustment were used to obtain the right number of participants with both similar and different experiences that related to the study goals.

Confirmability

NVivo was used for text search queries of transcribed interviews for specific responses related to coding markers to evaluate the manual efforts to ensure there was a representation of all viewpoints and validation of patterns (Houghton et al., 2012).

Coding queries were also used to identify and obtain coding to twenty-eight nodes that were connected to the data (Houghton et. Al., 2012). Results of this search ensured it supported analysis of quoted responses (Houghton et al., 2012). "Matrix coding was the third query strategy used to check the rigor, and repeated instances in the research" (Houghton et al., 2012, p. 15)

Study Results

The research questions were employed to assess these leaders' knowledge of relevant medical conditions, and health challenges facing their congregational members, and community residents and to gain information about the interventions used to address them. Congregational members and community residents confide in their pastor, and that becomes evident in regards to his or her knowledge of their health concerns (Allen et al., 2010). Flexibility with the delivery of all questions, and probes was utilized to ensure the information consisted of fertile details to identify the categories, themes, patterns, and reach data saturation (Abrams, 2010; O'Reilly & Parker, 2012).

Transcripts, observations, reflective notes, field and journal notes, and all other data sources were reviewed multiple times to hear these study participants' stories to meet these research goals. Each research question will be addressed through the organization of themes, quotes, documents, observational notes, follow-up questions, and probes presented to support each finding. As a result of the data analysis, the three themes in the next section were developed to increase the understanding of RQ1.

Theme 1: Prevalent Congregational Health Challenges

The first research question was given to all ten African American pastors to find out how they feel about their ability to conduct health advice guidance within their faith-based institutions to achieve positive health outcomes of their members. The initial interview questions were asked to understand what types of health challenges their congregational members and community residents have been presented to them for assistance. All the responses were related to the categories of chronic diseases, and medical conditions

Pastor A said, "I think talking to persons in our congregation is diabetes, high blood pressure, and heart disease."

Pastor B stated, "Well strokes, heart disease, I mean these are all big chronic diseases when you think about African American communities. Whatever is in the society is mirrored in the church."

Pastor C stated, "As clergy you know, when you dealing with members in the community and they confide in the clergy, so I know these are the leading ones."

Pastor E stated, "Ok, obesity, diabetes, high cholesterol, high blood pressure, depression, cancer . . .Then with the aging population we got arthritis and then growing one we are seeing now is dementia."

Pastor E stated, "Ok, obesity, diabetes, high cholesterol, high blood pressure, depression, cancer . . .Then with the aging population we got arthritis and then growing one we are seeing now is dementia."

Pastor I stated, “I’m seeing a lot of Alzheimer’s, in fact, I am the primary caregiver for one of my members.”

To ensure all pastors included all age groups in regards to health challenges a probe was given to remind them they see generations of people so what are the health concerns in your younger members. Pastors’ responses specifically targeted the youth health challenges in many cases as being related to their parents and grandparents

Pastor E stated, “I have noticed that depression can run in the families, so those types of things.”

Pastor F “I have seen diabetes in the grandparents, the parents, and kids, all generations. High blood pressures the same thing it’s a pattern.”

Pastor J “Asthma is the main allergy for the younger people, so that is what I mostly see in younger ones.”

A total seven of the pastors surprised this researcher with responses that were causes, health risks, cultural influences, dietary concerns, and sedentary lifestyle. Instead of health problems and mental health illness this data led to the development of the following theme:

Theme 2: Precursors to Ill Health

Pastor A stated “I think what is going to happen is lack of exercise, inactivity, eating junk food that leads to diabetes, overweight, and a lot of other health issues.”

Pastor B stated “We don’t eat a lot of fruits and vegetables; they are missing from our diets but we love a lot of meats and sweets.”

Pastor C stated “I believe that the mental health issue is in many single parent homes because there is some instability if you will, which is the reality, that is what I see in the kids and behavioral problems may stem from that.”

Pastor D stated, “Like sugar is a drug, it is crack, it is food crack, so it’s sugar, salt, inactivity, and stress. (Interviewer states right, right) I think those are contributing factors.”

Pastor E stated, “There are some families seem more susceptible to certain types of cancer, there are certain types of cancer that can be prevented might be a lifestyle or environmental type issue, those type of things.

Pastor F stated, “Neglect really is something that will cause a problem to be amplified if you don’t catch it, you know like diabetes . . . One of our members their eyesight . . . she couldn’t drive anymore.”

Pastor H stated “To start off with the obesity it appears as if it is more prominent with the children and I can see it starts off with the children it goes with them growing up as adults.”

Pastor I stated “There are some you can’t do nothing about it because it’s heredity but we can do things like the diet, the exercise, so we don’t fall into that.” (Interviewee smiles and does light laughter, Interviewer states that’s right and all efforts count)

Pastor J stated “I know for a fact that most of the people in our ministry that have high blood pressure is because some, well most of it is heredity but there are some who just want to eat what they want to eat.”

All of these responses provided contributing factors, unhealthy lifestyle habits, and environmental hazards and societal concerns that led to this theme. All the data collected from these pastors in response to the interview questions documented an acknowledgment of the theme of prevalent congregational health challenges, the recognition of theme precursors to ill health, and the request of their members to help them with these issues. Pastors do represent the pulpit and congregational members, and community residents do seek their counsel. This first research question was supported by these two themes but addressed by the following theme:

Theme 3: Pulpit Health Promotion Communications

This theme was generated from data obtained using several subsets of questions and probes that directed all pastors to reflect back from their early years of ministry to the present regarding giving health advice guidance. In the midst of this self-reflection, they had to consider themselves as a minister whose actions are accountable to God and the members they serve. Their words reflected the codes of health advice, sustainment, ongoing sermons, storytelling, and testimonies.

They were asked to do a self-evaluation of these efforts and identify the outcomes of this intervention. Their responses supported the codes of personal and family experiences, competency, confidence, and health behavioral changes and spoke to their many roles of adult child, parent, caregiver, spouse, faith leader, and as an individual. All of the multiple responses from participants who took their time to address this first research question contributed to the categories of health promotion messages, biblical instructions using faith jargon, health interventions and health outcomes.

Pastor A stated “I think earlier on I would just pray for the person then as I gained knowledge I encourage them to seek medical attention and prevention. So, refer them so they can get solid and sound information.”

Pastor B stated, “One of the things I don’t do as a pastor is walk into a hospital room and ask you what is wrong, now if you share it with me, I’ll accept that and I may say I know this and that may help with that.”

Pastor A further stated “I’m more able to do it, I’m more ready to do it. I stressed the importance of being healthy.”

Pastor B further stated “As a matter of fact, in some of the areas I have seen people get many types of supplements. I do try to discourage it.”

Pastor A stated “As you know in the African community it’s a taboo . . . I have shared with my members that I have had to talk to a mental health professional” (Interviewer states that is outstanding).

Pastor B stated, “There is a passage in the scripture where Aaron had just lost two sons of his sons... Our calling is…about helping people with the meds, they need to keep them in good health, bright and sunny.” (During field visit the female teacher for adult women Sunday school class interjected health messages about stress management, community safety, and the importance of health screenings).

Pastor A also stated “I try to model the behaviors I informed my members. For example, I tell them from the pulpit “I’m going to have my annual checkup let’s go guys.”

Pastor C stated, “In my earlier ministry, I did a whole lot of Googling trying to search things.”

Pastor D stated, “My parents have grown older so that it changes your mind set because you are dealing with that more intimately, my father is a cancer survivor . . . has given me a heighten sensitivity.”

Pastor C further stated, “Now it’s a simple phone call it could be a psychiatrist, it could be a medical doctor, whatever it is, I have a personal relationship and it has helped tremendously.”

Pastor D further stated “Praying for people, exposing people to a different method, a different model . . . I guess confidentially, wisdom, and referral.”

Pastor C stated “I did some healthy things, so I have been taken off of medicines, lost 33 pounds, and you got to practice what you preach.”

Pastor E stated “I have always been consistent because I have always had a sense of taking care of yourself.”

Pastor C further stated, “There is about five-six members who used my diet. They lost from 20-30 pounds then they got other members to get on that diet, and they have lost too.”

Pastor F stated “We don’t have a problem working with outside agencies to obtain help with people when they have problems, sickness, and illnesses.”

Pastor E also stated “I tell them what they need to do, men, in particular, they need to have a prostate exam. For the ladies, in particular, I tell them they have to get a mammogram.”

Pastor G stated "I probably would have done in that particular time when they approached me with their condition . . . would want to make sure that doctors are involved, that you are attending counseling and doing what the doctors say."

Pastor E stated "I know for sure they have been some successes . . . For example, people who are riding bikes now, because one brother bought this expensive bike. But there's still a long way to go in terms of eating."

Pastor H stated "Sister number one said . . . when I went to pray with her, we are not going to be able to stay in the home any longer, we needed to have made some plans to leave the home earlier."

Pastor J stated, "God can heal you but once He heals you, you can't go back to the same thing."

Pastor H stated, "All I could do is just pray, encourage her and read Scripture, I pray that the Lord would show her the right decision for her life."

Pastor G also stated, "You know Cynthia ministry, of course, is a growing process and in my thirty something years as pastor you learn the dos and the don'ts, what work for one don't work for the other."

Pastor J stated "I'm a health person, so I'm always trying to tell them to eat healthy . . . I told them to cut out your fried foods, stop eating late at night, stop eating all of that pork, and . . . ice cream every day."

Pastor G also stated, "So I started praying and seeking the Lord to identify the people in the congregation to help me deal with these things."

Pastor J further stated, “It did not happen overnight it was a gradual process . . . they started changing their diet . . . then they saw their weight starting to come off and they begin to feel healthier.”

The data analysis did indicate that these pastors were comfortable with providing health advice guidance and they are fully aware of their professional limitations. Even though, pastors were not questioned about what type of health advice they gave, they were asked to describe the actions they took. The pastors’ responses all indicated they grew in knowledge of health concerns, life experiences, utilization of health care professionals, and personal changes to improve their performance of health advice guidance and recognition of when referrals to health care professionals were needed. Discussion for the next section addresses the acquired three themes from the data to increase the understanding of RQ2.

