2017

African American Pastors' Perspectives on Health Promotion Ministries

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This is to certify that the doctoral dissertation by

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2017

Abstract

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MS, North Carolina State University, 2005

BS, North Carolina State University 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Public Health

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Abstract

The centrality of the church in African American communities makes it a culturally compelling sponsor for health promotion activities targeting health disparities among the medically underserved. Pastoral support is critical in determining whether a church initiates or supports a health promotion agenda, but there is little understanding of the variables that influence this decision. The aim of the qualitative study was to investigate the perceptions of African American pastors regarding the decision to incorporate health promotion programs in their churches. This study was guided by the health belief model using a phenomenological approach. Data were collected using both semi-structured and open-ended interviews. Ten pastors of North Carolina African American churches, with and without health promotion ministries, were recruited for the study. Eight pastors agreed to participate in the study. They were interviewed, and interviews were recorded and transcribed. The data were open coded and analyzed. NVivo 11 was used to manage the data. Five themes emerged from the study: the importance of health promotion, pastor support of a health promotion program, pastor influence on individuals in the congregation, the health status of church members, and barriers and facilitators. Positive social change may be realized by using this information to increase the effectiveness of culturally sensitive health information and developing health education programs that specifically target the African American faith community. Information from this research could help guide public health agencies on how to approach health programming in this specific area and for this population.

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Dedication

This dissertation is dedicated to my family: first, to my mom and dad who have taught me that with the love of God, anything is possible. Through this journey, they have loved and supported me in every way possible. Next, I'd like to dedicate this to my husband and sons. Their patience in going through this long journey with me was amazing. They were with me night after night, as I went through every emotion struggling to keep it together for the day ahead. Last, but never last in my heart, I want to dedicate this to my brothers and sister. Without the love of the "Watson Clan," I would not have been bold enough to take this journey. Knowing that I have four siblings who "have my back" at all times is a great comfort.

My family, you are amazing, wonderful, crazy, and you helped me to become the person I am today. I love you with all my soul.

Acknowledgments

I am grateful to the church leaders who agreed to participate in this study. Without your help, none of it would have been possible. In the process of completing this study, you have touched me in such a way that my views of health promotion ministries will forever be changed.

I would like to thank Dr. JaMuir Robinson and Dr. Egondu Onyejekwe for your expertise in research that has proven to be valuable. Your guidance throughout this process has contributed to my successfully completing this program. I also want to thank Dr. Earla White for promoting the proper APA format in my writing. I would also like to give special thanks to Dr. Mary Lescoe-Long. Your help in starting this process was a blessing. You didn't finish the journey with me, but you were a major part in my success.

I would like to give a very special thanks to Dr. Rick Brandenburg who was a huge inspiration and influenced in my life in too many ways to mention. Thank you doesn't seem to be sufficient. I also have to thank Brian Royals for going through this journey with me. You've encouraged me throughout the entire process. I really needed it. Most important, again I would like to thank my family who are the most important people in my life. I love you Mom, Dad; husband Zeph, sons Zeph II and Jason; brothers Andy, Joe, and Al, and sister Yvonne. This PhD I am sharing with all of you.

Thank you, Lord, for allowing me to complete this stage of my life. I can't wait to see what You have in store for my next. To God be the Glory!

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Chapter 1: Introduction to the Study

Pastors are typically respected for their overseeing and organizing of community activities (Webb, Bop, & Fallon, 2013; Williams, Glanz, Kegler, & Davis Jr, 2012a) and can be environmental change agents in health-related, social, and behavioral matters (Williams et al., 2012b). As a result, the pastors' beliefs in, and endorsement of, church health programs are crucial to their success (Webb et al., 2013). Researchers have suggested that health beliefs and behaviors of church leaders also influence practices of their congregation. (Baruth, Bopp, Webb, & Peterson, 2014). Not all pastors, however, endorse a church health ministry (Webb et al., 2013), and the influences and beliefs of pastors concerning church health promotions are not well understood (Baruth et al., 2014).

The African American church is a central institution in the African American community. Through the church, the leaders interact with the congregation and the community to define values and norms of the community and to preserve African American culture (Levin, 1984). Church leaders provide spiritual guidance and engage with community members to sponsor community-directed education programs, social programs, and community development initiatives (Rowland & Isaac-Savage, 2014).

The Centers for Disease Control and Prevention (CDC) reported that despite recent progress in reducing health disparities in the United States, African Americans continue to lag behind their Caucasian American counterparts in multiple key measures of health status and risk (Frieden, 2013). In 2011, the life expectancy for the average African American was 3.7 years less than that the average Caucasian American (Hoyert & Xu, 2012), and African Americans also reported significantly higher rates of

HIV/AIDS infection, infant mortality, obesity, hypertension, and diabetes (CDC, 2013a). Although the rate of influenza vaccination of African Americans increased from 33.7% in 2009-2010 to 39.0% in 2010-2011, it is still lower than the Caucasian American rate, which increased from 43.9 to 44.3. The rate of colorectal cancer screening in African Americans is 64.8% compared to 66.4% in Caucasian Americans; however, the death rate from colorectal cancer is 53.9% in African Americans compared to 43.8% in Caucasian Americans (CDC, 2013a). The percentage of African Americans without health insurance is significantly less than that of their Caucasian American counterparts with a percentage of 26.2 compared to 16.1 respectively (CDC, 2013a). These health disparities, coupled with a high mortality rate linked to culturally influenced lifestyle choices, underscore the need for health behavior modifications in the African American community (Ford, Bergmann, Boeing, Li, & Capewell, 2012; Lynch, Liebman, Ventrelle, Avery, & Richardson, 2014).

Researchers have also demonstrated that access issues, ranging from financial concerns to apprehension about the potential for discriminatory practices, make African Americans less likely to use the conventional medical care system than other racial or ethnic groups (White & Williams, 2012; Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). Because of these lower utilization rates, many African American communities remain medically underserved, and finding culturally acceptable venues for health promotion interventions is an ongoing challenge for public health practitioners (Sherman, 2015).

The African American church is one such culturally acceptable venue for health promotions (Lancaster et al., 2014). Researchers examining the contribution of this venue

to the effectiveness of health promotion activities have provided evidence that faith-based health promotion programs significantly impact health behaviors in African Americans (Cooper, King, & Sarpong,2015; Lumpkins, Greiner, Daley, Mabachi, & Neuhaus, 2013). The church has been a site for health and wellness collaborations for many years (Levin, 2014). According to Webb et al. (2013), church attendance in the United States is highest among the African American population (Lumpkins et al., 2013). The church is, consequently, a potentially high-impact location for health promotion-related interventions in the underserved African American population (Cooper, King, & Sarpong, 2015; Lumpkins et al., 2013).

Chapter 1 provides general overviews of the research study. The background provides a summary of the relevant literature, a statement of the problem, and an assessment of the knowledge gap addressed by this investigation. The statement of the purpose, a listing of the research questions, and a discussion of the theories and conceptual frameworks used to ground the investigation follow those sections. Also included is a rationale for the study, study design, and analysis techniques used to answer the research questions. The definitions section clarifies study terminology and is followed by the assumptions that underpin the research. The scope and delimitations section describes the particular focus of the investigation and establishes the inclusion and exclusion criteria that apply to both the study focus and the operationalization of that focus. A statement of the significance of the investigation follows limitations of the study. The chapter concludes with a summary of key information.

Background

Health disparities are the persistent gaps between the health status of people or populations, in this study, between minorities and those who report themselves exclusively as Caucasian, non-Hispanic in the United States (United States Department of Health & Human Services, 2011). Despite general advances in health care and technology, African Americans continue to experience higher rates of cardiovascular disease, diabetes, cancer, stroke, chronic lower respiratory disease, and HIV than nonminorities. Diabetes, kidney disease, and HIV account for the greatest disparities in mortality, as African American mortality from these diseases is twice that of Caucasian Americans (North Carolina Minority Health Facts, 2010).

Community-based health promotion activities that seek to improve the health of populations by developing structured and targeted interventions to support healthy lifestyles and provide access to preventive services, are cornerstone interventions in the drive to reduce those disparities in the United States (Minkler, 2010; Wallerstein & Duran, 2010). These health promotion activities have the potential to reduce barriers that prevent African Americans from accessing healthcare. These barriers include a lack of understanding of the need for healthcare, a lack of culturally competent communication among employees in the medical establishment and minority patients, and mistrust of physicians and conventional service delivery venues (Feagin & Bennefield, 2014). Power differentials related to sociocultural status, both historic and current, act as barriers to using conventional health care venues (Feagin & Bennefield, 2014). The distrust in the conventional health care system has its roots in the 18th and 19th centuries when African American slaves were exploited as medical specimens (Feagin & Bennefield, 2014). The

Tuskegee syphilis study is still the hallmark of medical discrimination and continues to reinforce African American distrust of medical institutions (Scharff et al., 2010).

Culturally distinct values and norms further limit interest in accessing health services and health programming from sources outside the community (Dickson, McCarthy, Howe, Schipper, & Katz, 2013). Kelch-Oliver and Ancis (2011) investigated norm-based cultural barriers that are contrary to Caucasian American social norms and found that African American culture is supportive of fuller figured females, so females who are overweight are less scrutinized about their weight (Kelch-Oliver & Ancis, 2011). As a result, African American girls and women are more satisfied with their bodies, even when they are clinically overweight, setting the stage for diabetes and heart disease later in life (Baruth, Sharpe, Parra-Medina, & Wilcox, 2014; Overstreet, Quinn, & Agocha, 2010). Hall et al. (2013) determined that importance attached to hairstyles add to culturally determined health risk factors, as African American women are less likely to exercise than their Caucasian American counterparts are because sweating can ruin hairstyles, especially when the hair is unprocessed. Aside from Hispanic American men, African American men have the lowest medical care utilization rates among all racial and ethnic groups, a phenomenon partially explained by cultural definitions of masculinity (Schoenfeld & Francis, 2015; United States Department of Health & Human Services, 2013). Many African American men view the need for medical treatment as a sign of weakness; this makes them reluctant to seek medical care and treatment (Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith 2010).

When these barriers have been successfully overcome, community-based intervention programs have demonstrated positive health-related outcomes such as the following:

- A culturally targeted faith/community-based educational intervention increased the colorectal cancer knowledge and screening of African American participants residing in the Fayetteville/Cumberland County area in North Carolina (Morgan, Fogel, Tyler, & Jones, 2010).
- Alabama REACH, a breast and cervical cancer coalition, helped to increase the number of African American women in Alabama who had a mammogram and Pap test screening (Fouad, Partridge, & Dignan, 2011)
- Barbershop Talk With Brothers program, a community-based HIV prevention program set to improve skills, decrease at-risk sexual behavior and improve health and provide health education for African American men (Wilson et al., 2014).
- Chicago's Department of Health established health education classes in North and South Lawndale, predominantly African American and Hispanic neighborhoods, to increase community residents' knowledge about the risk factors for diabetes, cardiovascular disease, obesity and other lifestyle changes to prevent chronic diseases. African American or Hispanic volunteers taught the classes that were part of the Lawndale health promotion project. The literature given to the residents were at a reading level deemed appropriate for them and contained pictures of people of color. Many residents who obtained knowledge from the intervention sought medical attention for symptoms they recognized (CDC, 2013b).

The success of these interventions supports the continued development of acceptable, accessible health programming to counter health disparities in the African American population. Developing culturally compatible interventions that engender trust and respect and honor community norms and values are vital to reaching this population (Barrera Castro, Strycker, & Toobert, 2013).

Church leaders share the same cultural norms as the communities they serve and help define and keep community values while interacting with the congregation and community at large (Levin, 1984). They also have a greater potential to influence health behavior change in both church members and the larger community of the area than do health practitioners of another race or from outside the community (Williams et al., 2012b). Their support and participation in health promotions are vital to their success (Webb et al., 2013). The church is a community resource and an acceptable venue for reaching large gatherings of African American residents, including those at greatest social risk for poor health outcomes (Lumpkins et al., 2013). Pastors, as heads of the church, play a role in how the church deals with community health issues (Baruth et al., 2014); however, studies on how African American pastors decide to promote or not to promote health ministries in the church are lacking.

Catanzaro, Meador, Koenig, Kuchibhatla, and Clipp (2006) conducted one of the first studies on church leaders' views of health promotion ministries in a church; however, theirs was a quantitative study on nonminority church leaders. Lumpkins et al. (2013) studied clergy's perspective of health education from the pulpit. Rowland and Isaac-Savage (2014) conducted a quantitative study of African American pastors' views on health and health education in the church. A qualitative study conducted by Baruth et

al. (2014), sought to understand the influences faith leaders had on health-related issues in their church; however, the majority of participants were Caucasian American. There are also several research studies like that of Baruth, Wilcox, and Evan (2014) of pastors' health. However, there is no research, to date, on the reasons African American pastors decide to have or discourage a health promotion ministry in their churches. This research study sought to fill gaps in the literature on beliefs of pastors concerning health and wellness promotion and consequently expanded information about this population concerning health promotion. With this study, I explored the reasons some pastors do incorporate health promotion ministries in their churches. To do that, I sought to understand the social factors, facilitators, barriers, and personal beliefs of pastors concerning health promotion ministries (Bopp & Fallon, 2011; Webb et al.,2013; Williams et al.,2012b). Webb et al. (2013) also suggested interviews as a better way of assessing the perceptions of pastors.

Problem Statement

African Americans are less likely to have a regular source of healthcare that provides risk reduction information, early detection services, or consistent disease management (Hammond et al., 2010). As a result, the African American community suffers from diseases that have been treated and controlled in Caucasian areas. Some studies have shown that faith leaders recognize the importance of health promotion in the church (Rowland & Isaac-Savage, 2014; Williams et al., 2012b). Lumpkins et al. (2013) also showed that pastors see themselves as health promoters, discussing health in the pulpit as well as during health promotion programs. They are also important in

implementing successful sustainable health promotion programs (Baruth, Bopp, Webb, & Peterson, 2014).

However, although many pastors embrace the importance of health promotion in the church, many oppose using the church to promote health, seeing it as inappropriate in a religious setting (Webb et al., 2013). Pastors may not incorporate health promotion in the church because their own unhealthy lifestyles may cause them to be uncomfortable preaching a health-related sermon (Baruth, Bopp et al., 2014) or promoting a health-related program because of it appearing hypocritical in light of the pastor's own lifestyle and health. Anshel and Smith (2014) suggest that pastor's health status and lack of time, knowledge, and support are reasons for not having such a ministry. However, Williams, Glanz, Kegler, & Davis Jr. et al. (2012a) suggested there might be other individual and interpersonal level beliefs that may assist in understanding why some pastors endorse health promotion programs and others do not. Attitudes and beliefs of church leaders are socially and culturally relevant factors when considering health promotion (Webb et al., 2012).

To date, there are few published studies that have examined this aspect of perceptions of African American pastors as it related to the implementation of health ministries in their churches. This research study sought to understand these beliefs about why some pastors endorse health promotion ministries while others do not.

Purpose of the Study

The purpose of this qualitative study was to investigate the attitudes and beliefs of African American pastors when making the decision to support or reject a health promotion ministry in their church. The intent of this research was to identify what drives

church leaders to develop health ministries. Phenomenology was the research method used in this study because it describes the human experience (Creswell, 2013). Phenomenology was the process that enabled me to gather information about the perceptions and experiences of the pastors that shape their options concerning health promotion programs. Data collected using semi-structured interviews guided me to understand how African American pastors made their decisions to either have a health promotion ministry or choose not to promote such a ministry.

Research Questions

The guiding research questions associated with the study of African American pastors' perceptions towards health promotion ministries were as follows:

RQ1: What are the perceptions of African American pastors about health promotion ministries?

RQ2**:** What are the factors that affect African American pastors' decisions to implement a health ministry for their congregation?

RQ3: What are African American pastors' perceptions of the motivators and barriers to implement a health ministry for their congregation?

