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Congregational Health Promotion by African American Female Pastors in the Christian Faith

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2018

Abstract

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MPAS, University of Nebraska, 2010

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Dissertation Submitted in Partial Fulfillment

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Abstract

Health disparities have mostly affected African Americans who are poor, uninsured, under insured and unemployed. This population of African Americans seek spiritual solace and social counseling from their pastors, and church-based health promotion (CBHP) offers the opportunity to reach millions of the U. S. Black population. The lack of studies on female African American pastors implementing congregational health promotion activities influenced this study. This qualitative study helped in understanding the experiences, perspectives, and influences of 13 female African American Christian pastors on health-related issues within their congregation. Feminist theory and CBHP model guided this qualitative case study. Open-ended interview questions, field notes, and audio recordings were used to collect data. Data analysis was done using constant comparison method. Open coding and categorizing were done to develop the final themes and subthemes for the study. This research study has the potential for other researchers to replicate this study elsewhere in the United States. Potential positive social change may lead to increase in young female pastors in the churches. Possible social change benefits also include the increase of African American female pastors implementing CBHP activities in their own churches, change in congregation's health behaviors and habits, and improved health status.

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Dedication

This dissertation study is dedicated to my wonderful children, Samuel Jr. and Samantha. They have been my driving force from the start of this doctoral journey. I am deeply indebted to them for helping me to get to this level.

My mother in the Lord, Dr. Beatrice F. Arowolaju, who called or texted me every day and week with prayers and encouragement to always put God first and other things would come easy for me. She said, “Quitters never win and winners never quit.” “You can do all things through Christ who strengthens you.” “Stay focus Arlene and let no one derail your purpose and set goals.” “Keep doing what you are doing and stay focused.” I thank you from the of my heart ma.

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Chapter 1: Introduction to the Study

Introduction

The African American church can be a site for increasing health awareness and developing support for health promotion programs that can improve health outcomes for African American congregants and the community (Lott-Collins, 2015). Traditionally African American churches influence and support their congregations and communities with social support and outreach in economics, politics, spirituality, health, and social welfare (Lincoln & Mamiya, 2001; Lott-Collins, 2015). Additionally, research has revealed the key roles African American churches and communities have played by initiating health promotion programs that targeted African American congregants and the population in the community (Austin & Harris, 2011; Butler-Ajibade, Booth, & Burwell, 2012; Lott-Collins, 2015; Parrill & Kennedy, 2011). Pastors of African American churches are seen as influencers in instituting church-based health promotion programs (CBHPPs) for their congregations, as well as being active from the pulpit teaching and preaching the Bible in order to address their churches' health issues (Lott-Collins, 2015); it is for this reason that I examined congregational health promotion among Christian female African American pastors.

Although there have been many studies on CBHPPs, there has been little investigation on the perspectives and experiences of Christian female African American pastors implementing health promotion programs for congregants in their places of worship. Female pastors have ability to communicate and show emotional and caring aspects within their congregations; their caring natures reveal their willingness to share and extend their love to the church and their congregations. It is important to understand the experiences of female African American pastors who implement CBHPPs due to the differences in how they experience life in comparison with

their male counterparts. The female African American pastor's perspective can be used to inform program designers and government health policy makers about how to approach all leaders of the African American faith community about health promotion programs in their congregations and communities (Lott-Collins, 2015).

The intent of this study is to inspire and impact lives through CBHPPs. This study can provide understanding of female African American pastors' perspectives on health promotion for their congregations, which can serve as an example to other pastors who are looking for ways to implement health promotion within their congregations. African Americans previously depended on other nonprofit and health care organizations to obtain information on their health issues. The collaboration between nonprofit and health care organizations with CBHPP has brought about social change, prevention, education, and awareness of chronic diseases amongst African American communities (Lott- Collins, 2015). Chapter 1 consists of the background of the study, the problem statement, the study purpose, the nature of the study, and the research questions. In addition, I provide a summary of the theoretical/conceptual framework that guided this study. Other areas covered in this chapter include the scope and delimitations, the study significance, assumptions, study limitations, and definitions of key terms in the study.

Background of the Study

According to the World Health Organization (2016), health promotion is commonly defined as permitting people to increase their control over their health resources. African American Christian faith pastors and Black churches play an integral role in addressing the health issues plaguing African American communities (Austin & Harris, 2011). High blood pressure, stroke, and diabetes—which all lead to cardiovascular disease—are more prominent in African American communities than other ethnic groups according to the U.S. Department of

Health and Human Services (DHHS; 2014a). Minorities also suffer more disparities than Whites, though the government is trying to improve underserved people's access to health and social services (Taylor & Nies, 2013).

Despite any efforts to improve healthcare access, in 2010, African Americans were 30% more likely to die from heart disease (DHHS, 2014b). African Americans are also 30% more likely to develop cancer, which leads to a higher rate of death than other ethnic groups in the United States. In addition, African American adults are 40% more likely to acquire high blood pressure earlier in life and twice as likely to die from it as Whites (Hicken, Gragg, & Hu, 2011; National Stroke Association, 2016). In 2010, 21% of the black population were 1.20% more likely to die at any age from chronic diseases (Murphy, Xu, & Kochanek, 2013). African American adults are 77% more likely to be diagnosed with diabetes, which leads to diabetes complications (Murphy et al., 2013; National Diabetes Fact Sheet, 2011), resulting in early death in the African American population.