Theme 4: Health Behavioral Change Agents

The second research question was given to all ten African American pastors to find out about their lived experiences as members of the clergy and health promotion advocates. The interview questions were asked to determine their health leadership, their involvement in health promotion activities, the different types of health promotion activities offered in their churches such as health awareness, health education, and health policy, and their lifestyle changes. The data provided categories of health advocacy, health promotion activities/outcomes, and pastoral health beliefs and changes which generated this theme.

Pastor A stated “About two years ago we had a four-week class on how to manage diabetes . . . We brought in professionals from the health department, and it was offered to . . . the community.”

Pastor B stated “We will have a men’s group . . . a couple of times we have had a general practitioner that has come, we do use this opportunity to do some teaching about health and wellness.”

Pastor A stated “I made a decision to stop eating pork and beef, and I don’t have high blood pressure or diabetes . . . People ask if I’m muslin because I don’t eat pork . . . no I’m not that’s a joke in the church.”

Pastor B stated, “Some of us have come aware of the fitness challenges, and we are now monitoring our steps…I got some of them that have join the gym I work out in...” (This pastor was observed walking to his church while traveling to his interview).

Pastor A further stated, “As a result, people have started to cook healthier, using turkey instead of pork. Whenever people cook meals for the church, they will use turkey instead of pork.”

Pastor B also stated, “We offer water as one of those healthy choices, along with fruits and vegetables out of our garden.”

Pastor C stated, “I have dealt specifically with obesity because in the black church everything we have we eat.” (Bulletin board displays information on healthy eating using the plate by American Diabetes Association outside the Health Coordinator’s office).

Pastor D stated “I think this is the first generation that has been taught how to eat healthy. I’m praying I’m going to do it, give up red meats.”

Pastor C stated "I have dealt specifically with obesity because in the black church everything we have we eat." (Bulletin board displays information on healthy eating using the plate by American Diabetes Association outside the Health Coordinator's office).

Pastor D stated "I think this is the first generation that has been taught how to eat healthy. I'm praying I'm going to do it, give up red meats."

Pastor C also stated "I tried to change it all to healthy eating, and that did not go over so well. So, what we did is give people alternatives which has worked well."

Pastor D stated "I have to eat to live and be intentional about eating to live." (Interviewer that is so true I heard that for the first time from a registered dietician and that is so good.)

Pastor C stated, "We have seen and heard from testimonies from several people telling us that they have made conscious efforts to change their eating habits and are doing more exercise."

Pastor D stated "Portion size, it's the small things instead of serving Kool-Aid just water…If you don't have it, you don't eat because it's not here."

Pastor E stated "What's also involved in body and soul is shared yoga . . . program with . . . all white Lutheran church . . . which has been very successful . . . We want people to be healthy . . . the oldest person in program is about 98 years old." (This activity is posted on the church website along with a variety of health promotion events)

Pastor D further stated "We do gospel aerobics, we do gospel Zumba, we have meals church-wide we try to be intentional about servings like we did a vegan there is a Vegan African American Cater."

Pastor F also stated, “We joined one of the local churches and presented a health fair about a month or month and a half ago.”

Pastor D stated “On Wednesday well every Wednesday we have Daniel fast where we give up meats and sweets.” (This activity is posted on the church website).

Pastor F stated “There is a walking program (Interviewer states physical activity) as well there are a lot of things we are connected with.”

Pastor G stated “We have blood pressure screening, we check the blood sugar, and we have classes, all of that.”

Pastor F further stated “We have different professional people coming in as presenters…we have a multiplicity of things that is offered.”

Pastor G further stated “We help people if their sugar drop or they have a medical condition, and we have an area where we can take them.” (Interviewer states yes, I saw that)

Pastor F stated “There was this guy who told me when I was early in my ministry, find out what the people need and do it better than anybody else.”

Pastor H stated “This church has an after-school program where we partner with the local city with their parks and recreational services allow us to . . . tutor the children educational wise and to provide a healthy meal for them while they are here.”

Pastor G stated “It’s been mostly through testimonies where individual members who come back and share with us how their life was changed because we implemented this program or that one.”

Pastor H also stated “In the tutoring part not only is it educational . . . there are individuals brought in from the community to talk to them about health issues and healthy eating.”

Pastor J stated “I used to be an aerobics instructor . . . So, I started an exercise class in the church a few years ago…they just don’t want to come out and exercise.”

Pastor H stated “When we partnered with the American Heart Association we were able to monitor some of the behaviors that changed . . . We did some wonderful things with helping people to change some of their unhealthy eating habits.”

Pastor J stated “I work out every day . . . I have given Bible studies on healthy eating, I have done workshops and seminars talking about health, I have some Zumba classes . . .” Pastor J also stated “We have tried to incorporate things like that we have done cooking classes, we have shown videos of how you can make food healthy…”

The data analysis indicated that these pastors and their churches are offer health information, teaching, self-management of chronic health conditions, and policies to help their members and community residents achieve positive health outcomes. These pastors demonstrate health leadership: they share their health beliefs and changes and encourage their members to engage in healthy activities.

Theme 5: Separation between Health Maintenance and Spiritual

During the interview when discussion centered on how members and community residents respond to health advice and health promotion activities, responses communicated nondisclosure of health status, fear, reluctance, and disinterest. Also, several pastors began to discuss how the health status of the Shepherd could reduce their

ability to lead their congregation to health. This theme was originated from data that generated categories of health privacy and avoidance of health promotion activities.

Pastor A stated “One of the things with some males has been prostate cancer, a taboo thing.”

Pastor B stated “Most people in the congregation don’t share that well, they wait until it’s a serious problem, because it’s not something they are accustom to doing.”

Pastor C stated “But there are those that pull back the reason why is they are private and don’t want people to know.”

Pastor F stated “There was this organization providing an eight-week session on human immune deficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and the members pushed back . . . I had to take a stand . . . we are going to have those classes here.”

Pastor A stated, “I do advocate going to see mental health professionals . . . As you know in the African community it’s a taboo, we don’t want to talk about that.”

Pastor B stated “When they do share it’s a serious problem they want to bring it to the pastor and they want a miracle.”

Pastor C also stated “There are some people that are afraid, and they will not participate or go to their doctor because they are afraid of what they may hear.”

Pastor B stated “Most of the time people just want you to think that they are completely healthy . . . I had a lady . . . I did not know had kidney problems . . . I had visited her once in the hospital.”

Pastor C further stated, I have encountered so many pastors . . . who are on the verge of mental breakdown because of the calling and what we do . . . Some of whom are obese and do not take care of themselves."

Pastor B stated "And even for pastors . . . we don't want to talk about certain stuff because we are unhealthy we don't feel comfortable talking about healthy lifestyles."

Pastor D stated "I don't know if seminaries have a vested interest but seminaries should because pastors are some of the unhealthiest people on the face of the planet."

Pastor E further stated "Now here's the other thing, pastors are not always healthy, pastors are overweight, eating those fried stuff, folks are baking them cakes and all of that."

Pastor D also stated "Oh yeah, absolutely there have been publicized events of a pastor who took his own life in Macon, Georgia and I think last year you had a rash of pastors taking their own lives."

Pastor E stated "You know that, it's just like anything, you got some people who are interested, you got some people who don't want to change right now, so you have to keep working because it's hard."

Pastor H stated "We look at the medical our health as being separate from our faith but the two are entwined together, and so it's a holistic concept so we are still struggling with that because we rather see more Jesus than we would more health."

Pastor J stated "My heart goes out because I do see my congregation suffer from a lot of things and you try to help them and tell them to try this and do that and some will and some won't."

Pastor H stated “Here in our congregation we had minimum participation simply because there was a stigma that somebody was getting in my business and we have our own doctors so we don’t need to tell you about our medical condition which is fine.”

Pastor J also stated “You know some people have this mindset that I’m going to die, of something, that is not the way I want to die so they were using that as an excuse to continue to live that lifestyle.”

Pastor H further stated “It was not getting into your business . . . it was preventative research so we can find out what the needs are in cancer arena for women and girls . . . We were successful with the community but not with our congregation.”

Pastor H stated “Have we not been able to have them come to the table to talk openly no because it’s none of your business because it’s that privacy concept where did they get it from they got it from the women in their 50-60’s.”

Pastor I stated “That is an area that is lacking there are not resources for pastors, and you find pastors who are walking away from the pulpit by the day, by the hour because of burnout.” (Interviewer states absolutely).

Pastor I also stated “I find there are not enough resources for pastors to get the help they need and most of the time as pastors you don’t have the individuals that you can talk to, you have to rely on the higher spiritual power in order to deal with it, but sometimes you want just to be able to share.”

Pastor J stated “I do hear that a lot especially with the healthy eating . . . people

say wait a minute it cost a lot of money to do this fast but it really doesn't Daniel fast is healthy eating but it does cost to eat healthy."

All of these responses presented the acknowledgment of these pastors of the challenges in leading people to health validated this theme. The blended efforts of these pastors as health behavioral change agents and meeting the challenge of separation between health maintenance and spiritual wellness set the stage for sharing their lived experience as clergy and health promotion advocates. This second research question was supported by these two themes but addressed by the following theme:

Theme 6: Health Promotion Guidance

The data analysis indicated mind, body, and spiritual wellness, holistic health, learning opportunities, opinions on health and wellness, curriculum changes, integrated health ministry, nursing guilds, and health ministries. These coding units produced categories of pastor and church roles & responsibilities; professional training and support; and seminary inclusion curriculum. This theme was created from the data that examines their lived experience.

Pastor A stated "I not only advocate for your spiritual health but for your physical and mental health too."

Pastor J stated "I tried to get them have healthy foods here . . . if you have never seen it demonstrated or shown how to eat a healthier way then somebody has got to show them how."