Theoretical Framework

I used a phenomenological approach to examine the perceptions of African American pastors' decision to include or not include a health promotion ministry as part of their church program. This study did not address the individual health behaviors of the pastors. As of yet, no relevant health behavior theory about pastors' decisions about this area of church life has been identified in the literature. I used the health belief model (HBM) as the theoretical framework.

The HBM developed in the 1950s explains why people were not participating in health programs that prevented or detected a disease (Glanz, Rimer, &Viswanath, 2015). The HBM consists of six belief concepts.

1. Perceived susceptibility, the belief about the risk of contracting a disease.

2. Perceived severity, the belief about the seriousness of the disease.

3. Perceived benefit is the belief in the efficacy of the action to reduce the risk of getting a disease.

4. Perceived barriers are beliefs about the opportunity and financial costs of the advised action. (Glanz, 2015)

Concepts three and four are cues to action, strategies to remind or encourage a person to take action as well as to self-efficacy, which refers to one's confidence in the ability to take action (Glanz et al., 2015). The HBM is essential for understanding perceived barriers and benefits, health beliefs, and personal experiences of pastors that include a health promotion ministry in the church. The HBM is presented in Figure 1.

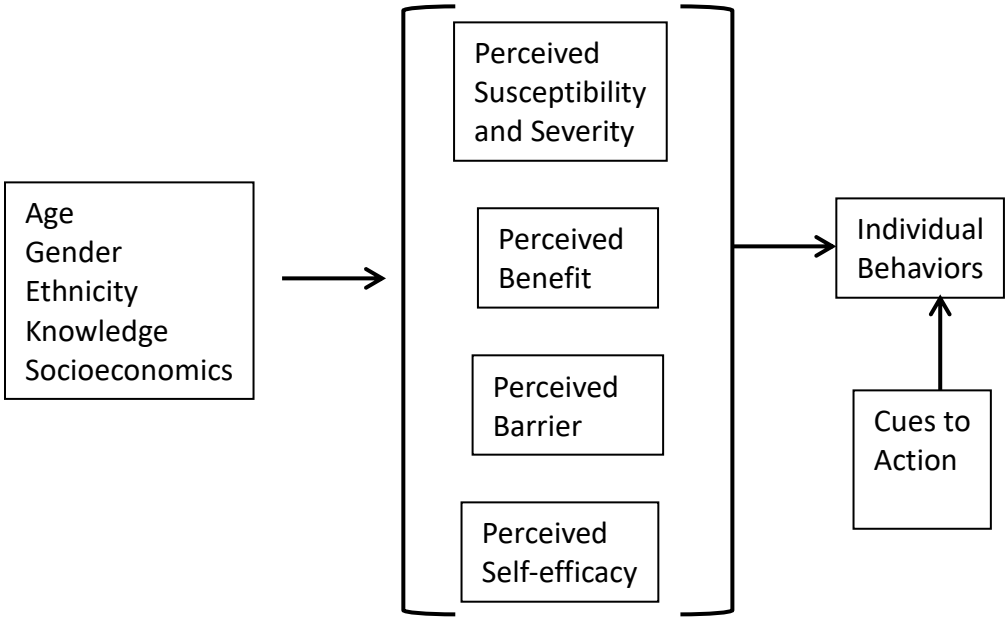

Figure 1. The health belief model

Constructs from the HBM, including health beliefs, personal experiences, health–related behavior and social perceptions, were used in the development of the interview guide. The research study addressed pastors' perceptions and beliefs concerning health promotion within their congregations. This theoretical model may help researchers understand the factors in pastor's decisions concerning health promotion ministries in their churches. The HBM is explained more thoroughly in Chapter 2.

Nature of the Study

I conducted a qualitative phenomenological investigation aimed at investigating how certain perceptions and beliefs either influence pastors' decisions to develop a health ministry or are perceived as barriers to such development. I contacted African American pastors in and around Wake County in North Carolina and invited them to participate in

the study. I used semi-structured interviews to answer the research questions. The semi-structured interviews included demographic questions to explore pastors' attitudes toward and experiences with (a) knowledge of health concerns, (b) attitudes towards perceived congregation's benefit of a health promotion ministry, (c) attitudes towards maintaining personal health, (d) attitudes towards the perceived role of the pastor in promoting health in the church, (e) why pastors take action to have a health promotion ministry (f) pastors' vision and commitment to a health promotion ministry, and (g**)** the frequency of existing health promotion and disease-prevention activities.

I located participants using current phone books, the Internet using EditGrid, and, *The Carolinian*, a local bi-weekly African American newspaper. Each issue lists several local African American churches. EditGrid.com lists African American churches with their contact names, pastor names, and addresses. The current Wake County phonebook lists churches in operation, and most Wake County churches now have websites. Pastors were recruited by letters followed by phone calls and e-mail. Participation was voluntary. I identified 29 churches in Wake County whose pastors who could potentially participate in the study. Of those churches, my goal was to interview between five and 10 pastors, and, according to Starks and Trinidad (2007), typical phenomenological studies have a sample size ranging from one to 10 participants. Semi-structured interviews were audiotaped, and I continued asking questions until the interview information reached data saturation.

Collected data (audiotaped semi-structured interviews and general demographic surveys) were transcribed and coded using open coding I compiled and analyzed. Phenomenology yielded insight into pastors' experiences or what influenced their

experiences. It was also used to understand the essence of the experience of each pastor, not to create a theory about their experiences (Creswell 2013). This method is explained in more detail in Chapter 3.

Definitions of Terms

Black church health and wellness ministry: An informal or formally structured program in the African American Church dedicated to improving the health of the congregation and community. It stresses wellness, health promotion, and disease prevention by encompassing congregational and community resources and partnerships. It focuses on body, mind, and spirit for the health and healing of the community (Rowland & Isaac-Savage, 2014; Series, 2010).

Church health promotion environment (CHPE): Church facilities, policies, programs and health messages (Williams et al., 2012b).

Church-placed health promotion: Interventions developed outside the faith-based organization and carried out inside the church that do not attempt to incorporate elements of the faith-based organization (Whitt-Glover, Porter, Yore, Demons, & Goldmon, 2014).

Facilitators and barriers: Facilitators help to bring about an outcome by providing indirect or unobtrusive assistance, guidance, or supervision. Barriers are anything built or serving to bar passage or anything that restrains or obstructs progress. In the current research, facilitators and barriers are those that help or promote the incorporation of a health promotion ministry as part of the church's program and those that obstruct or hinder the incorporation of a health promotion ministry as part of the church's program (Dictionary, M W, 2005).

Faith-based health promotions: These are interventions that include tenets of the faith-based organization (scriptural references, religious beliefs) and involve the organization in the planning of the intervention from start to finish (Whitt-Glover et al., 2014).

Health disparity: Differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes (CDC, 2011).

Health promotion: Any activity that seeks to improve a person's or population's health by providing information about and increasing awareness of "at risk" behaviors associated with various conditions and decreasing those behaviors (Farlex, 2009).

Health promotion ministry: An informal or formal structured program dedicated to improving the health of the congregation and community It stresses wellness, health promotion, and disease prevention by encompassing congregational/community resources and partnerships. It focuses on body, mind, and spirit for the health and healing of the community (Rowland & Isaac-Savage, 2014; Series, 2010).

Assumptions

I assumed that qualitative research would be the appropriate approach because study participants are usually in a setting where they are comfortable and able to feel relaxed while revealing personal information (Marshall & Rossman, 2014). As a result, that was the approach I selected. Qualitative research is also subjective in that participants are revealing their personal thoughts and feeling on a particular topic. The interaction between the participants and the researcher is in the form of dialogue in which researchers ask open-ended questions, and the participants explain their points in

everyday language (Marshall & Rossman, 2014). Assumptions made when speaking with the pastors about their attitudes and experiences with their health promotion ministries at their churches included that participants would speak freely and provide honest and candid responses.

Sensitive data such as those concerning attitudes or behavior were self-reported, although research shows self-report of attitudes and behaviors may be invalid (Jehn & Jonsen, 2010). To put the pastors at ease and increase the likelihood of truthfulness, I conducted the interviews using a one-to-one setting at a location of their choice (Jehn & Jonsen, 2010). They were encouraged to provide candid responses to the interviews and respond on a personal level and not on any third-party experiences. Because many African American pastors in the Triangle area in Central North Carolina know each other. There was a possibility that pastors could speak to each other during the data-collecting period. To lessen that possibility, I respectfully asked each pastor to refrain from speaking to each other about the study.

Scope and Delimitations

The scope of the study was the perceptions and beliefs of African American church leaders as they related to health promotion ministries. This focus was chosen to learn how African American pastors incorporate health promotion ministries into their churches.

The study included African American pastors of various denominations in urban and suburban areas in Wake County in North Carolina who may or may not have health promotion ministries. I chose Wake County because it is a central location in North Carolina and closely resembles the population of African American and Caucasian

Americans as the state of North Carolina. In Wake County, 21.4% of the population is African American and 69.3% Caucasian American. In the state of North Carolina, the populations were 22% and 71.7% respectively (U S Census Bureau, 2010). The study did not represent all African American churches because I was not able to locate all of them. Some in the area are in homes or in buildings that have no identifying markings as churches. I also did not seek the congregations' view on the health and wellness ministries, and it did not seek to learn whether health promotion was presented from the pulpit.

Limitations

I relied on data obtained from African American faith-based church populations in urban, suburban, and rural areas of only Wake County in North Carolina. Therefore, the findings may not apply to churches outside North Carolina. Studies of one specific ethnic group may not reflect the thoughts and experiences of other ethnic groups (Steinhauser & Barroso, 2009). Data obtained in this research were self-reported and therefore may be subject to response bias. My role as a health promotion ministry member did not conflict with my role as the researcher. To ensure this, the church I attend, or any church I am associated with, was not included in the research. Because I conducted the interviews, collected, and analyzed all data to reduce bias, I used a written script to ensure that I approached each participant in the same way. I also enlisted the assistance of an expert panel of pastors and scholars to ensure that the questions asked were appropriate and respectful. I was aware of my reactions and reflections during the interviews. I also used debriefing from pastors who were not part of the study. This procedure checked my work to ensure the credibility of the writing. Reexamining the

recorded interviews helped to decrease errors in the conclusions. Pastors may restrict information that may depict themselves or their church negatively. Reassuring the pastors that their identity and the churches were confidential and no one would be privy to any information associated with an individual helped them to feel at ease and forthcoming about disclosing personal information.

Significance of the Study

Attitudes and beliefs of pastors are the driving force for guiding beliefs and values of church members (Webb et al., 2013). Williams et al. (2010) also suggested there might be other individual and interpersonal level beliefs that might assist in understanding why some pastors endorse health promotion programs and others do not. My research provides additional information about pastors to gain a better understanding of how they decide whether to include health promotion ministries in their churches. The information obtained through this study revealed how to overcome pastors' barriers or identify how specific facilitators helped in the development of health promotion ministries. The results may inform other interested pastors about the process of assessing the potential for a health promotion ministry in their church. By understanding how to incorporate successful health promotion ministries into the church, more pastors of African American churches may be able to develop these ministries.

The study results may also lay the groundwork for African American pastors to collaborate with public health practitioners to develop strategies to offer culturally acceptable health promotion programming in the churches in their communities. Collaboration with public health professionals could expand to policy makers to assist in the formation of other health ministries or to host events for other communities, thus

broadening and extending the delivery of health promotion and disease prevention services to medically at-risk African American community members. Positive social change may be realized by giving culturally sensitive health information and limited health care to individuals who might not have access to health care. Involvement in ministry health promotion programs could also help individuals change unhealthy behaviors to healthy ones. An example of how a faith-based health promotion can have an effect on health disparities is the Body & Soul program. This program was designed to be spiritually and culturally appropriate for dietary change among African American church members. Essential elements of this program include pastor involvement and support, peer counseling and church activities to promote health. The program, designed to promote healthy food choices, incorporates healthy lifestyle education, church events, and peer counseling (Tussing-Humphreys, Thomson, Mayo, & Edmond, 2013). Because of its success, the American Cancer Society embraced Body & Soul as one of its national cancer control programs (CDC, 2013b).

Summary

The purpose of this chapter was to present a general overview of the research study. I outlined the importance of the pastor in the African American church and community and their role as the church leader and gatekeeper for social change. I presented the focus of the research study, the gap in knowledge, the purpose of the research and its significance, the theoretical framework, and how these related to the study approach and research questions. I further presented the rationale and methodology, relevant definitions, assumptions, scope, and limitations of the research. Information concerning the state of health of African Americans and health disparities were also

included. I used the HBM to develop the interview guide to answer the research questions.

An expansion of the literature review related to the theories, the role of pastors' role in health promotion, and the African American church is found in Chapter 2. Chapter 2 also presents the most recent literature regarding health disparities and health and promotion ministries. To give a more comprehensive understanding of the relevance of the culture of the African American church, I included a brief history of the African American church.

Chapter 2: Literature Review

This review details the literature search strategy and provides the development of an expanded rationale for the theoretical foundation of this study. In addition, it presents an integration of its foundations into a conceptual model used to examine the decisions of pastors considering the creation of a health promotion ministry. Also included in this chapter is current and historic literature concerning the African American church and the pastor's role in health promotion. Finally, there is an analysis of literature regarding the potential for church-based health promotions to decrease racial disparities. Pastors' perceptions of health promotion sponsored by the church is vital to the decision to have such a ministry (Webb et al., 2013).

Literature from Williams, Glanz, Kegler, and Davis Jr. et al. (2012a) suggested other beliefs may assist in understanding why some pastors endorse health promotion programs and others do not. Because pastors' beliefs inform their views on health promotion (Webb et al., 2012), I examined personal and interpersonal factors and beliefs that may affect their decisions when deciding whether to have a health promotion program in their churches.

Literature Search Strategy

The information in this research paper was acquired from peer-reviewed sources using Medline, PubMed, CINAHL, ERIC, PsycINFO, and Google Scholar. I utilized the libraries of North Carolina State University, Walden University, Duke University, and the University of North Carolina at Chapel Hill. I also gathered on-line sources via the Internet, using key words such as pastor, community leader, health ministries, church, African American church, black churches, health promotion, faith-based health

promotion, church-based health promotion, health disparity, and church health and wellness ministry. Due to the limited information found on health behavior models addressing pastors' reason for creating or not having health promotion ministries, literature concerning pastors, health ministries, health promotion, and faith-based ministries were combined to support this research. Literature obtained for the study ranged from 2010 through 2015. However, when sufficient data were unavailable within that range, I extended the literature search to earlier dates.

Community Health Promotion

Community-based health promotion programs are locally organized in one's community and promoted through community institutions and community channels (Farquhar, 2014). Community-based health promotion services develop structured and targeted interventions that support healthy lifestyles and provide access to preventive services that seek to reduce health disparities in the United States (Minkler, 2010; Wallerstein & Duran, 2010). These health promotion activities have the potential to remove barriers that prevent African Americans from accessing healthcare. (Feagin & Bennefield, 2014).

Barriers to using conventional healthcare venues include different treatments of different races, power differences of racial and socioeconomic groups, and differing socio-cultural status--both historic and current (Feagin & Bennefield, 2014). The distrust of the conventional health care system has its roots in the 18th and 19th centuries when African American slaves were exploited as medical specimens (Feagin & Bennefield, 2013). The Tuskegee syphilis study is still the hallmark of medical discrimination and

continues to inspire the African American distrust of medical institutions (Feagin & Bennefield, 2013).