Pastor H stated "The next concern we have for health is the overall availability of services for the past two years this church has been the site for the affordable care act."

Pastor J stated "I have to set the example, and if I'm telling you not to do something, then I got to watch what I'm doing. I'm the type if I say something then, I'm going to be the first partaker of that."

Pastor B stated "That is a preacher's role, and I tell preachers all the time around here that it's not so much about telling people what they ought not to do but we need to be more encouraging."

Pastor A stated "I think the church must take a much more proactive role, we got to do better…We are doing some things in our church, but we can always improve."

Pastor E stated "So its two-fold for the pastor himself or herself in terms of taking of themselves, but also he or she is modeling for the congregation, so they have to take care of themselves."

Pastor C stated "We have a health ministry here so we try to encourage people to seek help.

Pastor E stated "I believe in getting the proper rest . . . We have had stop smoking classes here, and currently, we have a health ministry, body and soul ministry."

Pastor F stated "We have health and wellness ministry . . . We have two on call nurses every Sunday . . .we had one of our deacons fainted right before communion, and one of the nurses was right there."

Pastor A stated "In beginning, there were nurse guilds in the African American churches and the nurses did not offer any medical support, now they have grown into full pledge ministries to include…medical emergencies."

Pastor G stated “We call it the nurses’ guild those are in place of course they are registered nurses, one sing in the choir and the other is with the deacons and they are all around, praise God they do what is needed to done.”

Pastor C stated “I have had different people to head it but this young minister who is a health person has been very efficient. He came aboard because he is a health trainer by profession he heads up our health ministry and he led our weekly aerobics.”

Pastor D stated “We do have a health ministry . . . The person who leads it is a health fanatic, so she is the one who leads the gospel aerobics and Zumba; she is a model of fitness.”

Pastor E stated “We have a health ministry and the person who handles our health ministry, she is in her 80’s she is a retired registered dietician. She heads our body and soul ministry which is a program through the American Cancer Society.”

Pastor I stated “Now our health ministry, we have a grant through Balm of Gilead . . . They provide a lot of training, and they give us a lot of videos to give to our congregation.”

Pastor C also stated “Yes, I’m concern about the whole body of Christ, too often we forget about the Shepard and the Shepard has to be ministered to as well. We have to preach health we have to minister to ourselves.”

Pastor B also stated “Actually we have a combination we have some health ministries, and we have a Christian education department. I know that for some people it’s all about book knowledge but Christian education is about healthy living.”

Pastor J stated “Not particularly, it is integrated. So, we don’t have one set organization or ministry that just focus on that but we do integrate and implement it in different areas of ministries.” (During worship service this pastor led the entire congregation in light aerobics were danced to music while she had us turn 360 degrees twice)

Pastor C stated “For Bible study sometimes people they have to be on the run so we provide fruit and raw vegetables.”

Pastor B stated “One of the things I discovered several years ago was about keeping food around so that if people feel like they are going into an attack they can have some orange juice or some type of the foods, we keep diabetic foods around.”

Pastor C stated “It has helped because we can apply for mini grants it’s not a whole lot but it helps us to do some of things we need to do. For instance, we bought scales; I’m working out but how do I know I’m losing weight” (Interviewer states outcomes).

Pastor A stated “As we sit here I’ve been thinking about some things I need to get back with our nurse and enhance some of things we are currently doing.”

Pastor B stated “I just refused to have a worship service too long because I recognize the need of our people we have those who have to go to the restrooms a lot, or they need to get a little snack.”

Pastor A also stated “There was an initiative back in the 1990’s called Five a Day. It was a five-year grant, and it was tedious. After the grant cycle concluded we moved on.”

Pastor B stated “So one of things we like to do is to keep around here is laughter and joy.” (This pastor provided humor during his worship service).

Pastor C stated “I believe in preventive medicine . . . No there has never been a situation that I can think of maybe it was not the season for it because if there is anything that can help an individual health wise I embrace it.”

Pastor B stated “Honestly for us sometimes the challenge for us is to continually re-make ourselves . . . we started a karate group . . . it began to fizzle out then you got to retool to bring back that excitement.”

Pastor B stated “We have had to separate the men from the women . . . because women suffer from illness different from men. We also had to separate them because men will frequently dominate the conversation.”

Pastor C stated “Yes and this is why. I can remember a time when domestic violence had nothing to do with ministry. Domestic violence has gotten so bad that now it’s a part of the curriculum in some seminaries.”

Pastor A stated “Oh yeah, we had something at one of the universities where I attended; they did something with health and disparities in communities. They did some seminars, and they brought people in to talk about health and wellness.”

Pastor C also stated “Health matters now and it’s so bad across this country and at least arouses awareness for health for pastors and as ministries, we must do holistic ministry, we must administer to the whole person.”

Pastor B “In church administration, it talks about all of those auxiliaries and one of them is health and wellness. There could be more on health and wellness.”

Pastor F stated “Yes I do, they have electives; (He starts laughing) maybe it should be an elective. Maybe it could be included as part of the curriculum they can do that, at some point in time I agree they need to be introduce to it.”

Pastor A stated “Again I’m not an expert in that area so I use the experts in that area to help me but I can come up with ideas.”

Pastor E stated “I’m also one of the volunteer chaplains in the hospital, so we went through training and they prepare us for that but I have always been health conscious.”

Pastor F stated “I supposed because of my training I was in the chaplaincy in the military so consequently you know you see things, you identify it and then you move towards resolution.”

Pastor D stated “I don’t think a seminary will add it as a required course because seminary teaches you to think theologically, it does not teach you the grass roots of ministry.”

Pastor C stated “I spent 24 years in the military; I was a master fitness trainer. I have not had formal health training just experience through the gifts from God.”

Pastor D also stated “Seminary teaches you that the body is Holy, 1 Corinthians 6:19, the body is the temple but what does that mean practically? . . . I think every seminary needs to require a course on holistic health before students can graduate.”

Pastor I stated “Seminary prepares individuals to basically look after the spirituality, theology . . . we have to be holistic ministry not just the spiritual although that is extremely important because that is what’s going to help us make it from earth to glory.”

Pastor D stated “The Baptist church is unique because it’s congregational but other denominations I think Methodist and Episcopalians have mental health analysis that is necessary before ordination, I think it ought to be universal.”

Pastor I stated “We have to look at mental health issues . . . in our African American population . . . That has to be addressed . . . I know that it has to be incorporated into the curriculum in the schools of Divinity, absolutely and most definitely.”

Pastor D further stated “I’m not saying that God cannot use you but you need to be mentally well to the best of your ability while responding to your call.”

Pastor E stated “I’m one in terms of doing healthy things and I try to model that for the congregation . . . I’m wearing the Fitbit . . . I try to walk at least three times a week for a least an hour.”

Pastor E stated “One thing we did was a test pilot for six weeks with our Sunday breakfast . . . we learned that instead of just giving fruits and nuts folks wanted a full breakfast.” (I enjoyed this healthy breakfast and ate turkey bacon for the first time).

Pastor J stated "I have had some members come back and said I have started to exercise, some have come off their blood pressure medicine . . . off of their insulin, some has lost weight so it has changed their lifestyle."

Pastor F stated "Everyone has been certified is it the defibrillator, I'm have also been certified, and we have about 50 people in the church who are certified to use that machine."

Pastor G stated "No just a little in the military . . . when I first got here the pastor used to be a fire chief and . . . he helped people with breathing I can't think of the name of the classes . . . yes we had some classes on CPR."

Pastor F also stated "Cardiopulmonary resuscitation (CPR) and all of that we do the certification every year, we have to go through that in the evening; I had to go through everything."

Pastor I stated "So I try to do as much community health teaching . . . within my congregation, I have a health ministry within the church, a health coordinator . . . four RNs working with her, a dietician, and a physical fitness instructor." (During observational visit, pick-up several health information pamphlets printed by American Heart Association from table display in the church).

Pastor H stated "This particular church is a field site for this university's social work department, and both pastors here are field instructors."

Pastor G also stated "We also have those young people from school with that hyperactive condition, and so we are blessed because one of our deacons works with the county and he meets with the kids here and mentors them."

Pastor H further stated “We felt that we can best serve this community . . . having the social workers here . . . they need to learn the . . . political piece but the faith community in which they are serving.”

Pastor I stated “In other words just providing a holistic ministry it’s much more than the spiritual aspect, much more.”

Pastor J stated “I wanted to be healthy, I saw what my mom was going through with her body back then, aunts, uncles and other cousins were having all of these medical conditions, and I declare that’s not going to be me.”

Discrepant Cases

All of the pastors agreed that seminary should include more information on health and wellness into the curriculum. However, their deepest desire is that schools developed resources to assist them with managing their health. One pastor suggested that seminaries should help them deal with congregational members with mental health issues, and another pastor recommended they assist the ministers with mental health concerns.

Pastor I stated, “That has to be addressed, so I don’t know how but somehow I know that it has to be incorporated into the curriculum in the schools of Divinity, absolutely and most definitely.” Pastor C stated “I would say that for the minister they need mental help as well.” One pastor advocated a universal screening for mental health before the person is ordinated for this position. Pastor D stated “The Baptist church is unique because it’s congregational but other denominations I think Methodist and Episcopalians have mental health analysis that is necessary before ordination, I think it ought to be universal.” Pastor D further stated “A lot of people are not mentally well

themselves, the last thing you need to do if you are not mentally well, the last thing you need to do is respond to your call to ministry."

According to Holman Study Bible, New King James Version (2013) shepherds are the spiritual leaders who provide the knowledge and understanding of God's Holy Word (Jeremiah 3:15). Within this data, there was meaningful discussion about pastors who are the shepherds being unhealthy to lead their congregational members. Pastor C stated while discussing the importance of physical and mental for both members and pastors "Yes, I'm concern about the whole body of Christ, too often we forget about the Shepherd and the Shepherd has to be ministered to as well". This coded data shepherd's ill health was related to the category avoidance of health activities, which led to the theme of separation between health maintenance and spiritual wellness.