Culturally distinct values and norms further limit interest in accessing health services and health programming from sources outside the community (Kelch-Oliver & Ancis, 2011). Because fuller figures are more acceptable in African American culture, women are likely to be heavier than their Caucasian American counterparts are (Kelch-Oliver & Ancis 2011; Overstreet et al., 2010;). This acceptance of heavier bodies can discourage weight loss, creating greater possibilities for diabetes and heart disease later in life (Baruth et al., 2014). Hairstyles may be another cultural factor that can influence health risk factors. African American women are less likely to exercise than their Caucasian American counterparts because sweating can quickly ruin their hairstyles; therefore, women may avoid exercise (Pekmezi et al., 2013).

African American men have one of the lowest medical care utilization rates among all racial and ethnic groups, a phenomenon partially explained by cultural definitions of masculinity (Schoenfeld & Francis, 2015; USDHHS, 2013). Many African American men view the need for medical treatment as a sign of weakness, making them reluctant to seek medical care and treatment (Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010). Concerns of the family also influence healthcare utilization. Many African American men will prioritize family ahead of their own healthcare needs. A study by Schoenfeld and Francis (2015) showed that healthcare, even if it is a serious condition such as prostate cancer, may be delayed or stopped due to family financial concerns. Because of these barriers, African Americans are less likely to

have a regular source of healthcare to provide risk reduction information, early detection services, or consistent disease management (Hammond et al., 2010).

One community-based intervention program that helped African American men overcome barriers to healthcare is the "Barbershop Talk With Brothers" program, a community-based HIV prevention program. Because of the education component of the program, participating African American men learned more about the disease, decreased at-risk behavior, and consequently improved their health (Wilson et al., 2014). The Alabama REACH program helped to increase the number of African American women in Alabama who received mammogram and Pap test screening (Fouad, Partridge, & Dignan, 2011). Chicago's department of health established health education classes in North and South Lawndale, predominantly African American and Hispanic neighborhoods, to increase community residents' knowledge about the risk factors for diabetes, cardiovascular disease, obesity, and other lifestyles to prevent chronic diseases. African American or Hispanic volunteers also taught the classes that were part of the Lawndale health promotion project. The literature given to the residents was at a reading level deemed appropriate for the residents and used pictures of people of color in illustrations. Many residents who learned from this intervention sought medical attention for symptoms they had recognized in themselves (CDC, 2013c).

Schoefeld and Francis (2015) learned the reasons for the decisions and barriers to African American men to have prostate cancer screening and treatment by collaborating with church leaders, government, and the community for their study. The success of these interventions supports the need for continued development of acceptable, accessible health programming to counter health disparities in the African American population.

These interventions were culturally compatible with the community and community norms, which is essential to reaching this population (Barrera Castro, Strycker, & Toobert, 2013).

Church leaders share the same cultural norms as the communities they serve, and help to influence health behavior change in both church members and the larger community (Williams et al., 2012b; Timmons, 2012). The church is a trusted and respected community resource. It is an acceptable and valued venue for reaching large gatherings of African American residents, including those at greatest social risk for poor health outcomes (Lumpkins et al., 2013).

Currently, in the United States, church attendance is highest among the African American population (Lumpkins et al., 2013), where churches exist in almost every community (Webb et al., 2013). Members of African American churches range in age from infants to the elderly and include people from all occupations, from blue-collar workers to nurses, physicians, social workers, educators, and other professionals who could be instrumental in starting health promotion activities (Butler-Ajibade, Booth, & Burwell, 2012).

The church has a history of delivering health and wellness activities (Levin, 2014) that have helped to reduce health disparities in local African American populations. Documented faith-based health promotion programs include a faith-based physical activity program that has led to increased physical activity among church members (Lancaster et al., 2014). Members who participated in the program were more likely to meet the CDC recommendations for physical activity than members who did not participate. Project Joy, a faith-based cardiovascular health promotion effort, also

improved the cardiovascular disease risk profiles of participants one year after the initiation of the program. (Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001). Frank and Grubb (2008) fielded a faith-based program involving blood pressure, glucose screening, and educational information on diabetes, cardiovascular disease risk, and stroke reduction. Before the program, participants aged 18-30 and over 60 were the least knowledgeable about the risk factors for cardiovascular disease and diabetes compared to those between 31 and 59 years of age. The two subgroups showed significant gains in knowledge about the topic after program participation.

Churches that participate in faith-based health promotion programs offer a unique opportunity to provide health promotion and wellness services by combining education, screening, referral, treatment, and support (Levin, 2014). Faith-based health promotions also have the benefit of providing a holistic atmosphere where social, physical, emotional, psychological, and spiritual health issues can be justifiably addressed (Levin, 2014; Lumpkins et al., 2013). For this reason, Levin (2013) recommended that public health agencies partner with African American church leaders to develop and deliver culturally competent health programs to address health disparities. The CDC and National Institutes of Health (NIH) also recognize the importance of addressing cultural factors, such as religion and faith, when providing recommendations concerning health promotion, such as diabetes education (Newlin, Dyess, Allard, Chase, & Melkus, 2012).

Background

The African American Church

Christianity has been central to the African American population in the United States since the early days of slavery. Prior to the civil war, African American slaves

formed secret congregations because, in the South, slaves were restricted to side pews, back rows, and galleries, and in the North, African Americans were treated with hostility when worshiping in Caucasian American churches (McRoberts, 2001; Proach, 2009). Preachers in desegregated churches used the pulpit to reinforce the subservient and inferior status of slaves in antebellum consciousness and society (Johnson, 1975; Proach, 2009).

The evolution of African American churches began during the Revolutionary war; first in the North, then in the South (Hines (2007; Johnson, 1975). One African American Church withdrew from St George's Methodist Episcopal Church in Philadelphia in 1787 and formed the African Methodist Episcopal Church (AME) (Lincoln &Mamiya, 1990). The African Methodist Episcopal Zion Church (AME Zion) soon followed suit. In 1796, members of the John Street Methodist Church broke from the church and congregation and formed the AME Zion church in New York (AMZ Zion church, 20017; Lincoln & Mamiya, 1990). In 1844, after slavery in the South, African Americans formed the Colored Methodist Episcopal Church, now called the Christian Methodist Episcopal Church (Lincoln & Mamiya, 1990). In 1758, the William Byrd plantation in Mecklenburg, Virginia, became the home of the first Baptist church called the African Baptist or Bluestone Church (Lincoln & Mamiya, 1990).

In the South, a few African American preachers served churches due to the shortage of Caucasian American preachers who would normally serve the churches. In the North, African American preachers ministered in the African American churches (BlackandChristian.com, 2000). Currently, there are seven major historic African American denominations: The African American Church is comprised of the AME

Church, the AMEZ Church, the Christian Methodist Episcopal (CME) Church, the National Baptist Convention, USA, Incorporated (NBC); the National Baptist Convention of America, Unincorporated (NBCA); the Progressive National Baptist Convention (PNBC), and the Church of God in Christ (COGIC). Two more recently became incorporated in the tradition: The National Missionary Baptist Convention (NMBC) and the Full Gospel Baptist Church Fellowship (FGBCF), although the FGBCF does not refer to itself as a denomination (BlackandChristian.com, 2000).

The church was the first institution created by African American people (Lincoln & Mamiya, 1990). The primary purpose of the early churches was to serve as a place of religious worship. The church also served, however, as a place of refuge and life-direction for escaped slaves. For example, Methodist churches served as stations on the Underground Railroad (Lincoln & Mamiya, 1990). After slavery, the church became a place to educate former slaves, as church affiliates used the Bible to help African Americans learn to read and write (Johnson, 1975). During the depression years, the church fed and clothed those who needed assistance (Lincoln & Mamiya, 1990). The church also served as a place where community leaders promoted social, economic, and political change (Lincoln & Mamiya, 1990; McRoberts, 2001). From the church, secular organizations such as the National Association for the Advancement of Colored People (NAACP) and the National Urban League evolved (Lincoln & Mamiya, 1990). Institutions of higher learning such as Morehouse and Spelman Colleges started in the basements of African American churches and produced church leaders such as the Reverend Dr. Martin Luther King, Jr., who attended Morehouse College (Lincoln & Mamiya, 1990). In the 1980s, the church enhanced its involvement in community

economics, politics, education, housing, recreation, employment, and health and medical care (Johnson, 1975). Today the African American church still plays a role as an agent of social change. Only now, a great deal of this change involves decreasing health disparities of the congregation and the community (Brand, 2011).

The Pastor's Role in Health Promotion

Although the primary role of African American pastors is to serve the spiritual needs of the congregation, their duties also include teaching the traditional doctrine, being the caregiver to the congregation, acting as a counselor and performing rites of passage such as baptisms, funerals, and weddings (Wright, 2012). Churches may have short or long lists of expectations of its leaders, but the one consistent theme is to teach church members about God through the Bible (Wright, 2012).

Church leaders are also agents of change (Rowland & Isaac-Savage, 2014; Williams et al., 2012b). As agents of health-related, social, and behavioral change, church leaders can have a strong effect on the behavior of the congregation (Baruth et al., 2014; Williams et al., 2012b). They focus on health promotion at the tertiary (rehabilitation), secondary (screening and treatment), and primary (health promotion) levels (Lumpkins et al., 2012). At the tertiary level, these pastors offer counseling for terminal illness, during hospitalization, or as part of treatment for mental illness (Lumpkins et al., 2012). Counseling sessions may focus on crisis intervention, suicide, alcohol and drug addiction, unemployment, marital and family problems, grief, as well as mental disorders (Stansbury, Harley, King, Nelson,, & Speight, 2011).

At the secondary level, these pastors may aid in the discovery of illnesses before they become life threatening by referring church members to wellness programs in or

outside the church proper. Concerning primary prevention, the pastors may preach on the topic of prevention or engage the congregation in health promotion programs (Lumpkins, et al., 2012). These church leaders may also choose to discuss health-related topics such as healthy nutrition and weight loss in their sermons. The greater the pastor's personal dedication to health and prevention, the more likely the pastor is to counsel church members in this matter (Williams et al., 2012b). Church members who participated in the Praise Project, a National Cancer Institute-funded study designed to identify barriers and motivators to change the dietary habits of African Americans, noted the importance of the pastor's engaging in health-related activities (Ammerman et al., 2003). The church members stated, "If the pastor changes the way he eats and the people see that he's lost weight and is becoming more healthy, this will influence the people" (Ammerman, et al., 2003). Lumpkins (2011) and Levin (2014) both observed that successful health promotion programs require the blessing and enthusiastic participation of the pastor (Levin, 2014; Lumpkins et al., 2011).

Pastors may also address these issues from the pulpit (Lumpkins et al., 2012) as topics addressed from the pulpit can reach the entire congregation. They also address the congregants individually on an individual or individual family basis (Lumpkins et al., 2012). Pastors who were involved with the Genesis Health Program pledged to their involvement in the program, which seeks to improve the health of the member through diet and exercise. The involvement of the pastor was said to be crucial to the success of this program (Cowart et al., 2012).

Exceptions

Not all African-American church leaders support having their congregations participate in health interventions. Church leaders who are not involved in health interventions cite time limitations, scheduling conflicts, insufficient resources, or lack of trust in partnering organizations to evaluate the effectiveness of interventions as reasons not to have a health promotion ministry (Toni-Uebari & Inusa, 2009). One pastor involved in a Los Angeles mammography promotion study stated he was tired of Black people being researched (Markens, Fox, Taub, & Gilbert, 2002). Timmons found that unsupportive pastors did not fully understand the nature of program evaluation research, and, for that reason, might not support a study (Timmons, 2012). Some pastors are against health promotion in the church because they are aware that they live unhealthy lives and feel uncomfortable as role models for the congregation (Baruth et al., 2014b). Markens et al. (2001) found that pastors who initially were excited about participation in a health-related intervention were not as willing to give their time to the research component due to the competing demands of their ministry. The researchers also found that many pastors hold jobs outside their pastoral leadership roles, which places further constraints on their time (Markens et al., 2002).

Current Literature on Pastors and Health Promotion

Literature about pastors and health promotion suggests that the church is an ideal location for health promotion (Levin, 2013). Current researchers also show that some pastors of African American churches have positive attitudes towards the addition of health promotion in their church, either from the pulpit or as health promotion ministries (Lumpkins, et al., 2011, Williams et al., 2012b). They also show that pastors are aware of

the current health problem in their church (Butler-Ajibade & Burwell, 2012)). Health promotion in the church may also have a positive effect on the health outcomes of the congregants and the pastors (Carter-Edwards et al., 2012; Lumpkins et al., 2011). Collaboration with other institutions is an acceptable form of health promotion and health disparity research as long as the institution is committed to helping the church and the church is not exploited (Corbie-Smith et al., 2010; Timmons, 2012). Pastors also understand that their enthusiastic support of a program may help to increase congregant participation (Baruth, Sharpe, Parra-Medina, & Wilcox, 2014); however, over-commitment to other matters not related to health promotion can prevent pastors from becoming involved with the health promotion programs (Markens et al., 2002).

Researchers cited above show that the church is a good location for health-related programs, and there is a plethora of studies about faith leaders and health promotion. Some of the research studies presented are relevant to pastors' perceptions, beliefs, and attitudes; however, they may be about perceptions, attitudes, and beliefs about different aspects of health and health promotion. Webb et al. (2013) wanted to see if pastors thought there was a link between health, spirituality, and religion. They used an online survey system with both open- and closed-ended questions to understand faith leaders' positions on the topic. Faith leaders of various denominations, age, race/ethnicity, sex, marital status, ministry position, education, height, and weight answered questions about their health and wellness perceptions. Results of this study indicated that although faith leaders varied in their perceptions of the link between health, spirituality, and religion, they had similar concerns about barriers to promoting health. The major theme that emerged included lack of knowledge of health matters, lack of time, the nature of the

congregation, and lack of resources. The results indicated that some pastors were against health promotion in the church, while others thought health promotion is part of the religious experience and that there is a link between spirituality and health (Webb et al., 2013).

In another study, researchers examined faith leaders' perceptions, beliefs, and experiences concerning their own health. The understanding of faith leaders' health is important because some faith leaders believe they have influence and authority of their congregation in promoting health and should be a role model when it comes to health (Baruth et al., 2014). In this study, the researchers performed one-on-one semi-structured interviews using an interview guide based on the social ecological model (SEM),a theory-based framework for understanding the multifaceted effects of individual thoughts, interpersonal relationships, organizational factors, community and public policy to determine behaviors and for identifying behavioral and organizational leverage points and intermediaries for health promotion within organizations (Golden & Earp, 2012). Results showed that faith leaders were aware of the health of their congregants, with cancer, mental illness, high blood pressure, overweight/obesity, cardiovascular disease, diabetes, and stroke among the common illnesses experienced by their congregations. Inactivity, smoking, alcohol consumption, and drug use were among the health challenges faith leaders knew existed in their congregations (Baruth et al., 2014). Even with this knowledge, some faith leaders do not offer health promotions at their churches (Baruth et al., 2014). Some believed they could influence their congregations, while others did not believe this. Those who did not believe they could influence church members cited their own unhealthy habits as a reason for this (Baruth et al., 2014).

Another aspect of health promotion is mental health. Stansbury et al. (2011) used a grounded theory approach to understand clergies' beliefs and attitudes towards pastoral care and counseling. Pastoral care and counseling, in part, refers to the pastors' role in mental health services. Pastoral care and counseling range from ministering to the congregation to individual and family therapy. Interviews with African American pastors in urban and rural areas in central Kentucky showed that pastors perceived pastoral counseling as their single most important ministerial duty. Most pastors viewed pastoral care as a service used to assist members with spiritual growth, while pastoral counseling as a specialty area involved psychotherapy, theology, and faith. Most pastors believe that pastors without proper training and licensures for counseling were not qualified for pastoral counseling and might be subject to legal complications if congregants were dissatisfied with the counseling and, therefore, were hesitant to provide this type of service (Stansbury et al., 2012).