The clergy is charged with the responsibility to move their congregants towards spiritual wellness while keeping the body, the Holy temple well. This linking of the body and Holy temple is often stated within black churches to reinforce required efforts to be healthy (Campbell et al., 2007). Unfortunately, pastors don't provide specific details on how this should be done. Pastor D stated "Seminary teaches you that the body is Holy, 1 Corinthians 6:19, the body is the temple but what does that mean practically?

As result of seminary training, another pastor indicated that what happens in ministry the focus is just on the spiritual health. Pastor F "The holistic piece is so important, we became like you were saying well I can't speak for most Black churches but we became so one dimensional, you can't just be spiritual and leave the body out." Pastors will instruct their members to engage in behaviors that honor God, avoid eating to

excess; addiction to drugs and alcohol, adultery, and to keep the body, Holy (Campbell et al., 2007). Health matters and these influential leaders interface routinely with hard to reach communities, and should be formally trained to improve the ". . . health related quality of life . . ." for the residents they serve (Bopp, et al., 2013, p. 186).

Summary

RQ1: How do African American clergy feel about their ability to conduct health advice guidance within their faith-based institutions to achieve positive health outcomes of their members? These study participants' responses indicated their experience gained as pastors, their personal and family health challenges, the support of their administrative staff and congregational members, partners with the community agencies, and with the personal and professional training as of this date; they feel confident in their abilities to give health guidance. These pastors accurately acknowledged the chronic diseases and medical conditions and the contributing factors plaguing their congregational members and community residents. Although there is some evidence of positive health outcomes, they all indicated they still have a lot of work to do, and there are many areas where improvement is essential.

RQ2: What are their lived experiences as clergy and health promotion advocates? All of these pastors indicated that they are required to be health promotion advocates for their congregational members, community residents, themselves, and their families. All of these pastors recognized the importance of maintaining their health and the health of their members.

Pastors are health leaders mobilizing the skills and expertise of their members and working as a team to manage chronic medical conditions while increasing opportunities for health promotion activities within a faith-based foundation. They welcome outside resources and enjoy the partnerships with community agencies. Eight of these pastors have designated health ministries with a budget to support health and wellness activities long-term. The other two pastors are working hard to develop their health ministries while they provide opportunities to grow a healthy congregation.

In this chapter I provided a brief review of the purpose, the use of a pre-pilot study, changes in the research settings and influences, participants' demographics, data collection and analysis, evidence of trustworthiness, study results, and summarized responses to the research questions. In the final chapter I will reiterate the purpose and nature of this study, outline the key results, provide interpretation of the findings, describe the limitations, recommendations, and social implications, and conclude with the relevance of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to capture the perspective of African-American pastors' giving health advice guidance to congregational members to achieve positive health outcomes and to study their lived experiences as health promotion advocates. History has demonstrated that African-American pastors and Black churches have far exceeded the conventional method of only leading church members to spiritual health (Campbell et al., 2007). Underserved communities for centuries have turned to these FBOs for assistance with social, economic, political, and health injustices (Harmon et al., 2013). Faculty tasked with the responsibility for curriculum in seminaries should consider training their students how to lead congregational members to physical wellness (Bopp et al., 2013).

Seminaries do not train clergy to give health advice and to act as health promotion advocates, but previous studies confirm the highest incidences of death and disabilities occur in Black communities and African-American pastors are treasured and respected behavior health messengers (Lumpkins et al., 2013). These health messengers are able to articulate the connection between religion and health with specific Biblical references to assist efforts to reduce health disparities (Levin, 2009). According to Campbell et al. (2007), pastors are more than spiritual leaders they have to speak to the conditions and concerns of people who follow them and communities they serve. The majority of pastors understand how their words in support of healthy lifestyle behaviors can and do

make a difference in the mindset of congregants (Baruth et al., 2014).

In all interviews, pastors stated that, as a result of their professional growth, they were confident in their abilities to provide health advice guidance, make referrals to health care professionals, and use caring administrative church staff and members to ensure follow-up and resolution. All of these pastors have seen or heard from their members achieving positive health outcomes through testimonies shared with the entire church body and individual conversations with them. Pastors attributed this behavioral change to faith, individual's own actions, attendance at church-sponsored health promotion activities, compliance with medical instructions, caring and supportive church body, their health advice guidance, and their sermons dealing with unhealthy lifestyle habits. Pastors recognized that positive behavior health changes result from multiple not singular interventions (Campbell et al., 2007).

Seven pastors reported during the interviews that their health was excellent or very good, that they enjoyed their healthy lifestyle, and that they practiced and believed in holistic wellness. The remaining three pastors identified their health as good and that they engaged in some healthy habits, and they described their plan for personal health changes and uplifted whole body and spiritual wellness. Every pastor spoke with passion and pride about the various health promotion and disease prevention programs approved for their FBOs. All study participants communicated that people must be healthy in mind, body, and spirit during their interviews. According to Baruth et al. (2014), when pastors have a healthy lifestyle, they are more likely to communicate, support, and approve health promotion initiatives in their FBOs.

The study participants approved health awareness activities such as use of bulletin boards, written pamphlets, PowerPoint presentations, health fairs, health screenings, health-targeted discussions, and classes performed in their FBOs. During field visits, I observed both the pastor and health coordinators disseminating health information, and church websites announced health promotion activities and displayed pictures of attendees in past health events. Prochaska and Prochaska (2010) suggested that awareness activities should target people who have no interest in changing their unhealthy behavior habits and are not ready to change. The roles of health awareness activities are to (a) elevate the recognition of unhealthy lifestyle habits and their consequence, (b) encourage conversation about high-risk behaviors and share achievements, (c) learn how their negative and positive health behavior influence the people in their lives, and (d) help them visualize living a healthy life (Prochaska & Prochaska, 2010).

Pastors approved health interventions such as training for CPR and defibrillator use; diabetes self-management classes, how to care for persons with Alzheimer's and Dementia; healthy cooking classes, fitness challenges, walking programs, individual health advice guidance, and first aid performed in their FBOs. Pastors and designated health coordinators shared experiences delivering these interventions and pictures posted on church website validated these church-sponsored events. Prochaska and Prochaska (2010) noted these interventions target people who have developed plans, engaged in activities to change their behaviors, and working to maintain their efforts. Health interventions for all three of these target audiences are intended to: build the person's

confidence in their belief to change, provide specific tools to change behavior, offer incentives for success, and prompts available to facilitate healthier decisions.

Health policy was evident in the establishment of six health ministries within their FBOs, clearly stated in church bylaws, healthy consistent food fellowships, designated no smoking facilities, and integrated health promotion activities throughout all church ministries. These pastors articulated clearly during the interviews that health ministries are an essential function of their church organization. African American pastors have allocated budget for health ministry, health coordinators are leaders who must provide annual plans, and ensure the presence of ongoing health and wellness programs. Pastor F stated "Every church must have a health and wellness ministry…responsible for projecting what are you going to do for 2016… Where is our health ministry headed? I have a budget line item for this ministry". During field visits I participated in a weekly breakfast with healthy alternatives, observed no smoking signs, and heard from other church leaders how they integrated health in their ministries. For example, Pastor E discussed during the tour of his church, how his choir director had all members take a short walk around the church before they practice. Pastors instituting health ministry within the operation and management of FBOs demonstrates a commitment and dedication to sustainment of health promotion and disease prevention programs (Campbell et al., 2007).

Interpretation of Findings

The research study completed by Bopp et al. (2013) indicates that clergy provide

health advice regardless of their feelings of inadequacy. African-Americans pastors do provide individual-level health advice counseling, which supports Bopp's literature. However, in contrast, they feel confident in their joint efforts to improve health behaviors of their members. These collective efforts involve health advice guidance, health communications from the pulpit, biblical messages, health promotion activities, family and personal health challenges and changes, multiple years in the ministry, and support systems within their FBOs. Fallon et al. (2012) noted clergy should be formally trained in seminaries to give health guidance to increase their self-efficacy in changing congregants' unhealthy lifestyle behaviors. Although all pastors agree the seminary should do more to prepare them for this type of guidance, they don't believe it will happen because of the seminary's primary agenda to teach theology. DeHaven et al. (2004) showed pastors have been actively involved in ensuring their FBO's offer health promotion activities through the partnerships with community agencies and expertise of their members.

There is a level of acceptance by pastors that it is their role to give health advice guidance and to act as health promotion advocates. These responsibilities are validated with the historical evidence of these pastors fulfilling this role as social change agents for populations at-risk for health disparities (CDC, 2014; Lewis & Trulear, 2008; Tangenberg, 2005). Influential African American pastors and their FBOs directly engage communities of color to meet the health needs across generations for mental, physical,

and spiritual wellness without formal training in the presence of an overextended U.S. health care system (Carter-Edwards et al., 2014; Allen et al., 2010; U.S. DHHS, AHRQ, 2013). All ten pastors stated in interviews that all of their health promotion activities, disease prevention programs, and health messages are offered to the entire community. Pastor C stated "We have so many partners help us so my philosophy is that if I can do it for a parishioner then I ought to be able to do it for the entire community".

Harmon (et al., 2013) indicated that African Americans in the U.S. have the highest regular attendance at religious institutions in comparison to all other races. I demonstrated in this study African-American pastors have approved the dissemination of health information in their FBOs to influence the health behaviors of their members, which supported the study completed by Levin (1984). Each of these pastors has communicated evidence of their health promotion advocacy and their congregational members' healthy behavioral changes occurring inside of these FBOs, which supports the literature that these occurrences can happen outside of health care facilities (Asomugha et al., 2011; Whitlock et al., 2002). Pastor J stated "…I have had some members come back and said I have changed my diet …I have started to exercise…come off their blood pressure medicines… off their insulin… lost weight it has changed their lifestyle".