Another study of pastors' perceptions of health and health promotion focused on understanding the role of African American pastors in using health education to reduce health disparities and improve health outcomes (Rowland & Isaac-Savage, 2014). Data from mailed questionnaires indicated that the majority of pastors reported having health education activities at their church, but 40% did not. The reason cited for lack of health education activities were lack of finances, interest, space, time, and a qualified professional and coordinator. Some pastors were aware of some of the major health problems in the African American community and recognized that high blood pressure, diabetes and HIV/AIDS were top health concerns (Rowland and Isaac-Savage, 2014). In addition, some pastors acknowledged cancer as a leading cause of death in their

congregations but did not rate cancer as a major concern (Rowland & Isaac-Savage, 2014). Rowland and Isaac-Savage (2014) also showed that although some churches do offer health education, they had pastors who were more astute and responded better to the health needs of the church. Researchers also reported that to extend health education, community churches needed to provide broader and more relevant topics. Rowland and Isaac-Savage (2014) also noted that successful health promotion programs depend on the pastor, but more information is needed to understand how the pastor feels about health initiatives and interventions (Rowland & Isaac-Savage, 2014).

Finally, research by Williams et al. (2012b) sought to understand the pastors' perceptions of the church health promotion environment (CHPE). Researchers used telephone interviews to collect data from pastors (57.7% Caucasian American and 42.5% African American). Results indicated that most pastors felt it was appropriate to speak about healthy eating (55%), weight loss (47.5%), physical activity (77.5%), and smoking cessation (70%) in their sermons. Less than half of the pastors thought their congregation would not be receptive to those topics. Pastors were also in favor of speaking one-on-one with their congregants about health. The researchers concluded that there may be other beliefs not measured that may be essential in implementing a health program. Other individual, interpersonal factors should be studied in order to better understand health promotion in church (Williams et al., 2012b). Overall, the latter researchers showed that although perception, beliefs, and attitudes of pastors concerning health were examined, there were many dimensions of health that a pastor must consider before starting a health promotion ministry. When the current research about understanding pastors' decisions in establishing a health promotion ministry is included with other research, it should add

another level of understanding of the relationship of the pastor, and congregation, and how the ministry could be an asset to the church and community.

Conceptual Foundation

The HBM, used to design interventions to modify health behavior, was developed in the 1950s by social psychologists from the U.S. Public Health Service to explain why people did not participate in programs to prevent and detect diseases (Glanz et al., 2015). Constructs of the HBM consist of six belief concepts. The first, perceived susceptibility, refers to the belief about the risk of contracting a disease; perceived severity is the belief about the seriousness of the disease; perceived benefit is the belief in the efficacy of the action to reduce the risk of getting the disease; perceived barriers are beliefs about the opportunity and financial costs of taking the advised action. The last two concepts are cues to action that signal prompt awareness or encourages a person to take action, and self-efficacy, which refers to confidence in one's ability to take action (Glanz et al., 2015). Factors that may indirectly influence health behaviors are sociodemographic and socio-psychological factors and education (Glanz et al., 2015).

Research Questions 2 and 3 are applicable to HBM constructs. The threat-related concepts of perceived susceptibility and perceived severity relate to the pastors' perceptions concerning the health risks among congregants and are applicable to Research Questions 2 and 3. Perceived benefits address the perceived value of a health promotion ministry in addressing health disparities and relates to Research Question 2, while perceived barriers specifically address the costs associated with the development of the health promotion ministry, and relates to Research Question 2. Cues to action are facilitators related to the encouragement to start a health promotion ministry and are

applicable to Research Questions 3. The last HBM construct to address the psychosocial dimension related to the research questions is self-efficacy, which addresses the pastors' confidence in their ability to develop a health promotion ministry and ensure its success.

Researchers use the HBM to understand an individual's behavior, especially behavior that applies to health issues such as screenings, vaccinations, and other medication (Glanz et al., 2015). Studies below are examples of how this model explains medical some interventions in different populations.

James, Pobee, Oxidine, Brown, and Joshi (2012) sought to develop a culturally appropriate weight management program for African American women using constructs of the HBM. The qualitative design researcher used focus groups to plan and develop culturally specific weight loss messages and strategies for the program. Fifty women who met the criteria for the study, being overweight or obese, were recruited from beauty salons, churches, sororities, college campuses, and a low-income housing community. A moderator asked 13 "probe" questions about perception of healthy weight, overweight and obesity; barriers and motivators to weight loss; and diet to uncover the construct of HBM. From the questions, the researchers identified common themes and patterns and concluded that weight loss programs suited for African American women should focus on lifestyle management and define healthy weight as well as overweight and obesity. It should emphasize the health benefits of losing weight, no matter how slight. It should address ways to overcome barriers, manage stress, and increase self-efficacy. It should use means, other than BMI, to assess weight status and health risk. A weight loss program should acknowledge that it is acceptable to be motivated by appearance and emphasize the relationship between weight and chronic diseases. Emphasize should be

placed on the importance of physical activity and suggest ways to increase physical activity throughout the day. Finally, it should stress the importance of maintaining a healthy weight, not just losing weight (James et al., 2012).

Bynum, Brandt, Friedman, Annang, & Tanner (2011) used the HBM framework for understanding gender differences in college students attending historically black colleges and universities as well as their beliefs and attitudes, knowledge, and behavior about human papillomavirus (HPV) and the HPV vaccination. The cross-sectional research design studied students from undergraduate introductory classes in three such schools in the southeastern United States. Eligibility for the study included being 18 to 26 years of age, African American, having a comprehension of English, and no difficulties hearing, speaking, or writing. The students completed a 53-item questionnaire to explore awareness, knowledge, beliefs and behavior towards HPV and the vaccine. The HBM guided the questions in the questionnaire. Five hundred seventy-five students completed the survey. Researchers showed that students were not knowledgeable about HPV, with males significantly less knowledgeable about the vaccine than females. Men also scored significantly lower on perceived severity of HPV, perceived benefit of the vaccine against HPV, and cues to action compared to women. Men and women had no significant differences in knowledge of the HPV vaccine or its benefits. This research has implications for education and promotion targeting African American students about HPV and the HPV vaccine (Bynum et al., 2011).

Researchers also used the HBM to understand parents' decisions whether to immunize their children. Smith et al. (2011) used data from the National Immunization Survey to identify parents of children aged 24-35 months. Parents were placed into one of

four categories: (a) those who vaccinate their children on time (neither delay nor refuse a vaccination), (b) those who delay vaccination, (c) those who refuse vaccination, and (d) those who delay and refuse vaccination. Parents were evaluated based on constructs from the HBM. The survey contained questions about the children's vaccine status, parents' beliefs about and attitudes toward vaccinations, and vaccine coverage. Results indicated that parents who delay or refuse to vaccinate their children are associated with lower vaccination coverage. Parents who delay or refuse to have their children vaccinated are also less likely to believe their children are at risk of contracting a vaccine-preventable disease. These parents were also less likely to believe that vaccine-preventable diseases are of great concern. However, they were concerned about the safety and efficacy of the vaccination. They also believed that physicians do not have the best interest of their child. The data also show that mothers who delay or refuse to vaccinate their children are typically college graduates, live in suburban areas, and have a higher than average annual family income (Smith et al., 2011).

These studies employing the HBM highlight the model's usefulness in identifying psychosocial facilitators and barriers associated with the decision to adopt a specified program or behavior. The model was used in a similar fashion in my research. I will use the HBM as a guide for assessing the pastors' psychosocial reasoning around the decision to implement or not implement a health promotion ministry.

Conceptual Model

The purpose of the study was to learn perceptions and beliefs of pastors regarding whether to endorse health promotion programs in the church. Phenomenology was the chosen approach as the methodology for this study. While the HBM was used to frame

the questions in the survey instrument, phenomenology was the method used to understand the pastors' experiences. The use of a theory-based conceptual model gave direction to questions that helped clarify the nature of the pastors' health ministry-related behavior and aid in understanding the dynamics of their experiences. The threat-related concepts of perceived susceptibility and perceived severity related to the pastors' perceptions concerning the health risks among congregants. Perceived benefits related to the value pastors attach to a health promotion ministry in addressing health disparities. Perceived barriers were related to things that hinder or prevent pastors from implementing health promotion programs. Cues to action were factors that encouraged or aided pastors in choosing to implement a health promotion program.

Summary

Literature on church-based health promotion and the role of the pastor were identified and compiled in a logical fashion to learn the information needed for this study. Older studies were included to fill some of the gaps where more recent literature was not available. Because there were limited studies on this topic in recent literature, this research helped to fill the gap because it examined the African American pastors' experiences in making decisions about health promotion programs at their churches.

Throughout this chapter, I presented research that indicated that the church was an appropriate place to address health concerns. In addition, African American pastors played a major role in the success of health promotion programs. The HBM was described, and constructs from it were employed in the study's conceptual framework. Unlike other models such as the innovation theory, this study gave answers that helped fill the gap in knowledge of pastors' decisions by seeking the deep, personal factors and

beliefs that revealed their thinking about embracing or rejecting a health promotion ministry.

This chapter also described the rich history of the African American church and the role of the pastor as a minister and as a health advocate. It also illustrated the use of HBM in health-related behavior studies. The next chapter contains the methodology underpinning the research, including the design, participant data, data collection, and analysis.

Chapter 3 Research Method

The purpose of this phenomenological study was to identify those perceptions and beliefs that facilitate the development of a health promotion ministry or mitigate against it, from the perspective of the church pastor. This chapter presents an explanation of the methodology and design relative to the research questions. I follow that with a section defining my role as the researcher in the investigation. Next, I present the details of my study methodology beginning with a description of the study population and sampling strategy. Next, I discuss the data sources, the origin, and format of the data collection instrument. I follow this with the recruitment and data collection plan and complete this section with my data analysis plan. This was followed by discussions of how I ensured the trustworthiness of my data and how I addressed ethical considerations associated with this investigation. The chapter concludes with a summary of key features of the methodology and an introduction to Chapter 4.

Research Design and Rationale

The following reprises the research questions that supported the design and rationale of this investigation.

Research Questions:

RQ1: What are the perceptions of African American pastors about health promotion ministries?

RQ2**:** What are the factors that affect African American pastors' decisions to implement a health ministry for their congregation?

RQ3: What are African American pastors' perceptions of the motivators and barriers to implement a health ministry for their congregation?

Conceptual Framework for the investigation

Constructs from the HBM form the conceptual framework of this research. This model focuses on different beliefs, attitudes, or interactions that ultimately shape a behavior. I chose the model mentioned above because it provided the information to construct questions for a survey instrument that best answer the research questions. The survey instrument contains questions that elucidated the decision-making process of pastors. In this research, the decision-making factors were those that affect whether or not pastors promote or not to promote a health promotion ministry in their church.

Research Tradition

Researchers, to date, have not examined the personal decision-making factors of why pastors decide to either support or reject a health promotion ministry for their congregations. This lack of understanding limits health advocates' ability to expand these ministries and successfully collaborate with pastors to extend health promotion efforts. The purpose of this study was to identify those factors that facilitate the development of, or mitigate against, a health ministry from the perspective of the church pastor. In addition, I constructed a conceptual model of the pastor's decision-making process to guide other pastors contemplating such a ministry, and to assist public health practitioners in advocating for and collaborating with, these ministries.

In this qualitative study, I examined the perceptions of African American pastors regarding health promotion ministries in their churches. I strived to identify and understand the factors that lead pastors to support a health promotion ministry. Factors that determine whether a given church serves as a community health resource have not been well examined, so the research was a fresh inquiry, and the goal was to understand a

phenomenon. For that reason, it was considered exploratory, with a qualitative approach considered appropriate. Bhattacherjee, 2012). The flexibility of the qualitative method allowed participants to fully describe their experiences that resulted in new discoveries and knowledge about the pastor's decision-making process concerning the incorporation of a health promotion ministry (Ulin, Robinson, & Tolley, 2005). Quantitative research methods are less flexible and objective. It is based on deductive logic in which hypotheses are developed a priori, and tested. This type of design is static, resulting in numerical data focused on statistical connections (Blumenthal & DiClemente, 2004). Quantitative methods also test theories, however, do not consider the deeper subjective beliefs of individuals. These deeper, subjective beliefs are the precise qualities needed for the current research. I chose to use a qualitative research method because it considered the beliefs of the individuals studied.

Phenomenology

Phenomenology is the study of events, situations, experiences, or concepts that shape our lives (Astalin, 2013). A phenomenon (as used in phenomenological research) can be an emotion, a relationship, or an entity such as a program (Lin, 2013). Phenomenological approaches seek to explore, describe, and analyze the essence of an experience; how it is perceived, feels, remembered or judged (Marshall & Rossman, 2014).

Philosopher Edmund Husserl launched modern-day phenomenology by combining psychological theory and logical theory (Smith, 2008). The classical form of phenomenology derived by Husserl is called transcendental phenomenology (Smith, 2008). This method focuses on the natural attitudes or life experiences of the participants,

rather than the researcher's interpretation of that experience (Smith, 2008). In this process, researchers use bracketing as a way to set aside the experiences of the researcher and focus on the experience of the participant.

Compared to other qualitative methods, phenomenology yields the best answers to my research questions. Other qualitative methods, such as ethnographic or grounded theory were not considered because these methods would not answer the research questions. Ethnographic studies focus on the culture of the participants. In ethnographic studies, researchers immerse themselves in the culture over extended periods, and most data are collected via observation **(**Bhattacherjee, 2012). The goal of grounded theory research is to develop a new theory, and neither method was appropriate for this study. The goal of this type of research is to study the conscious experience as a way of understanding a person's reality.

Role of the Researcher

Although I currently participate in the health promotion ministry at my church, I did not have a participatory role in this study. As the researcher, I was neither observer nor observer-participant. I had no relationship with the participants; therefore, there was no power relationship over the participants. My role was strictly as the interviewer.

Addressing Bias

Qualitative researchers acknowledge the possibility that investigators' values and beliefs may influence their research studies (Jootun, McGhee, & Marland, 2009). To address this issue and defend against biases, I used bracketing to eliminate the potential of preconceptions about the topic or participants (Tufford & Newman, 2012). I also kept a reflective journal, a common procedure in qualitative research (Ben-Ari & Enosh, 2011;

Nelson, 2015). Nelson (2015) identified journaling as a way of acknowledging researchers' personal assumptions and goals. Reflective journaling creates transparencies in the research, revealing any biases (Ben-Ari & Enosh, 2011; Nelson, 2015). Nelson (2015) calls this reflective commentary and uses this form of journaling to monitor the researcher's development of the constructed theory and emerging patterns to establish credibility (Nelson, 2015).

Another method of reducing bias tendencies is to use a script to eliminate flexibility in the wording or order of the questions. This reduces bias by ensuring that the researcher asks each participant the same questions in the same manner. I made clear that there was no compensation for their participation other than a nominal gift of $10.00 Walmart gift certificate for each pastors' time. If there were participants who started the study then decided to withdraw, they would have received a $5.00 Walmart gift certificate.

Methodology

Participant Selection

The population of interest was pastors of African American churches in North Carolina. To obtain the information needed to answer the research questions each pastor had to be the pastor of a predominantly African American church that had existed for at least 2 years.

Sample strategy

My method of sampling was a purposive nonprobability technique in which the researcher selects participants based on relevance to the issues in the study. It allowed the researcher to focus on the specific type of people who have the expertise and experience

needed to provide good quality information and valuable insight on the research topic. This type of sampling produces the most valuable data (Denscombe, 2014; Ritchie, Lewis, Nicholls, & Ormston, 2013).

Participants were recruited from a sampling of pastors of African-American churches in Wake County in North Carolina. I developed the sampling frame using information obtained from EditGrid (www.editgrid.com), a website that lists various establishments in a spreadsheet. The list from EditGrid revealed a spreadsheet of African American churches along with contact names and pastor's names and addresses. Other sources were the *Carolinian*, a local African American newspaper in Wake County and The Black Church Network (http://theblackchurches.org/). I also used stratified sampling, a method in which the sample is divided into select categories or groups based on the research topic (Robinson, 2014). In this study, the sample of pastors of African American churches was divided into two categories or strata, those with health promotion ministries and those without health promotion ministries. The sample was further divided into denominations. In Wake County, the predominant denominations of African American churches are Baptist, African Methodist Episcopal Church (AME), and Methodist. Stratified sampling focuses on characteristics of a particular population of interest, unlike stratified random sampling, which takes a random sample of the population to reach generalizations (Palinkas, Horwitz Green, Wisdom, Duan, & Hoagwood, 2013).