All of these pastors shared their beliefs in holistic salvation where God intends for all of His children to be spiritually and physically well. Although these pastors held advanced degrees, one pastor did not major in theology or ministry (Harper, 2012, Jenkins, 2006; Lummis, 2006; Maddox, 2003; Valburn, 2009). A study completed by

Lummis (2006) found the lowest percentages of black clergy with graduate degrees in the Southern states and this level of education in Theology or Ministry is required to address 21st century needs "to change the world through changing individuals" (para 4). During recruitment for this study, pastors with a master's degree were found, but it was difficult to recruit participants with completed terminal degrees. Peterson et al. (2002) found clergy with post-graduate degrees are more likely to engage in healthy behaviors and present multiple health promotion activities to improve the health of their members. I expanded the geographical recruitment area from one to three states to obtained eight pastors with advanced college degrees to meet the goals of this study.

The pastors held beliefs of a healthy mind, body, and spirit, and achieved some successful health outcomes for members. They also stated they recognized the connection between religion and health so health messages are based on Biblical Scriptures. Lumpkins et al.'s (2013) study identifies faith doctrine as one of the key motivators for congregational members to change health behaviors because pastors use biblical scripture where God said so. The clear message from every interview was that
God deserves all the credit for achievement of positive health outcomes for these African-American pastors and congregational members. Each pastor expressed their involvement in approval, planning, delivery, evaluation, and participation in health promotion activities during interviews. The study participants expressed their personal health changes, being role models for healthy living for their congregation, and actively involved in health promotion activities which supports the literature in regards to the

readiness of these pastors and black churches to lead their members to health (De Marco et al., 2011; Catanzaro et al., 2006; Goldmon, 2004; Lasater et al., 1986).

Conceptual Framework

The conceptual framework, SCT aided the efforts for data analysis and interpretation of findings for this qualitative research study. SCT was selected to examine the behavior of African-American pastors giving health advice guidance, their role as health promotion advocates, and because of these key constructs: self-efficacy, modeling, observational learning, collective efficacy, and reciprocal determinism (Bandura, 2004). Pastors reported feelings of being confident in their ability to provide health advice guidance to assist their members in making healthier lifestyle decisions. They firmly stated during interviews that one of the responsibilities of a pastor is to model healthy behaviors. Pastor E stated "…I'm one in terms of doing healthy things and I try to model that that for the congregation."

Seven pastors readily acknowledged they had no formal training for delivering health advice guidance and their confidence and competency is a result of many years performing this task and taking the initiative to learn. One pastor felt his chaplaincy training in a local hospital and the other pastor 's training through the military instilled self-efficacy for health guidance. Another pastor was trained as a registered nurse and healthcare administrator to perform health counseling. The research study provided by Fallon et al (2012) identified health counseling as the most common tool utilized by clergy to change behaviors and achievement of positive health outcomes for members

builds their self-confidence.

All pastors believed it is the faith in God that gives anyone the power to change their unhealthy habits and the motivation to do so. Glanz and Bishop (2010) noted SCT integrates the knowledge, actions, and feelings of health transformation, "so it can be readily applied to counseling interventions for disease prevention and management" (p. 403). African-American pastors speak directly to unhealthy behaviors, the consequences, difficulties and joy of having a healthy body. Pastor C stated "To be able to talk or to speak truth to power to people with these issues, encouraging people has helped out tremendously."

Pastors and congregational members share their personal and family health challenges through testimonies and how their faith helped them to implement the actions to successfully change unhealthy behaviors. Some of the cultural traditions for worship in black churches are an expression of faith, development of skills to manage stressors, the experience of love and joy, a sense of security, and empowerment (Allen et al., 2010).

According to Allen et al (2010) the ability to overcome obstacles and attain healthy outcomes are due to the traditional helping methods of sharing experiences, faith leader and congregational prayer, gospel music, and receiving the loving support of members "are cultural tools passed from one generation to another..." (p. 122).

Opportunities for observational learning are presented in the midst of these worship experiences in black churches to learn about self, others, and the outcomes of

efforts to change health behaviors. Health promotion initiatives such as demonstration of healthy cooking, health education classes, and participation in eating healthy alternatives during fellowship also provides observational learning. Pastor D stated "Praying for people, exposing people to a different method, a different model…we have not been taught how to eat healthy".

Collective efficacy was demonstrated through the testimonies of congregational members, pastors, and administrative church staff that they were able to change unhealthy lifestyle behaviors due to their faith and actions to achieve this goal. Pastors shared their personal and family health challenges; congregational health concerns and how behavioral health changes were the result of these interactions. Pastors influence and are influenced by the members in the process of dealing with health challenges and achieving health goals which reflects reciprocal determinism (Bandura, 2004).

Grounded theory was used to explore the data collected through digitally recorded interviews, field visits, journal notes, church websites, taped and online sermons, and data analysis. Purposeful sampling was used initially to obtain participants who could give rich details and during the start of data collection theoretical sampling was used for analysis, coding, constant comparisons of the data, recognition of patterns, and to construct themes. Inductive analysis was conducted on all the data collected first to develop codes on the units within the data then group the categories and generate the themes (Creswell, 2007). I completed marginal notes during manual coding and NVivo software supplemented efforts for data analysis.

Limitations of the Study

The restrictions considered for this qualitative study were validity and reliability, the pastors' knowledge and understanding of their members' health concerns and health goals. Several methods were used to validate and ensure reliability of the data to include: Ten digital recorded interviews with rich details, transcribed interviews checked by the study participants, and collection of various data sources during field visits. Implementation of these multiple strategies achieved validity and reliability, responses obtained from pastors revealed an acute awareness of congregants' health challenges, and their desired health changes.

Consistent measures were used in manual coding with notes in the margin, a code sheet, and use of NVivo software for comprehensive data analysis. The average time for field visits was three hours, and the average total number of eight contacts with each participant to build trust, an effective working relationship, and maintain the flow of essential information. This study provided a clear summary of the researcher's bias and discussed discrepant data.

Additional limitations were the dependency on these pastors' abilities to recall events and to overcome their personal resistance to share their techniques in providing health advice guidance, male dominance in this profession, and sampling size. The study depended on pastors' self-reporting of their feelings regarding giving health advice guidance and acting as health promotion advocates. While validation is not required for self-report of their emotions, health advocacy was validated with posted health events on the church website, health information on visual screens, written programs, attendance at

weekly Sunday breakfast, pulpit health communication, health promotion displays, and interactions with designated health coordinators.

A total of three female pastors, two of them were primary for this study, which is reflective of the gender ratio in African American Christian churches proved to be strategic decision (Chaves, 2009). Inclusion of women sharing their perspectives in this research study added different voices to ensure integrity (Tracy, 2010). Considering the historical pattern of educational disparities for this precise group of clergy, the acquiring of participants from three states, and the use of purposeful and theoretical sampling strategies resulted in an adequate sample size. These efforts also supported grounded theoretical approach, themes generated from the data, and data saturation was reached (Marshall, 1996).

Recommendations

African American pastors and their FBO's are receptive, ready, resourceful, and responsible for building healthy communities (Bopp et al., 2013; Goldmon & Roberson, 2004). These health leaders and congregations are willing to learn more to use their faith and collective knowledge, skills, and expertise to improve health behaviors (De Marco et. al., 2011). The health needs of the pastor, his or her family, congregation members, their families, and community residents are a concern for the church body.

It is essential to empower these pastors with higher levels of knowledge and skills to develop interventions to change unhealthy lifestyle behaviors to lead people to health and wellness. Not one of these African American pastors during interviews stated they were formally trained in seminaries to address physical and mental health and how to

become health promotion advocates for individuals or groups, yet they all have accepted this task (Baruth et al., 2014; Carter-Edwards et al., 2014; Harmon et al., 2013). Seminary must begin to provide required training to their students to increase the understanding of the health concerns of their members, strategies to use to change health behaviors, identification of federal, local, and state resources to assist them.

Seminaries should address the whole body; physical and mental health needs are also concerns clergy must intervene on behalf of their congregants and communities they serve. Pastor D "I think every seminary needs to require a course on holistic health before students graduate" and ideally it should be the place to begin the process of training. This should occur for several reasons: these schools have responded before to social situations and added training for clergy students. Pastor C commented "Domestic violence has gotten so bad that now it's a part of the curriculum in some seminaries."

There is already recognition from these academic institutions that health education must be provided. Pastor A stated, "They did some seminars and they brought people in to talk about health and wellness". Seminaries must initiate the training on how to give health advice guidance, how to promote health and wellness, and how to use resources within their FBOs to improve the health conditions the members they serve. The study results provide evidence that pastors and their FBOs are receptive to training and assistance to take care of congregational members and community residents' health needs.

There is a designated area within the curriculum according to Pastor B "In church administration, it talks about all of those auxiliaries, and one of them is health and

wellness", Pastor H stated "I think there is an area in which it can be addressed, and this is in the pastoral care piece because that is what that piece should be about". The justification for inclusion into the curriculum was best stated by Pastor D "I don't know if seminaries have a vested interest but seminaries should because pastors are some of the unhealthiest people on the face of the planet". Seminaries have to acknowledge the significant demands on clergy and the importance of keeping these professionals healthy in mind, body, and spirit. Pastor E stated "…In Hebrew where the Jews talk about wholeness in totality, spiritual…financial wholeness, and…the body…if you just take those principles and apply them in terms of wholeness, with that in mind…seminaries should do that." Seminary students major in Theology and this doctrine advocates wellness for the mind to follow in obedience, body as the Holy Temple, and spirit to worship.

Health promotion advocates working hard to address the health disparities in hard to reach populations and their FBOs must do more than partner with them and offer support for their health promotion activities. All public health and healthcare organizations that are required to train leaders in health promotion and wellness should consistently extend their services to the FBOs in their geographic area. All FBOs with congregational health ministries and FBOs working to build one should have access to these designated professionals who can train them as health promotion leaders. The literature does acknowledge their leadership skills regarding influence, health communicators, and the authority to host health promotion activities for at-risk communities (DeHaven et al., 2004).

The literature also provides evidence that these pastors and their FBOs are implementing interventions to address members and community residents' health care needs (Fallon et al., 2013; Lasater et al., 1986; Levin, 2014). Although the research recognizes that clergy and FBO's are poorly used resource to reduce and eliminate disparities, there is no formal training plan to increase their abilities as health leaders to effectively change their members' unhealthy lifestyle behaviors (Bopp et al., 2013; Levin, 2014). As clergy are formally trained for health advice guidance and health promotion advocacy resources should be directed to assist them to create effective health messages to use from the pulpit, appropriate health care referrals, and for individual and family health counseling.

These pastors have accepted the role and responsibility of assisting their members to reach their physical and mental health goals, in their own words Pastor C states "Health matters now and it's so bad across this country and at least arouses awareness for health, for pastors, and as ministries we must do holistic ministry, we must administer to the whole person", Pastor I "We have to look at mental health issues that is an area that is truly lacking in our African American population; we are not addressing it, as we should" and Pastor J "…It would be a great idea to include it in any college curriculum…" Considering this comment, an argument could be made that formal training for health guidance and health promotion should be considered in all college curriculums for all helping professions such as social workers, mental health, therapists, educators, and first responders. Pastor J also stated "…There needs to be a change in…the church and any part of society health is an important issue and it needs to be incorporated in what we are

doing." This study revealed that faith leaders are willing, able, and actively engaged in meeting the physical and mental health needs of their members and community residents. African-American Christian pastors desire ongoing formal training to maintain their health, the development of skills for health advice guidance and health promotion advocacy, and partnerships with public health organizations to address the health needs of their members (Levin, 2014; Lasater et al., 1986).

Additional research should be focus on obtaining the data needed to justify formal training, mentoring, and coaching as learning opportunities for clergy to empower them in the utilization of strategies to change unhealthy behaviors. Research studies are also needed to understand when and how they refer members for extensive health care guidance, and what is done for follow-up and ongoing interventions to reach positive health outcomes. Clergy must be given guidance to identify members with expertise in health promotion and how to develop ministries who visit members confined to their homes, hospitals, and residential facilities due to mismanagement of chronic disease and disabilities.

Pastors frequently expressed the need for health and wellness resources targeted for clergy to keep themselves healthy, who are in many respects, at-risk professionals. If studies continue to determine how best to utilize clergy to address health disparities for at-risk communities and maintain their health, future research should build upon this data to determine the successful tools pastor can use for themselves and for the communities they serve to achieve positive health outcomes. Educational investment in clergy and

their FBOs has the potential of significantly reducing health disparities in underserved communities (Bopp et al., 2013)

Implications

The implications for social change are, to heighten the clergy's sense of responsibility and to foster encouragement to utilize their leadership skills to lead their congregational members to health. The research acknowledges that African-American pastors and their FBO's are a barely used resource and they have the potential to reduce and eliminate health disparities, it is time to change this situation (Levin, 2014; De Marco et al., 2011). Increasing the utilization of clergy who can reach underserved populations and empower them with the expertise to change unhealthy lifestyle behaviors to achieve positive health outcomes is a powerful strategy for social change on the individual, community, organization, society, and national health policy levels.

It is imperative on global, national, state, and local levels to identify all potential resources that can be employed to address the rising numbers of deaths and disabilities related to health care disparities for at risk communities. These pastors, who are faith-based assets outside of health care systems, academic institutions, public health organizations, public and private agencies need to be educated, equipped, guided, and groomed as health leaders to accomplish this type of social change. Clergy has the access to people of all ages and African-American Christian pastors are directly involved in meeting the health needs of a growing black elderly population suffering chronic diseases and disabilities that are economically devastating (Carter-Edwards et al., 2011).

This qualitative research provides evidence, supported by previous studies that these African American pastors are engaged in the activities of health advice guidance and health promotion advocacy for the hard to reach communities they serve. These pastors in their words welcome information, training, and more resources to improve the efforts of themselves and FBOs to lead members and community residents to health. These faith leaders have a documented history of achieving social change for underserved populations, and they should be cultivated to demonstrate their effectiveness in addressing health disparities.

Conclusions

Based upon the data analysis the goals of this study were met. Exploration and documentation of the perspectives of ten African American Christian pastors expressing their feelings, thoughts, and lived experiences providing health advice guidance and acting as health promotion advocates was obtained. This study has filled that gap in the literature with the collection of data through the lens of these faith leaders engaging in self-assessments of a specific type of guidance and performance of health promotion advocacy, they were not formally trained for, but are in the best position with strategic resources to address health disparities in black communities.

When a significant reduction of health disparities occurs in this country due to the cooperative efforts of diverse group of health promotion advocates, one major injustice for at-risk communities would be attainable. The world would have to take notice if the group responsible for this reduction were members of the clergy, specifically African American pastors utilizing their formal training and experience gained from working with

other health promotion advocates to nurture the mind, body, and soul of their members so communities flourish that would be holistic salvation, Amen (Maddox, 2011).

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Appendix A: Presentation Checklist Protocol

Pastor: (Title) _____

Church (Name)

_____

Interviewer:

_____

Areas that will be addressed:

_____A: Written Presentation (Introduction of the Study & Interviewer; Goals and Procedures; Numbers and time limits for each interview; Observations and follow-up visits; Consent Form, If Consent is signed the Biographical information will be completed and Initial interview will be scheduled.

_____B: Formal Interview Protocol / Initial interview using the research questions will be completed and discussions regarding observation visits.

_____C: Biographical data (form completed)

_____D: Observer/Participant Form

_____E: Field Notes

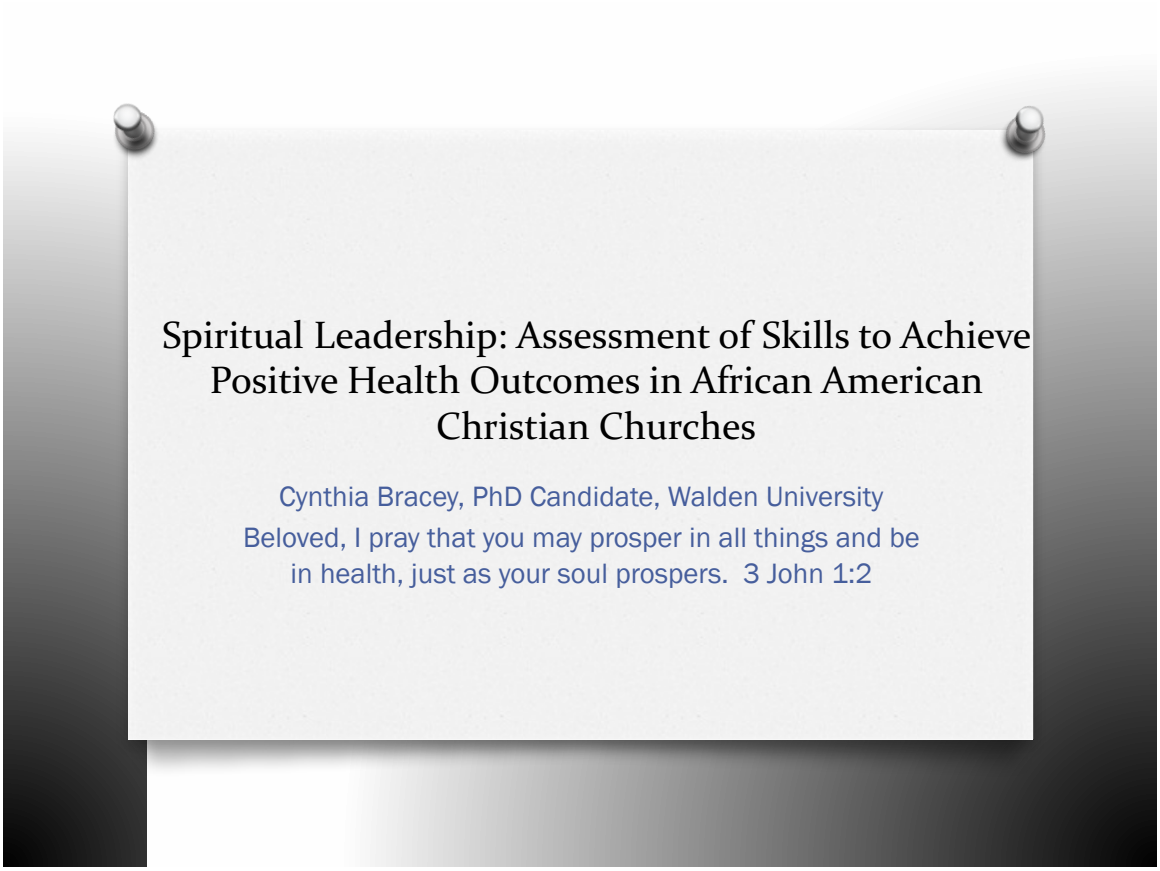
Documents Obtained:

Recruitment recommendations/:

_____

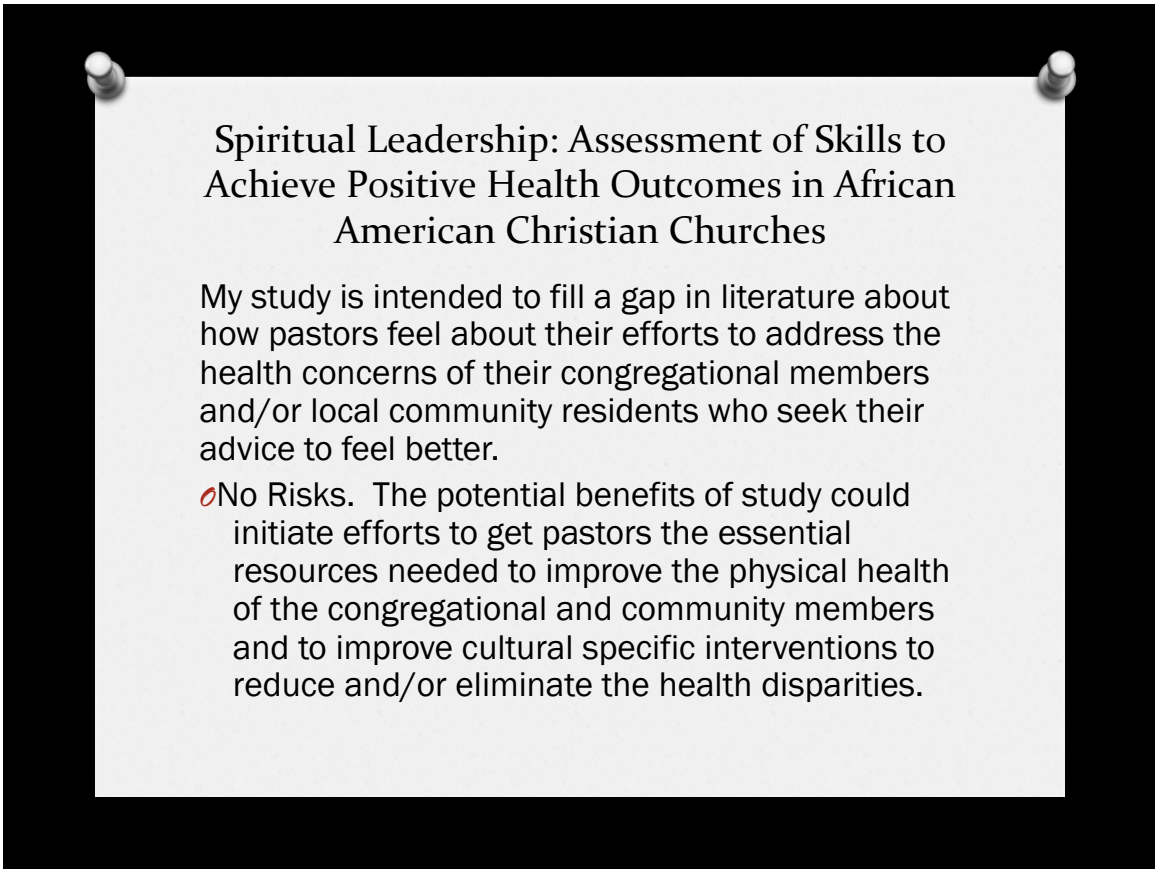
Appendix B: Presentation

A. Introductory Visit Protocol: Presentation/Introduction (15 minutes). Pastor will be provided a written copy and Researcher will address each slide with the following



Pastor_____ I want to first thank you for allowing me to spend time with you. My plans today are: 1) Introduce this study and myself 2) Inform you of the goals of this research study, risks and benefits, the procedures, requirements that includes anonymity, consent, audiotaping, notes, shared transcripts, and repeat interviews 3) If consent is signed will need to schedule interview, if not stop, leave a copy of this

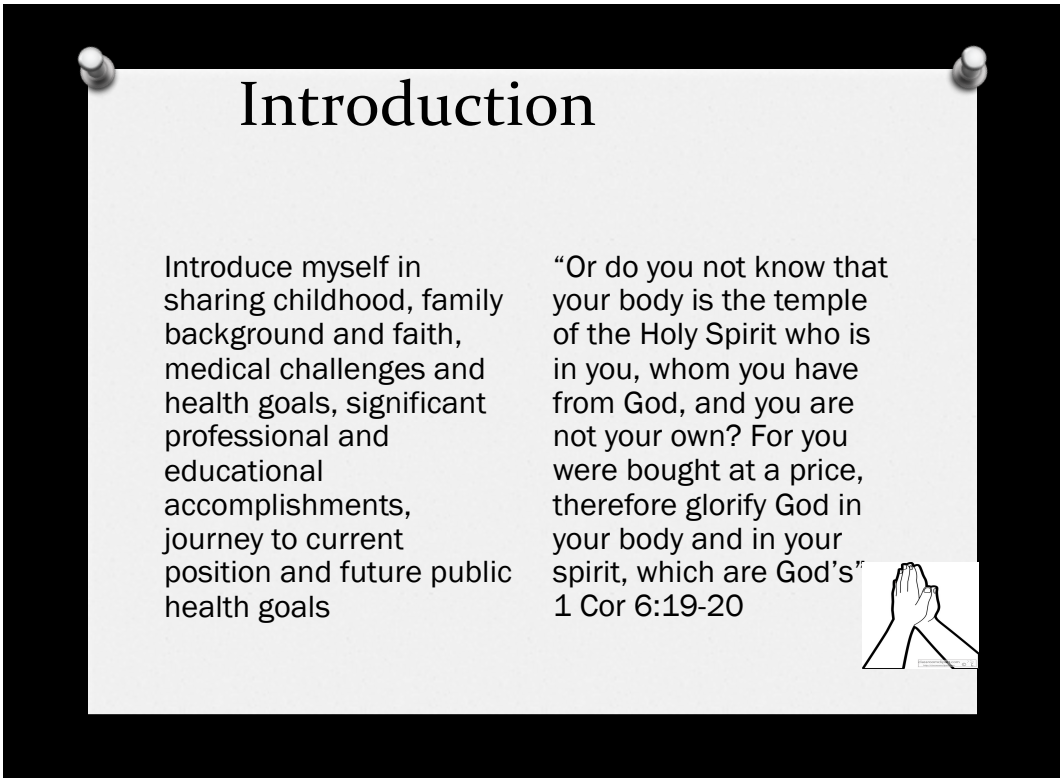
presentation and my contact information. Let me tell you more about my research study in the next slide



In the past 2 years, I have found a great deal of literature discussing pastors and members' responses to health promotion activities that has been held within churches. I have even found studies of black churches in partnerships with universities and researches in planning health promotion activities and the pastors' health examined. I have even found literature where pastors admit to giving their congregational members and community residents health advice in addition to their many roles and responsibilities. regardless if they feel confident or not. What I did not find in the

literature are the pastors' words about their experience in giving health advice to their congregational members and/or local community residents who request help in dealing with a health concern

The purpose of this study is to allow pastors an opportunity in their own words to describe and evaluate their experiences in giving health advice guidance. This study is for teaching and learning. My aim is not to evaluate or judge your experiences and practices. There are no risks each participant will be given anonymous designation like Pastor Blue to hide the identity in published study. In regards to the benefits the study results could help pastors obtain essential resources to help improve the physical health of the people they minister to. Next I would like to give you more information about myself.



My grandfather and parents provided the initial biblical training about God. God and the

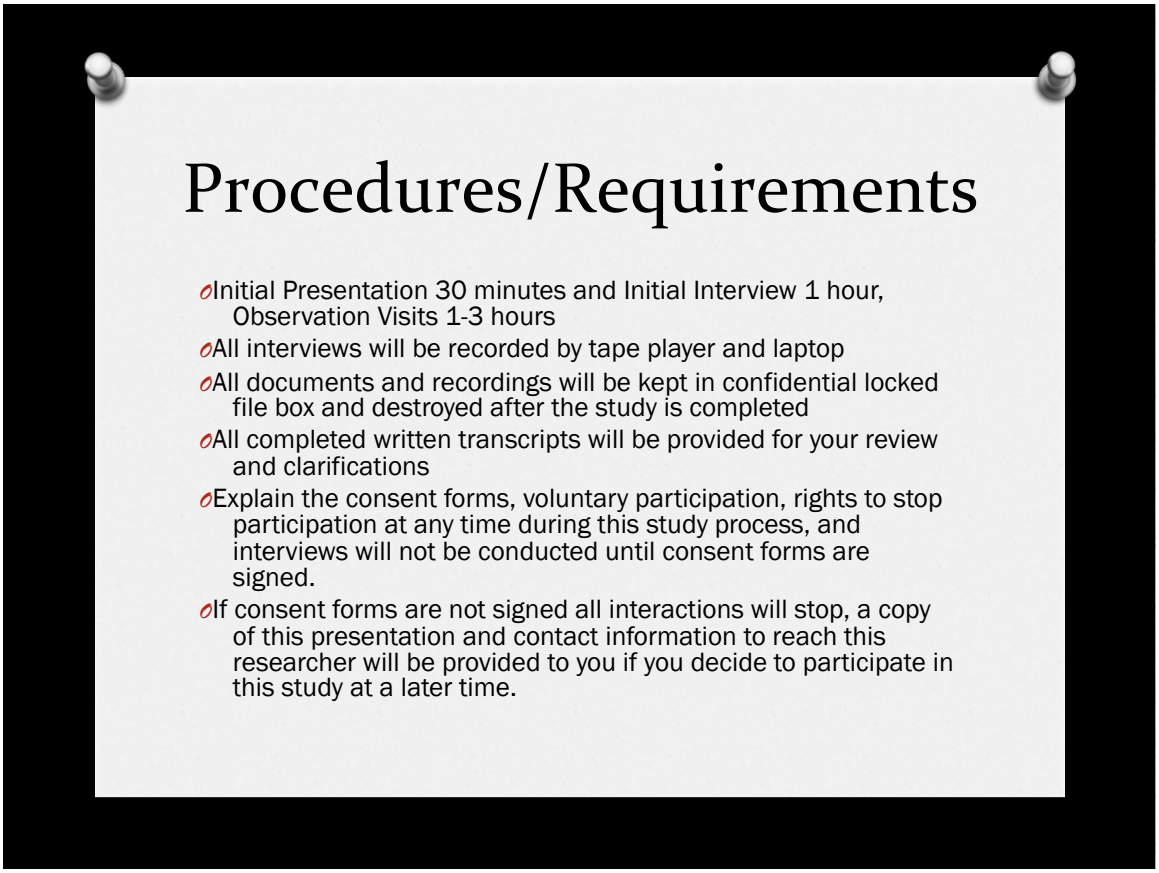
Baptist church has always been a significant part of my life and I accepted Jesus Christ as my Savior at the age of 10. My family medical challenges have included but not limited to hypertension, cancer (pancreatic, prostate, and breast), obesity, heart disease, and disability. From an early age, I always enjoyed taking care of my grandparents, younger children, and elderly people in my church eventually I felt led by the Holy Spirit to become a nurse. In 1980 with God's grace and mercy I became a RN. I believe my mission is to help build healthier communities so in 2009 I decided to begin another educational journey to obtain PhD in Public Health.