The sample size was determined as the study progressed. Phenomenological studies tend to have small samples, ranging from one to 10 participants (Starks & Trinidad, 2007). I expected a population of 29. I conducted semi-structured interviews with pastors of African American churches, which is a homogeneous population. The

sample numbers in qualitative research are small because samples are evaluated by the quality and amount of the data, not the number of participants (Jeanfreau & Jack, 2010). I collected data until the point at which information collected was repeated. This was the point of saturation. At this point, data collection ceased.

Instrument and Materials

The instrument served as a guide used to help maintain consistency of the interviews. The researcher-created, semi-structured interview guide consisted of open-ended theory-driven questions based on literature and components of the HBM. The questions were developed to expand on the current literature examining pastors' knowledge of health disparities, health, attitudes towards health promotion, role in health promotions, and influence to start a health promotion ministry. Complete details of the full instrument are in the appendix.

Operationalization of the instrument guide:

- Five questions in the instrument represented knowledge of health concerns.
- Two questions were perceived benefits of a health promotion ministry
- One question was about the pastors' personal health
- Two questions were about the role of the pastor in health promotion
- Five questions had to do with influences pertaining to promoting or not promoting a health promotion ministry.

Because the pastor of the church I currently attend was not involved in the study, he acted as an expert reviewer and inspected the interview guide for proper protocol, word choice, and sensitivity. In addition, pastors who were also academics at Shaw

University assisted in the development of the interview guide. They read the research, read the instrument guide, and gave feedback that led to revisions in the instrument guide.

Data Collection

I sent letters via the US postal service inviting pastors to participate. I contacted each pastor by phone a week after mailing the invitations. Pastors who agreed to participate received a consent form and a letter of confidentiality by US postal service or e-mail. I called each pastor who agreed to participate to establish a time and place for the interviews. Interviews were scheduled to ensure sufficient time for me to ask and clarify questions as needed as well as to allow for their further comments. Interviews were recorded using an RCA VR5220 digital recorder. Time was also set aside for comparative analysis. A comparative content analysis is a form of validation and a way to identify emerging themes (Anderson, 2010). I recorded each interview and hand wrote keywords in notes. As in the tradition of phenomenology, sampling and data collection were done simultaneously but not completed until each area in the theme had reached saturation (Corbin & Strauss, 2014). At the conclusion of each interview, participants could ask any question about the procedure, all aspects of the research, and the results. There was a statement reassuring the pastors about confidentiality and sharing the knowledge upon completion of the study. I thanked each participant and gave each one a written debriefing statement (in the appendix), that contained contact information and information on obtaining the final results of the study.

Data Analysis Plan

In a phenomenological study, data collection and analysis are conducted simultaneously. I transcribed the audiotaped interviews and incorporated data with the

background/demographic information to represent the experiences and perceptions of participants. The data were analyzed to answer the research questions.

The four major steps to analyzing phenomenological data are collection, reviewing data, identifying themes, and synthesizing results (Laureate Education, n.d.) After recording each interview, I immediately transcribed the verbal data. I listened to each recording multiple times before coding the information. Open coding was used to identify emerging patterns. From the first question of the first interview, I reviewed each line and phrase. Through this process, I identified a theme from each question. Each interview afterward was scrutinized in the same manner until all themes from each question for each participant were identified. Similar topics were clustered together to develop a broad coding scheme. Next, I examined the relationships of the codes (categories). Codes that showed a relationship or link were combined. As the analyses continued, more relationships and connections emerged and were used to synthesize the results (Creswell, 2013). After transcription, the collected data were entered into the NVivo 11 qualitative data coding software. To maintain the confidentiality of the participants, each pastor received a unique identifier.

Issues of Trustworthiness

Trustworthiness is a standard of quality in qualitative research that requires transparency, integrity, and reflexivity (Sinkovics & Alfoldi, 2012). Credibility (validity), transferability, dependability, and confirmability are four criteria that test the rigor of qualitative research (Thomas & Magilvy, 2011). Credibility refers to measuring internal consistency and establishing results from the perspective of the participant (Thomas & Magilvy, 2011). I established credibility by maintaining an accurate account of

participants' responses. To do this, I translated, verbatim, all participant responses. I also read back responses to each participant to ensure the accuracy of my transcription. Transferability refers to the degree to which the results of the data can be generalized or transferred to others in a similar setting (Thomas & Magilvy, 2011). Collecting data until saturation was the method to show transferability in this research study. Dependability is the ability to repeat research technique and get consistent results. A study technique is reliable if the research is done in a way that is repeatable. This means other researchers can follow the steps of the current research and observe similar results (Thomas & Magilvy, 2011). To ensure transferability of this study, I carefully tracked the research design, keeping detailed records of all research activities, processes, data collection, analyses, emerging themes, categories, and memos. I also conducted the semi-structured interviews using a script making the interview process consistent for each participant. The final standard of trustworthiness, confirmability, refers to the degree to which other researchers can corroborate the results of the study (Thomas & Magilvy, 2011). Qu and Dumay (2011) stated that result should be based on the researched data and not belief or biases of the researcher. The detailed procedures used in this study along with reviews of professionals in academia showed confirmability.

Ethical Considerations

The study presented no physical risks to the participants. Because of the personal nature of the qualitative research, however, potential risks of embarrassment and misunderstanding can arise. To ensure against this, I paid close attention to the ethical considerations as stated by the Walden University Institutional Review Board. The IRB process confirmed that the research fulfilled the ethical standards of Walden University

(Approval No. 11-10-16-0106780, expiring on November 9, 2017). After receiving IRB approval the researcher began study recruitment. All participants were provided a letter of consent and an assurance that all information would be held in strict confidentiality. They were told that they were participating on a volunteer basis and as such could withdraw from the study at any time. They also had the right to refuse any question they found uncomfortable answering. All audiotaped and transcribed interviews are now stored and maintained in a locked cabinet in my home. Access to the material is limited to me. After 5 years, the original data will be destroyed in the manner acceptable by Walden University.

The various sections of the survey instrument represented specific questions based on the theory discussed. Aside from the typical demographic questions, questions in this survey instrument represented the HBM.

Summary

Chapter 3 focused on the design and rationale of the study, the data collection methods, and analysis for the qualitative phenomenological research study. Instrument development was also described. Also included in this section was the conceptual framework for the investigation. My role as researcher and attention to bias avoidance were also included. Ethical considerations were maintained to ensure participants were treated with respect. Methods to ensure trustworthiness, specifically, reliability, and validity of the research were described as well. These methods of inquiry led to the research findings in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this research study was to investigate the attitudes and beliefs of African American pastors when deciding to support or reject having a health promotion ministry in their churches. The research objective was to identify what drives pastors to developer choose not to promote a health ministry. To address the objective of this phenomenological study, I formed three research questions. Research Question 1: What are the perceptions of African American pastors about health promotion ministries? Research Question 2**:** What are the factors that affect African American pastors' decisions to implement a health ministry for their congregation? Research Question 3: What are African American pastors' perceptions of the motivators and barriers to implementing a health ministry for their congregation?

Chapter 4 begins with an overview of location and setting of the interviews, followed by the demographics of the participants and the details of data collection and data analysis. Next is a discussion of the results of my findings. These included responses to the interview questions and a description of the categories and themes that emerged. The chapter ends with a discussion of discrepant cases followed by a summary of the findings.

Setting

Each interview was conducted at a private location convenient and comfortable for each participant to ensure confidentiality. Most were at the church in the church leader's office or in a conference room. Seating arrangements varied with each participant. In one interview, I sat directly across from the participant. In the other, we sat

adjacent to each other. Three took place in the church leaders' office, with me sitting across from the desk. Two took place with both of us sitting side by side in plush chairs in front of the main desk. One interview took place at the pastor's private residence at the request of the pastor. The pastor's spouse was present during the interview but had no input during the interview process. Except for an occasional telephone ring, each interview site provided a comfortable, quiet setting to engage in personal dialogue about the research questions.

Demographics

Eight pastors (seven male and one female) agreed to participate. All were African American church pastors of congregations who were predominantly African American. Their ages ranged from the mid-20s to late 60s. Two were in their 40s, while the other three were between 50 and 70. Four either had or were in the process of earning their doctorate, and the others had master's and bachelor's degrees. Their years of experience as a church leader ranged from fewer than 5 to over 25 years.

The location of the churches ranged from urban to suburban areas. The churches were Baptist, United Methodist, Congregational, and nondenominational. Their sizes ranged from less than 100 to over 500 members. Table 1 presents more detailed demographics of the sample.

Table 1

Study Participant Demographics

Identifier	Has health promotion ministry	Age (years)	Pastor's experience	Education (*PhD in progress)	Congregation size
P1	No	60-70	< 5	BA	<100
P2	Yes	40-40	<10	MS	>500
P3	Yes	50-60	>10	PhD	>500
P4	Yes	40-50	<10	*PhD	<500
P5	Yes	50-60	>10	PhD	>500
P6	Yes	30-40	>10	MS	>100
P7	Yes	20-30	<5	MS	<100
P8	Yes	30-40	>5	*PhD	<500

Data Collection

The participants received an invitation to participate in the study and a copy of the informed consent document. The invitation contained a short description of me and the nature of the research, along with my contact information. The informed consent document provided a longer explanation of the research, the procedure, which included the approximate time it would take to complete the interview, and an example of the type of questions I would ask. It also stated participation was voluntary, the incentive, the Institutional Review Board (IRB) number, and a place to agree or not to be recorded. All agreed to participate, to be recorded, and agreed to an interview time, place, and date.

Location and Duration of Data Collection

Each participant met for the scheduled 45-60-minute interview at his or her location of choice. Seven met at the church in either the conference room or the participants' office. One took place at the participant's residence. Before the interviews began, the participants had an opportunity to go over the informed consent document, and

we both signed it and checked the box that agreed to recording the interview. The interviews ranged from 20 to over 50 minutes depending on the details provided for each response. I read each question from the scripted interview guide, and the participants responded. At the end of the interview, I asked if there was any additional information they wanted to add. If no additional information was obtained, I thanked them and gave each of them a $10 Walmart gift card and assured them that no personal identifiers would appear in the dissertation. I informed them that at the completion of the study I would give them a summary of the findings.

Data Recording and Transcription

All participants agreed to be audio-recorded during the interview. I recorded all interviews using the RCA VR5220-A recorder. There were no technical difficulties with the recorder. Because the recording device worked well, and I performed the transcription after each interview, handwritten notes were not necessary, but nonverbal cues and responses were recalled during transcription.

Each interview was transcribed verbatim in immediately upon returning to my residence. The first interview was directly transcribed by listening to the recording and typing it into MS Word. Subsequent interviews were transcribed using Nuance Dragon Naturally-Speaking 13 translation software package. With this method, I used headphones to listen to and then recite the interviews. As I recited each interview, the Dragon software transcribed the words. This method is not 100% accurate; therefore, I again listened to the recorded interviews while reading the transcribed text, correcting errors as I listened. This approach reduced my time typing because I only typed

corrections, not the entire document. I offered the participants an opportunity to read their transcripts. However, they did not wish to review them.

I assigned a numeric code to the participants to ensure their anonymity. No names were associated with the transcribed interviews. All electronic data and hard copies will remain in a secured password-protected computer and a secured locked box. As required by the IRB, the data will be stored for 5 years then destroyed in a proper manner.

Data Analysis

Bracketing

Transcendental phenomenology is an approach that focuses on objectivity (Sheehan, 2014). Prior to data collection, I tried to suspend all personal biases, beliefs, and preconceptions about health promotion ministries. This "bracketing" allowed me to set aside my known predispositions, accept new ideas and perceptions, and allowed me to have a fresh view on the topic of my research (Moustakas, 1994). Preconceived biases I had were that health promotion ministries were well accepted by most pastors and their congregation; two of the most important barriers to the ministry is lack of time and money, that it takes a large number of people to have a successful health promotion ministry, and that health promotion ministries are primarily used for exercise classes and to promote awareness of health conditions such as breast cancer and prostate cancer. Because I bracketed my experiences I was able to focus on listening and engaging in the dialogue with each participant during the interviews. I was also able to focus the research on the experiences of the participants and the research questions while removing researcher bias transfer during data analysis (Moustakas,1994).

Horizontalization

After transcribing the interviews in MS Word, I read each one multiple times to check the accuracy of the transcription and to begin to understand the perspectives of each participant. I uploaded each transcript into NVivo 11 Pro software package. NVivo created nodes, a collection of references to a specific theme or relationship (NVivo 11QSR, 2015).

I coded the data from each participant's interview and sorted them into nodes. Nodes also allow a researcher to gather related material in one place to view emerging patterns or themes. Then nodes were categorized into themes. The five themes formed were the perceptions of health promotion, pastor support, pastor influence, health status of church members, and facilitators and barriers.

The interview consisted of 14 questions (Appendix F). The interview questions were based on the health belief model. Of the 14 questions, seven were used to directly answer the research question. Question 10 was designed to determine if the pastors advocate maintaining health within the church and community. Question 11 offered an opportunity to share the pastor's opinion of health promotion ministries in the church. The two questions were directed towards Research Question 1. Questions 6 and 7 asked if there were beneficial aspects of having a health promotion ministry. Question 12 addressed the opinions sought by pastors, when considering a health promotion ministry. Questions 13 and 14 were designed to explore facilitators and barriers when considering a health promotion ministry. Questions 6, 7, 12, 13, and 14 were directed at Research Question 2, and Questions 13 and 14 addressed Research Question 3.

Evidence of Trustworthiness

Trustworthiness is a standard of quality in qualitative research that requires transparency, integrity, and reflexivity (Sinkovics, &Alfoldi, 2012). Credibility (validity), transferability, dependability, and confirmability are four criteria that test the rigor of qualitative research (Thomas & Magilvy, 2011). Credibility refers to measuring internal consistency from the perspective of the participant (Thomas & Magilvy, 2011). Prior to data analysis, I used bracketing to write down and reveal all predispositions to examine the research data without bias. I also established credibility in this study by maintaining an accurate account of the participants' responses and recorded each participant's interview verbatim. I also gave each participant the opportunity, if so desired, to read the recorded words and respond. Transferability refers to the degree to which the results of the data can be generalized or transferred to others in a similar setting (Thomas & Magilvy, 2011). Collecting data until saturation is the method used to show transferability, with dependability the ability to repeat research technique and get consistent results. A study technique is reliable if the research is done in a way that is repeatable, allowing other researchers can follow the same steps and observe similar results (Thomas & Magilvy, 2011). To ensure transferability of the current research study, I carefully tracked the research design, keeping detailed records of all research activities, processes, data collection, analyses, emerging themes, categories, and all memos. I also used a scripted semi-structured survey for the interviews that enabled me to ask identical questions to each participant.

The selection of the participants was based on specific criteria that was specific to a particular location. The participants were African American pastors of African

American churches in North Carolina, and results may only be transferable to a similar population. The final standard of trustworthiness, confirmability, refers to the degree to which other researchers may corroborate the results of a study (Thomas & Magilvy, 2011). Qu and Dumay (2011) stated that the result should be based on the researched data and not beliefs or biases of the researcher. All detailed procedures and materials collected in this study, including audio recordings of each interview, written transcripts, and notes taken while analyzing the data, will be saved for a minimum of 5 years as required by Walden University and will be accessible for review if requested.