In regards to this scripture, it's my understanding that the bible illustrates God's effort to deal with the sins of Corinth Church leaders and members, yet these scriptures are my inspiration to work hard in achieving and maintaining the health of this body, this temple.

Now I would like to address the goals of this study

I'm attempting to interview a total of 10 pastors for their stories and their experiences in providing health advice guidance and efforts to promote health and wellness. As for the

procedures and requirements for this study



After a signed consent will obtain information about the pastor's background. The formal interview is dedicated to the study and duration is one hour. All interviews will be recorded and a few notes will be taken.

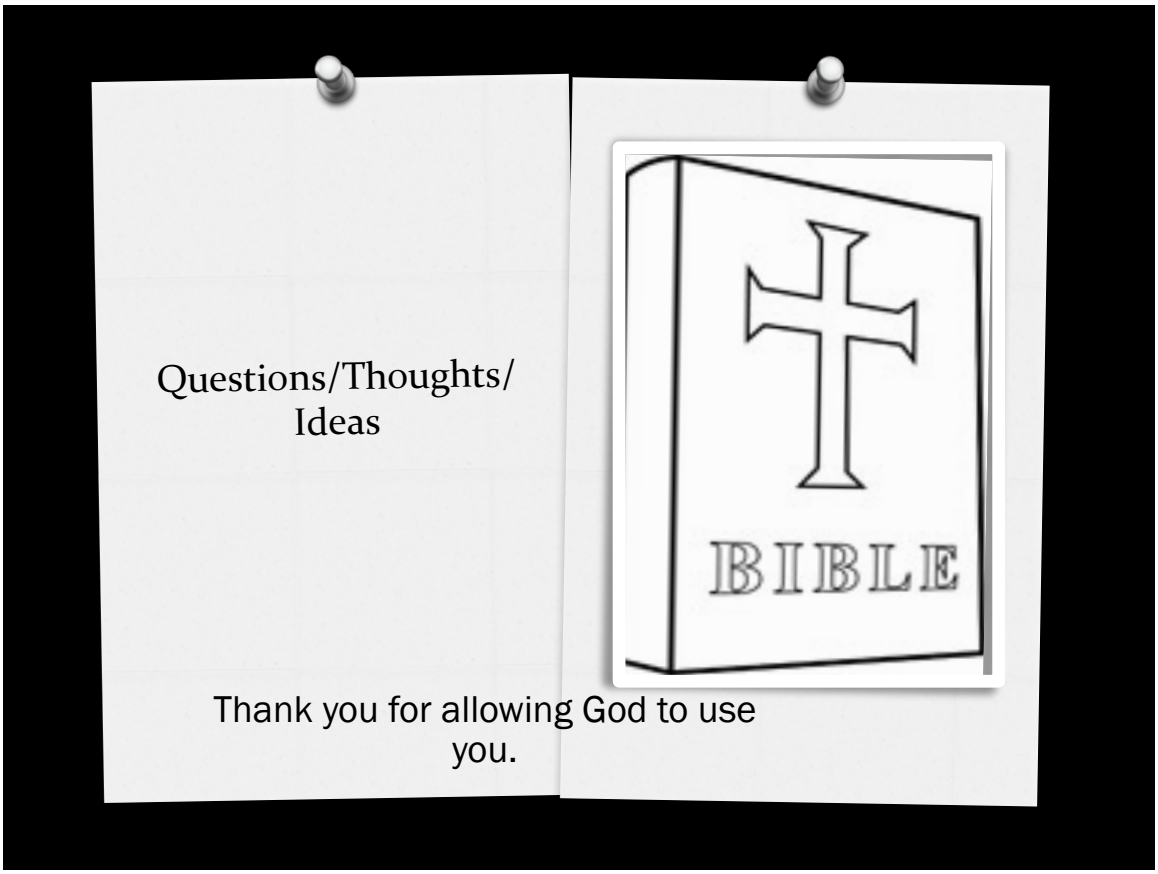
. Recordings and notes are done to ensure accuracy and to validate the information obtained

Observations visits which will must be done with your permission and you will be notified prior to these visits some of these observations will be done at Sunday school, Bible study, worship service, fellowship, and/or health promotion event. I would like to

observe the responses of the members to the pastor, health messages and activities, and interactions during health advice counseling I can only be present for the request, condition and advice given. Documents that will be requested are copies of your college diplomas, CV or resumes, and average number for church attendance

After each interview a written transcript will be generated and you will be allowed to review for corrections. In any research study your participation is voluntary and consent form must be signed before anything is done in relation to this research. Even after your consent, you are free to stop participating in this study at any time. If you refused to sign this consent form, you may contact me if you change your mind in the future about participating

At this time, I would like to go over the consent form line by line, please ask questions at any time



Do you have any questions or need any additional information?

. Please give me your decision regarding participation in this study

. If refusal, then leave copy of this presentation

Collect all signed consent forms and set up the initial interview and leave copy of this presentation and signed consent form and biographical form to complete

If Consent form is signed, collect copies of diplomas, CV or resume, record of average numbers for church attendance and ask the following questions

Pastor Comments 10 minutes

Please tell me about yourself, where you grew up, your family background, medical challenges and health goals, your path to your current position, your vision as the leader

of this church body. Describe your ministerial staff. What professional committees and/or organization, or community sponsored events, and typical week? What do you do to maintain your health?

s

Appendix C: Formal Interview

Greetings/Setting Up Equipment/Review of Transcript	10 minutes
Formal Interview	50 minutes
Closing Remarks	10 minutes

C. Introductory Interview Protocol: Initial Interview (1 hour)

Script: Pastor _____during our last visit we discussed this research topic and aims, background information on yourself and this church. We plan to use this hour interview to focus on questions that are related to health concerns that have been brought by the members and community residents to your attention and for assistance. Do you like to move forward with your participation if yes then begin the interview with the following questions?

1. Please describe the health concerns of church members and surrounding community residents? What do you believe are the causes and/or contributing factors?

2. What types of medical concerns have your congregational members or community residents have asked you to address? Please describe the actions you took? Please evaluate your actions? What were the outcomes? What were your thoughts, ideas? What types of support or training you need and why to assist your efforts?

Probes: As a Pastor how are you leading your church body to address their medical challenges and health goals?

3. What types of health promotion initiatives have been offered in this church? Why? How did the members receive it? What were the outcomes? Please identify the ongoing

health promotion programs and why are still in place? What programs would you like to see and why? What is the level of your involvement and why?

Probe: Please describe any occasions where you have felt the need to address health concerns from the pulpit?

4. What types of health issues have you discussed from the pulpit, are their copies of these sermons? What types of resources did you use to obtain technical information? Why or Why not? Did you use life experiences, if so please describe them?

5. How do you feel about your ability to conduct health advice guidance within your church to achieve positive health outcomes of your members? Why?

Probe: What situations or experiences increased or decreased your confidence in your abilities to move people to higher level of health?

6. What are your life experiences as pastor and health promotion advocate?

Probe: Please describe any health and wellness programs you have approved and/or considering for this church or community and why? Also provide information about these type of activities that you disapproved and why? Please describe any health education training? What is your opinion about health education training for clergy?

Post Interview Questions and/or Observations

Appendix D: Biographical Form

Pastor Biographical and Congregational Demographical Data

Pastor _____ Characteristics

Age_____

Please circle: Male or Female

Marital Status: Single Divorce Married

Educational Level_____

Number of years serving current FBO _____

Number of years as Pastor _____

Rating of personal health: Poor _____ Fair _____ Good _____Very Good _____

Excellent _____

Number of chronic conditions _____

Church Characteristics

Denomination _____

Number of years present in the community _____

Church size _____

Diversity of congregation (What is the percentage, should equal 100%): Blacks

_____

Hispanics _____ Whites_____ Other _____

What is the age range for church body? _____

What are the gender percentages must equal 100%? Females _____ Males _____

Please list the medical challenges for congregation/community:

Identify the Health Goals of

Your Members

List the positions of your ministerial staff

List the professional committees and/or community organizations

Community sponsored events

Identify the ministries that support health

Please rank in order of priority the following needs of your congregation and community Residents in terms of these needs: physical, emotional, social, spiritual, environmental, financial, intellectual, and occupational using 1 for highest priority and 8 the lowest priority:

Physical _____

Emotional _____

Spiritual _____

Environmental _____

Financial _____

Intellectual _____

Occupational _____

Social _____

Appendix D: Biographical Form

Pastor Biographical and Congregational Demographical Data

Pastor _____ Characteristics

Age_____

Please circle: Male or Female

Marital Status: Single Divorce Married

Educational Level_____

Number of years serving current FBO _____

Number of years as Pastor _____

Rating of personal health: Poor _____ Fair _____ Good _____ Very Good

_____ Excellent _____

Number of chronic conditions _____

Church Characteristics

Denomination _____

Number of years present in the community _____

Church size _____

Diversity of congregation (What is the percentage, should equal 100%): Blacks

_____

Hispanics _____ Whites_____ Other _____

What is the age range for church body? _____

What are the gender percentages must equal 100%? Females _____ Males _____

Please list the medical challenges for congregation/community:

Identify the Health Goals of Your Members

List the positions of your ministerial staff

List the professional committees and/or community organizations

Community sponsored events

Identify the ministries that support health

Please rank in order of priority the following needs of your congregation and community Residents in terms of these needs: physical, emotional, social, spiritual, environmental, financial, intellectual, and occupational using 1 for highest priority and 8 the lowest priority:

Physical _____

Emotional _____

Spiritual _____

Environmental _____

Appendix E: Participant-Observation Form

Location: _____ Date: _____

Time: _____ Duration: _____

Name of the Event:

_____

Purpose:

_____

The Setting-Physical Environment	Human, social environment	Implementation of the program	Language	Nonverbal behaviors	Notable Nonoccurrence

Additional observational notes:

Template updated September 2016.