Results

The purpose of this qualitative research study was to investigate the attitudes and beliefs of African American pastors when making the decision to support or reject a health promotion ministry in their church. The intent of this research was to identify what drives church leaders to develop their health ministries. To understand this phenomenon, I used three research questions. Research Question 1: What are the perceptions of African American pastors about health promotion ministries? Research Question 2: What are the factors that affect African American pastors' decisions to implement a health ministry for their congregation? Research Question 3: What are African American pastors' perceptions of the motivators and barriers to implementing a health promotion ministry?

A comprehensive literature review and consideration of the conceptual framework of the health belief model helped in the development of the research questions. The use of an interview guide further enabled me to identify and understand the lived experiences and perceptions of pastors of African American churches when deciding to support or not support the development of a health promotion ministry.

Transcribed interviews were carefully reviewed, including reading the interviews several times, constantly comparing them to the recorded interviews to ensure the accuracy of the transcription. During data analysis, I examined the interview responses, determined relevant statements, and sorted them under the appropriate nodes (categories). This process revealed relevant responses to the interview questions that corresponded to the research questions and to interview questions that did not directly answer the research questions. Coding the responses of the interview questions and finding themes was challenging because I had not only to compare the responses of each interview question with each other but across different questions. Participants, at times, went across questions when answering the interview questions. However, scrutinizing the nodes in conjunction with a constant review of each complete interview transcript showed that the nonconforming data did not affect the results of the study.

Interview questions one, two, three, four, five, and eight did not directly address the research questions, but were useful in acquiring information about the participants' knowledge concerning health disparities and the myriad of health outcomes that result from health disparities. When asked about the meaning of the persistent gap in health between African Americans and non-African Americans, participants used the terms health issues, lack of resources, decreased access to healthcare, food desert, fewer options, disenfranchised, lack of medical care, and other issues that affect African American communities such as lack of insurance and a lack of healthy options. These responses illustrated that the participants were aware of the outcomes of health disparities.

Interview questions two through five concerned the perceived susceptibility and severity of chronic lifestyle diseases These topics included top causes of death among African Americans and their risk factors; preventing chronic lifestyle illnesses such as cardiovascular disease, some cancers, and diabetes; what the participants can do to mitigate against these lifestyle illnesses; and the relationships between education and knowledge from health promotion activities and the prevention of chronic disease. The participants listed several causes of death, including cancer, diabetes, hypertension, dementia, Alzheimer's disease, abortion, cardiovascular disease, traumatic gun violence, failure to thrive, and renal failure. Risk factors mentioned were obesity, lack of exercise, poor diet, and genetics. Each participant had some knowledge of some of the particular kinds of causes of death among African Americans and their risk factors.

Research Question 1

What are the perceptions of African American pastors about health promotion ministries? Interview questions 10 and 11 addressed the research question. Nodes created to relate to the interview question included opinion of health promotion ministries (HPM) and advocate for health. To ensure confidentiality, I labeled participants P1 through P8.

Advocate for Health

When participants were asked if they advocated for maintaining health within the church and community, responses were similar:

P1. Within the church, I should. I don't do it, again, I used to do it more often than I do now. As a pastor we are establishing leadership and vision and going in a direction as a church.

P2. Yes. Yes, within the church absolutely. I think I should within the community. I don't have a problem with that, but primarily in the church though. Promoting health in the community, not necessarily, no, but in the church, the congregation, absolutely.

P3. Yes! Once again because we are a tribal people in the sense of what our leaders are doing. We look to see how our leaders are responding You are the man of God or woman of God, and if you're not ultimately your own self-test of stewardship, then you have failed that extended bearer for us. So, I think that I am my first test of stewardship. To adequately take care of me (himself) sends a positive message to the congregation, so then they will take care of themselves.

P4. Definitely. Definitely. And we've been doing that since I've been pastor. The first year was so we could eat in a certain way. And within about 18 months in, we started changing what we do. So, when have meetings, we serve fresh fruits; we serve granola bars as opposed to cookies and ice cream, and that kind of stuff. When we eat, we eat turkey, chicken, baked chicken, and not much fried chicken, though we still have some fried chicken. But we are more cognizant of folks whose diets require a certain way of eating as well. So, we even cook differently. We serve thing differently as opposed to previous times.

P6. Yeah I think as a pastor, you have to educate. Just because we educate, doesn't . . . we don't educate saying that we believe that, that everybody will take it to heed. You know, that it's a we do it because we know that we have to do it. It is important for people to know about their health. Very much important. I have to do it from a moral perspective, I think. And particularly for my community if I'm black. I am

black, so therefore I know certain things. I know prostate [health] is important, your prostate examination. I had one. I believe to that point. I live by that I'll say brothers, you need to have your prostate checked. I know what you don't want to feel. I know what you don't want to go through. Right? But I have gone through it. It ain't that bad, but you need it for your health. Right? So I guess by me saying I've done it, that could help some brothers do it. And so if there's an opportunity, I try to do it to the best of my ability.

P7. Yes. I think, as a pastor, you're not just a spiritual leader. You're leading people so you're, a community leader. So health should always be at one of the forefront of your ministry and one of your community activities. Especially when you look at your community. We have people dying early from preventable diseases on a regular basis. And you want to alleviate that grief and stress from family members, and in order to do that, we have to make some conscious decisions on how we're living and what we're involved in so that you don't have someone at 45 die of a massive heart attack. That's preventable!

P8. Yes, I think that I have a moral obligation to do that.

Opinion of Health Promotion Ministries

P1. I think it is relevant, and there is a need as long as it is health that has a biblical base What do the scriptures say? The scriptures say a lot about health, a lot about the body and . . . but it is paramount and essential to have a health ministry in the church.

P2. I'm totally in favor of it, especially considering how at-risk our congregation or community is. I think it's important; it's essential actuall**y**.

P3. I think they are vital. I think it addresses what is my passion. I'm very concerned about the emotional, psychological, and scriptural well-being of the people

that I serve. So Matthew 9:35 is very critical to me Somewhere there has to be an intentional response to addressing those three components so that you can be well. If a person is well physically, spiritually and emotionally, then that is my definition of what it is to be well.

P4. Somehow, I do not have a response to this question. However, from previous questions, it is evident that the participant has a positive opinion of health promotion ministries.

P5. I'm with it. I think it is a great idea. You can't preach the fullness of the scripture without it.

P6. I think a health promotion ministry is important. I believe it's important**.**

P7. I think that, my opinion is that, they're important. They're vital, and they should have a focus. And a pastor should support it. If not, be part of it and encourage their involvement from the church and encourage activities from church members. [What] I love about the work that we do is, you could always go out and attach it to some form of service and some form of ministry. So, if we want to stress walking more, there's plenty of 5ks and that are around here that are attached to a cause. Breast cancer awareness, pancreatic cancer, the crop walk. You could help us raise money for this and the team members. We're gonna be dedicated to train each month in order to prepare for the 5K. And then, there you go. You've incorporated service and health in your ministry.

P8. I'm in full support of improving. It's gone through several changes I think all ministries go [through] this waxing and waning period when things seem to be going very well, and then things kind of drop off. What I would like to see is more consistent ministry. As I said, I think the vision is to put together a really nice health fair once a

year. And it was really good.; it was excellent. So, what I would love to see is just more consistent programs throughout the year that focuses on different health concerns. And I think, as you begin to cycle through, it becomes part of the pulse of the congregation. The congregation is concerned about healthcare in diabetes and being more active. And obesity, that becomes part of our character, and I think that aspect is what changes over time, throughout the congregation. So, I think it's really important that we can do some of that.

Research Question 2

What are the factors that affect African American pastors' decisions to implement a health ministry for their congregation? Interview questions six, seven, 12, 13 and 14 addressed this question. Nodes created to relate to the interview question included benefits of HPM, members positive change, outside opinion for HPM, barriers, and facilitators.

Benefits of HPM

P1. Providing a holistic ministry for the congregation. This ministry involves the total needs of the individual .You need healthy people to carry out ministry, members who were or who worked in the health fields [as] professionals, so we utilized those individuals in our church to conduct various workshops, and it was very, very helpful and they were able to network with other healthcare agencies that they knew, and we brought them to our church.

P2. We tried to minister to the total person: mind body and spirit There's a very symbiotic relationship between all of them so you can't separate and say that we take care the spirit, we take care the body, and we take care the mind So, if you can have programs

[and] ministries that related to taking care of the body from a theological standpoint is the temple of the Lord. Right? So the body is not demeaned in scripture, but the body is esteemed. [We] have ministries that encourage and that promote healthy habits and healthy lifestyles.

P3. Matthew 9:35: preaching, teaching and healing And the health ministry of the church is that healing ministry of the church. Whether it's mental illness, whether it has to deal with physical ailment, chronic or acute or what have you. I think that the health ministry is addressing Matthew 9:35 [about] healing, our health ministry, and others who have equipped themselves such as yourself and other ministries that churches have positioned themselves, particularly for our community. I think the ministry has done an amazing job in keeping the people aware.

P4. The meals we do now with events that require food, we tend to have more fruits and vegetables. We serve more water, less cakes and pies We try to give as much fresh vegetables as we can. We try to give cereals that are whole grains and things like that. So that's part of, holistically, what we're doing. Like I said, we have a mental health ministry, and what we're doing is having conversations around depression, health care workers, or those who are taking care of elderly. Some in the congregation are taking care of parents and dealing with issues and mental health.

P5. We have the exercise class, but [laugh] physical health is something that we tried to keep at the forefront, but you can't teach that and not incorporate physical health because the Bible is clear on this. The Bible teaches that our bodies are the temple of the Lord and the Spirit. The Bible also says any man who defiles God's temple, the human

body, God [will] destroy. This is why [in] our church, we teach that smoking is a sin. If that is not defilement, nothing is.

P6. I think it's stupid. I'll tell you why I think it's stupid because the church focuses on just the members [and] 95% of the members have health insurance or are intelligent. They know about all the correct things to do. The impact as far as the community is not inviting the community in. Or we're not having it for the community. We're not giving it to the community. And the community doesn't know about it. Most of the people out in the community that are struggling with jobs, struggling, they are the ones that have the worst eating habits and all that stuff. Right. Can't educate them because we're not going where they are to present the health care ministry. There is a health care ministry for the church. I think the majority of church folk know what they need to know to take care of themselves**.**

P7. So we have the benefit of having three registered nurses here at the church, and so they have done some great work. We have working defibrillators here I believe health ministries are important. I believe that they should be a part of the ministry that should have an active role, and they should have a say in, kind of like, the menu for events And one of our members who's a nurse has started, preparing a dish each week through a, through a healthy option. So, when people eat the dish, that gives her an opportunity to say, [she] didn't use salt or didn't use lard, I used this or I used fresh basil or I used fresh parsley, so just, just those informal means of relations and communication allow people to begin thinking [they] maybe shouldn't use as much salt, or could find another option. And I've seen that happen with our members where they're actually asking questions. "How did you say you made that again?" or" What was in this again?"

Really? Or “Are you going to the farmer’s market? Let’s go together.” So that, I think, as the health ministry becomes more integrated, those informal types of connections happen. I think health ministry is very vital, and people who are part of the ministry should use any opportunity they can to promote health, even small talk just to say something like “Did you follow up on your doctor?”

P 8 I think any church and this is my philosophy about churches, the church should be concerned with the whole life or the total life of its congregation and its parishioners, not just spiritually but in terms of our health--physical health, mental health, our spiritual health, our relational help--all those things, I think, are important aspects of ministry for any church. For me, I think the health and wellness ministry plays a vital part in the health, the total health, of the congregation. Right now, in our congregation, we have members who are going through cancer or cancer treatment and people dealing with other kinds of health issues And when the physical body is impacted to that degree, it impacts so many other things in our lives. It impacts how we’re able to engage spiritually. It impacts the relationships with our families, friends, how we feel about ourselves. And so I think that a health ministry helps the total life of the church deal with and engage in those kinds of issues so that we can be more supportive of each other.

Members’ Positive Changes

P1. We had certain members in our church in leadership who had health issues, and because of those workshops, they were able to, you know, have that need met and went on and lived long healthy lives. They had health issues that they didn’t know they had.

P3. Absolutely! Absolutely! Yeah, people began to make little subtle modifications based upon what they stated, present company included Nothing radical but a slow movement, but there will be movement because there's always somebody that's listening.

P4. Definitely. Like I said, we have this food pantry. so we started doing some demonstrations of doing more healthy cooking and emphasizing meals that are simple and easy to make that are not as costly, like taking skin off chicken. The women have gathered and do a boot camp throughout the summer, and on every Wednesday evening, they have folks who come to address health care issues around breast cancer awareness, and eating and diet and cooking and those kinds of things.

P6. No, I do believe in educating, I just don't know if education if educating is creating the atmosphere of prevention. Right? Because prevention, giving knowledge for prevention, means the people actually have to take it and receive. Most folk, like everything else, it doesn't become a concern to them until it becomes a problem for them. Young folk don't even listen no more. They are the invincibles. Right? The older generation, they already, you know, some examples. For instance, men's prostate examination. We can educate them, but there's a certain generation that no matter how much you educate, that examination's just not going to happen to them. I just don't know if educating is creating prevention for them to receive it.

P7. Definitely, absolutely. I think they would. I think they, like I said before, when you know better, you do better.

P8. I think some will. Yes. I think some will [laugh]. I would love to say that, yes, we all would. I believe some will, but I also believe that it happens perhaps some at a

critical point when they realize they must make a change, and so I think that's when the health and illness ministry helps if it's an ongoing ministry and not just offering one program a year. That gives people the opportunity to make changes, lifestyle changes, and evaluate their health in a way that's productive for them.

Outside Opinion for a Health Promotion Ministry

P1. My wife for one [laugh], the leaders around me, the professionals that are around me, their opinions. I value their opinions, friends who are in the health field.

P2. So when I came here, they actually already had a health and wellness ministry. It wasn't as active as it is now, but we have a member in our congregation, a couple of members, that are very health conscious. The woman who actually leads the ministry is very health conscious, and they're passionate about the promotion of healthy habits, so she talks to me about different ideas that they want to do, and I'll give them my full support.

P3. I don't know that there's a single person, as much as there's a single need, a single need that will present itself as a community need. And then that then becomes a way that you serve for the purpose of addressing the community. Now we know that HIV/AIDS is very high in the black community, so that need, then, forces us to deal with that topic. We know that prostate cancer is very high in the black community. And so, the need for having addressed itself usually comes from the purpose, comes from within the context of someone's context And until it becomes real with me, then it may not really get traction in the heart of the community If I feel it and have experienced it, then that becomes the passion that brings me to healing.

P4. It was kind of, I would say, particularly with the mental health ministry, with the food pantry and the physical health issues and dietary needs that came as a result of the grant, it was partly a biblical theological rationale. Oftentimes, food pantries will give out any type of things because they give in bulk and, you know, processed food is already issued in our community. So we made a conscious effort that, even though it might cost [the church] a little more, we will try to not give processed foods as much as possible. Because we feed a lot of children and we want them to be healthy I'm studying in the field of mental health.

P5. [pointing to himself] Number one, because I greatly benefited over the years from working out. Well, it helps me preach. I can preach hard for a long time, and my energy [is] strong."

P6. I don't think it was a particular person's opinion. I think what it is, is that you can't be a pastor and be in isolation. Right? So, you want to have a ministry that is helpful for the congregation and for the community, and I think that having a health ministry is just, you need to. You need to have it here. The majority of the population here is African American.

P7. Because I have nurses here, [and] I listen to them. So, those health professionals who are members here were very influential in me saying that we need to focus on a health ministry. And also my wife because of my own personal health and my family's health history.

P8. I think for me it's probably coming more from what I understand this ministry that I have is about. And where the congregation is in terms of its readiness to do certain things. And [the congregation's] receptivity to certain things.

Barriers

P2. I wasn't here when [the health ministries were] initiated, but as they became more active over the years, there hasn't been any barriers. Yeah, you know there hasn't [*sic*]been any barriers to the health and wellness ministry. But participation and things of that nature, is it as strong as some of our other ministries? No. But, no, there's no opposition to health and wellness. No barriers, no.

P4. No surprisingly, not typically, there have not been [barriers], and people have appreciated, since they may have some personal health concerns, which help address some of the dietary needs [in the cooking] of the congregation.

P5. Not really. Not here. People who don't want to, don't have to. People who like it can.

P6. Two barriers. One is, having folk who are willing to work. I don't believe a church can do everything. So, I think an effective health ministry is more about partnerships. But having partnerships that are not afraid of the relationship between the church, I think that both partners need to understand that they need each other to be, to have a great impact Some folk want to use church as a safe haven You don't come to church to hide if the people, people compartmentalize where they work, their vocation to Sunday at the church. And that's probably the biggest barrier. I think your profession is part of your gift. Right? And I think the gift that you have is a gift that comes from God. So, if you have it, God wants to use it in the church. The priority, but some folk don't want to believe that. Overcome that through teaching and preaching. And helping folk understand that whatever your gift is, whatever your gift is, that He wants you to use,

ultimately, it's a sacrifice, and no matter how much of a sacrifice it is, it still does not compare, at least in my tradition. It still does not compare to the sacrifice He made.

P7. Lack of education and trying to teach people how to integrate it (health and their educational experiences). That has been a challenge. Because normally it's been like, oh, we'll just do a session and then that's it. I want us to live it and experience it. And that changes our consciousness and so when we are, as my generation says, WOKE about something, it helps our life to shape it around what we are woke about. So that was the barrier. It's still a barrier that we're trying to get through, so fortunately enough, I have a membership that is open to it and making strides to do, to do just that.

P8. I think one of the barriers is a barrier that we have in almost every church of any size. And that is the level of participation in terms of finding not just people who will attend the event, that's not necessarily it, but people who are really called to lead those ministries and really be committed to its growth and its vision. The other challenge has to do with the busyness of people's lives and investing part of that time into anything, including a ministry in the church. I think that's a general challenge that we have. As pastors, we know that our parishioners are busy, busy with their work, with their families, other obligations. Just carving that time out to dedicate to the ministry from a leadership perspective is kind of hard. It does require a big sacrifice, and that's not always easy to find.

Facilitators

P1. This interview is good because it's a motivation; it's bringing this awareness to me. I would think that consulting health providers that are already established [like] hospitals, community health organizations because there are individuals who are involved

in the health field who donate their time to nonprofit organizations without cost to get it started.

P2. Announcements [should] have a strong communication about what the health ministry is trying to accomplish within the congregation. It's also promoting opportunities for people to consider their health to participate in their program, to that nature, and improve their health Supportive leadership, supportive pastor, or whatever leadership structure you need to support so that they, specifically in an African American context, the pulpit. What is said across the pulpit is given greater weight. So, if the pastor can speak about health across the pulpit, it would help the congregation and give attention to it.

P3. But in my last work [church], it was the death of a loved one. And the consistent deaths of others with the same situation. So, not just one person, but now when you see several with the same thing, you say his prostate cancer must be pretty big, and most of the men that has passed in this church died of prostate cancer, which is 100% treatable So while it may not be preventable, it is treatable. With awareness, the time and your life is not affected but the prostate cancer is what lit this congregation to fire in dealing with the problem of cancer Because of what we've seen.

P4. Part of it came as a result of the stipulation of a grant that we start providing classes or information. [Because of an] overall desire for healthiness, we've had a group of women who started walking. [Church members] started walking as a group in the neighborhood. They started walking in the mall, and THAT led to we should start eating differently. And so in the way it bubbled up from the ground, but a lot of it was in fact that folks were getting older. We have recognized that we have lost some congregation

members who have not tended well to their health, and if there's something we could do, proactively about that. There's a responsibility within ourselves, but also the spiritual responsibility to take care of our bodies.

P6. Willing bodies. We can initiate anything if we have willing bodies If you get partnered with the right people. Right? And it ain't about just who gets the honors. As long as it happens for the community, God gets the honor.

P7. Again, having people who have life experience with the difficulties of health. We have a lot of elderly members, and seeing the shift from well to not well, and having people witnessing that. Because we want [a member] to be here a little while longer. If she doesn't eat this, and so in order for her not to eat it, we can't eat it! Right? Or I had a 91-year-old, remember, this past year diagnosed with breast cancer. Yeah, so now it's a conversation during Breast Cancer Awareness Month, and we talking about here at church; everybody needs to get a mammogram. Everybody needs to go get a mammogram. Or prostate awareness month. And because they are hitting them, we need to have a conversation about it so that we, not only support them, but in supporting them we help ourselves. So those experiences have really helped us begin incorporating this in our dialogue. Those experiences were conversation starters**.**

Themes

I created themes by reviewing the interview responses of each participant. The responses were categorized under nodes. I looked for patterns in the nodes and found that many of the participants' responses were similar. The actual words may not be similar, but the general messages conveyed in the responses were similar. These phenomena were not present just within separate interview questions but spanned across multiple interview

questions. These themes revealed the similarities in the participants' views of health and health promotion.

Theme 1: Importance of Health Promotion

All but one participant had a health promotion ministry in his or her church; however, all churches had some type of health promotion program. Although the health ministry of P8 held a successful large health fair, a health promotion ministry does not have to hold large events. P7 uses service to the community as one of the forms of health promotion. Participation in a 5K race for breast cancer or pancreatic cancer awareness encourages church members to exercise while raising money to create awareness of a need. Participation in Habitat for Humanity activities requires physical work. Church members get exercise while performing community service. These are some of the ways health promotion is portrayed. Also, incorporating dialogue about everything from food to illnesses is another method of encouraging health promotion. This participant stated "and because they are hitting them [diseases], we need to have a conversation about it so that we, not only support them, but in supporting them, we help ourselves. So those experiences have really helped us begin incorporating these in our dialogues. Those experiences were conversation starters."

The health promotion ministry of P5's church included exercise classes as part of the health promotion ministry. The development of a food pantry with fresh vegetables is part of P4's church's health promotion ministry. Referring to the community, P4 stated, "We should provide them with healthy food. We will try to not give processed foods as much as possible because we feed a lot of children, and we want them to be healthy." This participant also has a mental health component as part of the health promotion

ministry. P1 did not have a health promotion ministry in the church; however, it had workshops that addressed health issues. “Because of those workshops, they were able to, you know, have that need met and went on and lived long healthy lives. They had health issues that they didn’t know they had.” The health promotion ministry of P2’s church holds exercise classes, invites speakers, and conducts healthy eating classes as part of their ministries. They’ve incorporated what they learned in the food preparation classes into the church’s policy. “We actually have a policy for food here and things of that nature.” P3 and P6 also have health promotion ministries, even though P6 has some negative feelings member participation. Each participant showed how health promotion activities were important parts of their churches.

Theme 2 Pastoral Support

All participants supported having a health promotion ministry in their churches, and most thought having such a ministry was vital. P3 stated, “Because we are tribal, if you will. We have a sense of the pastor leads the charge. Pastor gives the direction.” P6 stated, “I think that having a health ministry is just . . . you need to. You need to have it here. The majority of the population here is African American. If you know that all the things that African Americans are dealing with, i.e. diabetes, why don’t you have a health ministry that speaks about diabetes for the person that may have diabetes? And help them be free if it’s an opportunity to reach . Then I will. And so, if there’s an opportunity, I try to do it to the best of my ability.” P2 supported having a health promotion ministry in his church, but he does not focus on community involvement. He stated, “Yes, within the church absolutely. I think I should within the community. I don't have a problem with that, but primarily in the church, though” When asked about advocating for health

promotion ministries, P4 said “Definitely. Definitely, but we also cater to the spiritual/biblical component because we have a responsibility to take care of this temple (the body). And taking care of the temple is more than just coming to church and getting your praise on. But you have to take care of the physical body.” P5 stated, “I'm with it. I think it is a great idea. You can't preach the fullness of the Scripture without it.” P7 not only supports having a health promotion ministry, he thinks pastors should be a part of it. “I think, yeah I think that, my opinion is, that they’re important. They’re vital. and they should have a focus. And, a pastor should support it. If not, be part of it.” P8 stated, “I’m in full support of it , improving it.” P1 does not have a health promotion ministry at his church at this time so he hasn’t supported the ministry; however, he stated, “I think it is relevant, and there is a need as long as it is health that has a biblical base.” All participants, in some way, supported a health promotion ministry in their churches.

Theme 3 Pastor Influence

I asked all participants if they followed a health improvement regimen. This question did not directly support the research questions; however, I found it imperative to understanding the participants’ influence over the members. Each had a health improvement regimen they followed daily or weekly. Their changes in physical health the congregants could observe and the pastors’ attitude influenced the congregation. Health practices, for example, having health screenings, can influence the congregants. The participants discussed how their changes in health influenced some congregants to make lifestyle changes. The results of this regimen played a role in most participants’ attitudes towards their role in influencing church members to become healthy. P1 stated, “if we serve in any leadership capacity, as I do, then I am a role model. And I know that

if my regimen, my exercise regimen, tends to motivate both men and women in our church, so, yeah I don't want to be fat and out of shape. I mean, that's just not a good testimony I just try to live it out, but they see it, and they model it."

Regarding influencing others to adopt a healthier lifestyle, P5 stated, "But ministers set the pace. If the minister is into health and wellness and that kind of thing, the members will follow because that's what shepherds do. Shepherds set the pace." P4 recently lost weight. He commented, " I talk about it personally from the pulpit. They've, the congregation, noticed that I've lost weight But I think it is important for the pastor [to] set an example as well as speak about it because, when I give voice to it, that gives a little more credence to it and that I should be thinking about these things."

In terms of health and wellness, P3 believes he leads the way: "We have a sense of the pastor leads the charge. Pastor gives the direction. Pastor's lifestyle tends to heavily influence the lifestyle of the church." P6 does not believe his health influences the health of the church members due to his age; however, he influences them in his actions. When speaking about the importance of a prostate examination, P6 stated, "I've done it. That could help some brothers do it. We had the HIV/AIDS test and right there in the pulpit, I let them come in and take my blood. Right? To show that I'm doing it, you can do it too." P6 also thinks a pastor should influence his church member about health issues. He stated, "A pastor needs to use his influence over its flock because the congregation is going to follow him. He needs to use that influence for good as a basis of their health." P7 believes he influences his church. He gave an example of how he decreased stress by taking a break. He stated, " Being active, and so when my congregation saw my change and saw me stressing Then taking vacation time, relaxation,

time, and resting time they, too, began taking that on and [realized] if you go, go, go, go, go, and you don't take the time to stop and rest, you're running yourself weary. And so, we have made it very important to have Sabbath here at the church. So every Monday, here at the church, everything is closed." P8 walks regularly and is in the process of increasing [his] activity level. "My health does influence the health of the congregation; it may not be a definite causal effect, but it's influential." Each participant also presented how their influence had helped to change the health habits of some of their church members.

Theme 4: Health Status of Church Members

The health status of church members had an impact on the participants' decision to form health promotion ministries. Both healthy and ailing church members impacted the participants' decision. P3 shared, "it was the death of a loved one. And the consistent death of others with the same situation. Not just one person, but now when you see several with the same thing so you say his prostate cancer must be pretty big So, while it may not be preventable, it is treatable. Prostate cancer is what lit this congregation to fire in dealing with the problem of cancer."

P4 church members sparked a church dietary change. "Thinking about eating differently" also came from other members of the congregation. A minister who had cancer several years ago dealt with her cancer by changing her diet " Congregants of P5's church held exercise classes. "We have people in here who are trainers who would do exercise classes " Members of P2's church led the charge due to health consciousness. "We have a member in our congregation, a couple of members, that are very health conscious, and they're passionate about the promotion of healthy habits " Having older

congregants who may be ill enhanced the health consciousness of P7. He stated, “People who have life experience with the difficulties of health, we have a lot of elderly members, and seeing the shift from well to not well, and having people witnessing that and now we have to have a conversation about, well what happened ” P8 has members dealing with cancer and other illnesses and stated that health promotion ministry creates support for the congregants. Each of the participants had church member at various levels of health, ranging from very healthy to extremely sick and dying. No matter the stage of health, the participants were able to use that state of physical being to promote good health.

Theme 5: Barriers and Facilitators

Throughout the interviews, participants mentioned the congregation as the most salient facilitators. P8 commented, “Healthcare professionals who work in our church have a crucial part in the ministry.” P6 said, “Willing bodies. We could initiate anything if we have willing bodies.” Other participants mentioned the willingness of their church members to take part in the ministry as the key component to having a successful health promotion ministry. If a participant mentioned a barrier, the most common barrier mentioned was the lack of church member involvement. Most participants did not say that lack of participation was a problem. I would like to note that finances were not mentioned as a barrier. Most of the participants mentioned that there was support for health promotion in their budget. Only one participant mentioned that finances could be a possible barrier.

Discrepant Cases

While most participants found that having a health promotion ministry at their church led to positive health changes in their congregants’ lives, one did not agree. This

participant thought age was a factor that, at least in the matter of health, congregants could not see past. This person felt that being a younger pastor did not influence the congregation because a young pastor was expected to be healthy, so they could not look to him as an example of health. However, this same participant thought it was so important to have health promotion in his church that he did a prostate and HIV/AIDS screening just to be an example of the "If I can do it, you can do it" mentality. That display was aligned with the attitudes of the other participants regarding their commitment to health and the health of their congregants.

Summary

The purpose of this study was to investigate the attitudes and beliefs of African American pastors when making the decision to support or reject a health promotion ministry in their church. The tradition of a phenomenological study focuses on the experiences of the research participant. The results present in this chapter were responses to the interview questions, which subsequently answered the research questions. Research Question 1 concerning the perception of African American pastors about their health ministries was answered by expressing the importance of a health promotion ministry to addressing the health needs of the congregation. Understanding the health needs along with the knowledge and experiences of the congregants answered the second research question that pertained to the factors that affect African American pastors' decisions to implement a health promotion ministry. Finally, Research Question 2 concerning facilitators and barriers was answered through the description of the availability of knowledgeable individuals willing to participate in the ministry. Chapter 5 will summarize the findings of the study and present the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this phenomenological study was to investigate the attitudes and beliefs of African American pastors when making the decision to support or reject the implementation of a health promotion ministry in their church. The focus of the research was to identify what drives church leaders to develop health ministries. In this qualitative study, I used a phenomenological approach to obtain information about pastors' perceptions and experiences that influence their opinions of health promotion programs. Semi-structured interviews were used to prompt responses from the pastors. The responses were analyzed and formed themes that were scrutinized to answer the research questions. The study revealed that the importance of the health status of church members, the pastors' support of health promotion, the importance of health promotion to the church leader, influence of the church leaders, and facilitators and barriers were all important factors when considering health promotion ministry.

Interpretation of the Findings

The findings of this study were based on the health belief model, which was the foundation of the interview guide. The HBM was developed to explain and predict health behaviors by studying beliefs and attitude towards health services (Glanz, Rimer, &Viswanath, 2015). Concepts of this model are perceived severity, perceived susceptibility, perceived benefit, perceived barrier, cue to action, and self-efficacy (Glanz et al., 2015). These concepts helped me to understand more fully the pastors' experiences with health and health promotion. Due to the nature of the study, the participants were similar in that they were all African American pastors of African American churches; however, their experiences as pastors were different. As the study progressed, the

uniqueness of the participants was manifested in themes used to interpret the attitudes and beliefs of the participant toward health promotion ministries. The study findings are presented in Table 2.

Table 2

Study Findings Related to the Health Belief Model

Constructs of HBM	Explanation of how pastors' responses related to HBM	Pastors' responses to interview questions in terms of the HBM
Perceived susceptibility and perceived severity	Pastors' perceptions concerning the health risks among congregants.	Knew health concerns (especially chronic diseases brought about by lifestyle) of their congregants and the community.
Perceived benefits	Perceived value of a health promotion ministry in addressing health disparities.	Thought health programs encouraged some to live healthier lifestyle by changing their own diets, becoming more physically active, or engaging in medical screenings.
Perceived barriers	Specifically addressed the costs or actions that are associated with hindering the development of a health promotion ministry.	Some stated that lack of participation hindered the development of health programs.
Cues to action	Facilitators that encouraged starting a health promotion ministry.	Said watching congregants in various stages of health (from healthy to death) encouraged them to advocate for health promotion programs.
Self-efficacy	Had confidence in their ability to develop a health promotion ministry and ensure its success.	Pastors were confident about the development of a health promotion ministry and understood how or who to contact for help when needed.

Responses to the interview questions revealed how the HBM was instrumental in understanding several characteristics of the pastors. The knowledge that each pastor has

of not only health concerns of their congregants, but of African Americans in their communities, demonstrated a concern about the perceived susceptibility and severity of lifestyle chronic diseases that plague these communities. The majority of pastors are ready to promote health. They are confident and understand how or who to contact for help when needed; this describes self–efficacy. Watching members of the congregation in various stages of health from very healthy to dying demonstrates a cue to action that propels most pastors to start a health program. Some of the pastors stated that watching their congregants become sick or die made them want to help prevent such a fate in others, so they advocated for health programs in their churches. In the case where a participant did not have health promotion ministry, the participant advocated for a health ministry. The church had several programs, but at the time of this study did not have a health promotion ministry.

Theme 1: Importance of Health Promotion

Each participant expressed the belief that health promotion was very important in the church. One participant called it "vital." Another called it "essential." Another said the health promotion ministry was "very important." No matter what terms were used, all participants thought health promotion was or should be an important part of church life. Several stated there was a link of mind, body, and spirit when it comes to preaching. "We try to minister to the total person: mind, body, and spirit " The health ministry provides the "body" link. Another stated, "You can't teach and not incorporate physical health." This theme corresponds with the theme from Webb et al. (2013). His results showed that some pastors think that health promotion is part of the religious experience and that there's a link between spirituality and health (Webb et al., 2013). Lumpkin et al. (2013)

also demonstrated the importance of health promotion. Participants in that study stated that it was necessary to combine the teachings of the scripture and advocate health. Research by Williams et al. (2012b) showed that church leaders not only thought promoting health was important, but they thought that church was an appropriate place to promote it. Participants supported health promotion by preaching about it from the pulpit. One stated that the pulpit is sacred; however, it is not so sacred that it cannot be used to help the congregation with their health situations.

Theme 2: Pastoral Support

All participants supported having a health promotion ministry in their churches. The shared support of health promotion ministries was summed up by a participant who stated. “I’m totally in favor of it, especially considering how at risk our congregation or community is.” Another participant stated, “We have a moral obligation to advocate for a health promotion ministry in the church.” Earlier studies conducted by Collins (2013) suggested that pastors supported health promotion programs and that their support was vital to its success. Results of the current research support that statement. It is also supported by the research study conducted by Timmons (2009). Participants in her study indicated that if the needs of the community are not met, then the church must serve as a link between the congregants’ needs and community services that are supposed to meet those needs. A participant in that study stated that he advocated for the things people are not getting but should get (Timmons, 2009). A participant in the current study stated, “ Health should always stay in the forefront of your ministry especially when you look at your community. We have people dying early from preventable diseases. You want to alleviate that grief and stress from the family.” Again, all participants had a positive view

about advocating health promotion and health promotion ministries in their churches. This study concurs with current literature concerning the support of health promotion ministry in the church.

Theme 3: Pastor Influence

A salient theme from the interviews was how the pastor's health and health regimen influenced the church members. Only one participant indicated he did not think his health influenced the health of the congregants. He influenced the members by being an example. He underwent a PSA examination and gave blood when discussing the importance of having annual physicals and HIV/AIDS testing. Although it was not his health and health regimen that influenced the congregation, his actions did influence them. Meanwhile, the other participants stated that they believed they greatly influenced the health of their congregation. A participant who exercises regularly stated, "Members don't want to see a preacher with a potbelly talking anything about nutrition. There's something inconsistent about someone who says that they shouldn't eat this or shouldn't eat that, but you look as big as you do. If you don't see what you hear, that kills the message " In another statement about church leaders who were overweight, a participant from the Baruth et al. (2014) study stated, "How can you talk to your congregation at all about health and wellness or about a lot of issues when you look the way you look?" This theme was also apparent in research conducted by Lumpkin et al. (2013). In that study the pastor's personalization of health theme showed that the pastors used their health and health behavior to communicate the urgency of adopting a health promotion program. The pastor's health, in that study, was one of the decision-making factors leading to initiating a health promotion program in the church (Lumpkin et al., 2013). Research by

Baruth et al. (2014b) also indicated that church leaders felt their health and health behavior influenced their congregation. Their study included participants who were African American as well as non-African American church leaders. The theme was similar to the theme of the current research. This led me to believe that the current theme may span different ethnic boundaries. More research is needed into that topic.

Theme 4: Health Status of Church Members

Another theme considered the health of the congregation. All participants in the study revealed how the health status of their church members impacted their decisions about health promotion in their churches. The health of the congregants ranged from healthy vegetarian to deaths from cancer. A healthy vegetarian member sparked the interest in health promotion in one pastor. Witnessing members die from preventable diseases sparked another's passion for having a health promotion ministry. This theme was apparent in research conducted by Lumpkins et al. (2013). Although the theme did not explain the impact of church members' health on the implementation of a health promotion ministry, it did reveal how mentioning the health status of a church member brought attention to health promotion. This also occurred in the current research. One of the participants stated, "Having people who have life experience with difficulties in health and seeing the shift from well to not well [means] we have to have a conversation" At this church, openly speaking about health problems was a method of providing awareness of the condition and need for education for prevention and treatment.

Participants were aware of the health problems that disproportionately affect African American people and their risk factors for contracting diseases associated with lifestyle practices. They were also aware of the health status of many of their

congregants. Participants indicated that the health problems include, but are not limited to, diabetes, hypertension, cancer, inadequate sleep (often associated with job hours and responsibilities), inactivity, poor nutrition, renal disease, and lupus. While understanding the needs of the congregation influenced the participants to promote and initiate a health promotion ministry, the readiness of the congregation to have such a ministry influenced another participant.

Research from Rowland and Isaac-Savage (2013) indicated that it is important to understand the pastor's perceptions, motivations, and barriers to promoting health education in the church. They also stated little is known about how pastors feel about health initiatives and intervention (Rowland and Isaac-Savage, 2013). Current literature concludes that there is limited literature on the how the health status of church members affect church health promotion. The themes discussed in this research study add to the knowledge of pastor's role in health promotion.

Theme 5: Barriers and Facilitators

Throughout the study, participants commented that the church members were the most important facilitators. Church members who are willing to use their talents and time to become involved in health promotion were consistently regarded as the greatest asset to initiating and maintaining a health promotion ministry. The participants showed that church members who are both healthy and ill contribute knowledge and the opportunity to expand the health promotion ministry. However, the lack of member interests and participation, though not mentioned by most participants, was one of the barriers. It is important to note that funding and facilities were not considered an important barrier.

Limitations

The first limitation was that the sampling technique was purposive sampling. This technique accumulated data that only represents individuals from African American faith-based churches in urban, suburban, and rural areas of Wake County in North Carolina. Therefore, the findings of this study cannot be generalized and therefore may not be applicable to dissimilar churches in other states. Studies of one specific ethnic group may not reflect the thoughts and experiences of other ethnic groups (Steinhauser & Barroso, 2009). However, the purpose of the phenomenological study was to understand the experiences of selected participants. (Sanders, 1982). Therefore, due to the nature of the stud, this limitation was permissible.

Another limitation was lack of participants without health promotion ministries. Because I was not able to have many participants without a health promotion, I was unable to fully get accurate information from church leaders without health promotion ministries. Because I have only one participant who represents this population my data may not reflect what other church leaders without a health promotion ministry might experience.

Another limitation was the small sample size. Creswell (2013) recommends between 5 and 25 participants. I originally planned to interview 10 participants. But due to lack of interest or time of the pastors, I decreased the number to eight. In a qualitative research study, the sample sizes may be small if the data reaches the point of saturation. By the eighth interview, I realized I was not hearing new information, that no new information would come from additional interviews, and that I had reached the point of saturation. Also in phenomenological studies, sample sizes are usually small as long as

the information provides a rich description of the lived experiences of the participants. Because the study was phenomenological, these limitations are accepted.

Recommendations

After conducting this research and reviewing the data, I would suggest future researchers to increase the sample size, which would provide for participation from a variety of churches of various denominations and sizes. Although saturation was achieved to the point the responses became repetitive, a larger sample size should provide a richer description of the experiences of the church leaders.

Another recommendation is opening the participant pool to African American church leaders in other areas. Many cited studies about church leaders and health promotion took place in Southern states on the East coast. Including church leaders of other areas would provide a richer description of the perceptions of African American church leaders about health promotion ministries in their churches and whether to include the ministry in their churches.

A practical recommendation I would make is to have public health practitioners develop a partnership with Africa American pastors and their churches to have health promotion programs in the church. This way the church could obtain resources such as up-to-date health information, including scientific information on disease prevention for richer program. The church could provide the information on how to make the program culturally appropriate for the target audience.

Implications

The interviews provided rich details of how participants felt about health promotion, their influence on the health behavior of the congregation, and their

advocating for health promotion ministries. Positive social change could be realized by using this information to increase the effectiveness of culturally sensitive health information and developing health education that specifically targets the African American faith community. Information from this research could provide information that could help guide public health agencies on how to approach health programming in this specific area. Studies by Tussing-Humphreys, Thomson, Mayo, and Edmond (2013) showed that health promotion programs that are culturally based and have the blessing of church leader are more effective than those programs that are not culturally based and not have the blessing of the church leader. Themes from this study showed that church leaders are aware of the health status of their congregants. They also understand health behavior, the risk factors of some preventable diseases, and how education through health promotion could encourage their congregations to change unhealthy behaviors to healthy behaviors. Public health agencies could use the themes realized in this research as a basis for future health promotion strategies when targeting African American communities. Long-term social change implications include the development of partnerships between churches, nonprofit organizations, and public health agencies.

The use of phenomenology and the HBM in this study was appropriately used to describe health behavior and the decision about whether to have a health promotion ministry. Recommendations from this study show that the themes from the church leaders, partnered with public health agencies and nonprofit organizations, may result in an effective way to deliver culturally specific health promotion to African American communities through the community churches.

Conclusion

It is important to understand church leaders' perceptions and belief about health promotion ministries. The current study showed that church leaders have insight into the health of their congregants. They also have an appreciation of health and fitness on a personal level. This research also showed that some African American church leaders not only have personal health regimens to get healthy and stay healthy, but also use this personal knowledge to influence the health of their congregation both in and out of the pulpit. They are knowledgeable about health disparities and the health problems faced by their congregation because of these disparities. They also use this knowledge to help initiate or sustain the health promotion ministries in their churches.

As health disparities continue, literature on how to deliver health information to the underserved population will continue to grow. This study contributed to the current literature by providing a rich description of the attitudes and perceptions of African American church leaders concerning health promotion ministries and the facilitators and barriers of initiating or sustaining such a ministry. The information from this research can be used by public health agencies to learn how to develop culturally specific, faith-based health programs and to gain access to knowledgeable church leaders to assist in forming partnerships to aid in the development of health programs.

This information might help other church leaders and public health practitioners better facilitate and expand faith-based health promotion. Most importantly, it might help to facilitate extending health services to African American communities, thereby decreasing health disparities of the population.

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Appendix A: Participation Letter

Dear Pastor _____:

My name is Brenda Watson, a PhD candidate at Walden University. I live in Fuquay Varina in Wake County and have been a member of Watts Chapel Baptist Church for over 20 years. I am conducting a research study to identify those factors that facilitate or serve as barriers to the development of a health promotion ministry. I will use a phenomenological approach to examine the factors concerning pastors' decision-making process to include health promotion ministries in their church**.**

You are invited to participate in this study. You were selected as a possible participant because of your position as senior pastor or minister in your church.

Your participation will involve an interview with the researcher. The interview may be conducted in person at a convenient location of your choice and will be recorded by the researcher with written notes and using a digital voice recorder. It is estimated that the interview will take between 45and 60minutes.

If you are interested in participating in the study or have any questions you may contact me at:biwatson@waldenu.edu

Thank you very much.

Sincerely,

Brenda Watson

Appendix B: Script for the Interviews

Script to be stated before proceeding with the interview

Thank you for agreeing to meet with me today. My name is Brenda Watson, and I am a PhD student in Public Health -Community Health at Walden University. I also live in and worship in Wake County. I want to understand how you made the decision to have or not have a health promotion ministry. The purpose on this study is to identify, as the church leader, what factors make it possible for you to have a health promotion ministry or prevent you from having such a ministry. Once completed, this study will help other pastors who are starting out or thinking about having a health promotion ministry develop strategies for making their own ministry. Increasing the number of these ministries could expand health promotion in our communities and could potentially help individuals become informed about healthy living and health services to help decrease the disparity and formulate a health initiative.

Appendix C: Demographics

1. What is your age? _____

2. Gender M F

3. How many years have you been a pastor? _____

4. How many years have you been the pastor of your current church?

5. What denomination is your church? _____

6. What is your level of education? . Some college . Bachelors .Masters . Doctorate

7. What is the size of your congregation? _____

8. What type of community is your church located in? Urban Suburban Rural

9. Do you have a health promotion ministry? Y N

Appendix D: Semi-structured Interview Guide

Date _____

Interviewee: _____

1. Introduction: Thank you for agreeing to participate in this research study

Knowledge of health concerns

1. There's a persistent gap in health between African Americans and non-African Americans.

In your own words, what does this statement mean to you? [HBM – health]

2. In your opinion, what do you think are the topcauses of death in African Americans? What are their risk factors? [HBM-health]

3. What do you know about preventing lifestyle illnesses like CVD, some cancers, diabetes, and the risk factors that lead to these diseases?

4. How much do you know about the relationship of life-styles and things you, as an individual, can do to prevent the illness mentioned earlier?

[HBM- health]

5. What do you know about the relationship between education through health promotion and the prevention of chronic disease?

[HBM-health]

Attitude towards perceived congregation's benefit of a health-related ministry

6. What do you think are the benefits of having a health-related ministry in your church?

7. Do you believe church members could/would make positive lifestyle changes because of things learned from the health-related ministry? Explain.

Attitude and opinion towards maintaining personal health

8. Do you have a health improvement regimen? If so what is it?

Attitude towards perceived role of pastor in promoting health in the church

9. Do you think your health is influential on the health of the congregation? Explain.

10. Should you as the pastor, advocate for maintaining health within the church and community? Explain.

Factor(s) that influenced (or will influence) pastors' decision to have a health and promotion ministry

11. What is your opinion about having a health promotion ministry in your church?

12. Whose opinion is/was important to you when considering initiating or continuing to have a health promotion ministry?

13. What are / were the barriers you face when initiating a health-related ministry? How did you overcome the barriers?

Please explain.

14.What are the things that helped to facilitate the initiation of a health-related ministry?

15. Is there anything else you'd like to mention before we close?

This concludes our interview, is there anything else you would like to add?

This is the end of the Interview. Thank you very much for your participation

Appendix E: Background of expert panel

Expert 1

The first expert is a male pastor of a North Carolina church. He holds a Ph. D in Divinity and has been a pastor in the community for over five years.

Expert 2

The second expert is s male pastor of a North Carolina church. He is also one of the department heads of a university in North Carolina.

Expert 3

The third expert is a retired male pastor of a North Carolina church.