Black churches are trusted organizations that congregants and community members look to for spiritual, economic, educational, and personal advice (Lincoln & Mamiya, 2001), which can also mean addressing health issues. It is important to know that leadership is vital in any organization; leaders of nonprofit organizations such as African American churches can assist congregants spiritually, physically, and emotionally (Rowland & Isaac-Savage, 2014). African American churches were the appropriate setting for this study because female African American pastors' were the intended study participants.

I searched for African American churches with female pastors from communities in South suburbs of Illinois, which contained more African American than any other race (Chicago Metropolitan Agency of Planning, 2016). I focused on congregational health promotion because

of the health disparities that exist in the African American population in the United States. I randomly selected different African American churches. It has been suggested that social workers should pay attention to African American communities for ways to collaborate with African American churches and their pastors because they are vessels that can be used to open doors to broader health involvement and effective partnerships (Rowland & Isaac-Savage, 2014). African American pastors and lay leaders are usually interested in issues relating to health problems within their churches (Rowland & Isaac-Savage, 2014).

African Americans suffer from a series of chronic diseases (high blood pressure, diabetes, stroke, coronary artery disease, HIV-AIDS, cancer) that affect families, individuals, and communities. Perhaps this is why African American pastors are known to establish health promotion programs to increase health awareness and provide access to health information in their communities. These pastors often collaborate with health organizations and government agencies as they initiate activities in their churches to address chronic health problems in their congregations (Lumpkins, Greiner, Daley, Mabachi, & Neuhaus, 2013; Williams, Glanz, Kegler, & Davis, 2012).

Social affairs among church congregations relate to health, housing, employment, marriage, and education, and African American churches are partnering with government agencies to implement health promotion to address all the social affairs of congregants (Lumpkins et al., 2013; Williams et al., 2012). For instance, CBHPPs can play a vital role in African American congregants' lives; having current and accurate health information and health resources is crucial for effective health promotion, prevention, and education programs that will decrease health disparities in U.S. African American communities (Butler-Ajibade et al., 2012). The role of communicating health behavior changes and the connections between health and

spirituality lies with African American pastors (Lumpkins et al., 2013; Williams et al., 2012). I studied female African American pastors to highlight their feminine and maternal abilities, which allow them to be more compassionate than their male counterparts as well as be good leaders who are able to implement health promotion activities in their churches. I chose this population because I found no literature on female African American pastors initiating health promotion activities in their churches; my intent was to highlight these women as equally capable of initiating CBHPPs as their male counterparts.

Female African American pastors are potentially teachers, preachers, counselors, and mentors, which are significant qualities in influencing their congregants (Newkirk & Cooper, 2013). According to Rowland & Isaac-Savage (2014), African American pastors in general are seen as trusted messengers of God, so their support for health promotion initiatives can expose congregants to programs such as screenings and health fairs that might encourage them to look more closely at their personal health problems.

Problem Statement

African Americans in the United States suffer from more chronic diseases than other ethnicities (Butler-Ajibade et al., 2012; Lumpkins et al., 2013; Williams et al., 2012). Each year according to the National Stroke Association (2016), 185,000 people die from stroke in the United States. The DHHS (2014) and Healthy People 2010 (2016) mentioned that despite increases in dissemination of health information, African American Americans are experiencing steadily increasing morbidity and mortality. They have disproportionate rates of coronary artery disease, cancer, stroke, COPD, diabetes, obesity, and other chronic diseases (DHHS, 2014; Healthy People 2010, 2016). Because of these health disparities, the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services are collaborating with African

American churches to address health disparities in African American communities to bring together third parties such as health providers, communities, health systems, and nonprofit organizations in order to expand care and empower Americans to make heart-healthy choices (CDC, 2015).

The literature I reviewed referred to African American pastors as having the ability to implement health programs in their congregations for the sake of positive social change within their communities (Lumpkins et al., 2013; Williams et al., 2012). African American pastors' harmony with their congregants generates trust and success in promoting health promotion within their churches (Butler-Ajibade et al., 2012; Rowland & Isaac-Savage, 2014). Authors also noted that African American church leaders and members were receptive to the expansion to health-related programs (Patel, Frausto, Staunton, Souffront, & Derose, 2013) and that health promotion was culturally compatible with African American clergy and congregants (Lott-Collins & Perry, 2015).

Despite the relevant literature on health programs in churches, there is a lack of research on female pastor's role in these programs. For example, Lott-Collins's (2015) literature review did not include any studies on the role of female African American pastors in church health promotion programs, and there were no studies of only female pastors. Thus, this study was necessary to focus on congregational health promotion among female African American pastors.

Purpose of the Study

The purposes of this dissertation was to explore (a) African American female pastors' perceptions about congregational health promotion in the church; (b) their roles in their churches' congregational health promotion programs; (c) the steps they use in influencing, motivating, and building congregational health promotions in their churches; (d) their insights

into health, spirituality, and religious beliefs as they differ between Black churches; and (e) the influences of feminist perspectives on female African American pastors as females in their field. The importance of this study is based on examining female pastors who are involved with health promotion in their congregations; the significant roles these female pastors play in congregational health promotion in their communities; and the roles of spirituality and religious beliefs in their congregational health promotion decisions as female African American pastors.

The qualitative approach to research allowed for in-depth thoughtfulness regarding the phenomenon of how Christian faith female pastors in African American churches interact with their health ministries to affect future health actions among their congregations and create positive social change (Kothari et al., 2016; Rowland & Isaac-Savage, 2014). African American CBHPPs are most successful when they take advantage of the churches' strengths and resources available for their communities' health needs (Campbell et al., 2007). With this study, I explored congregational health promotion by female African American pastors in the Christian faith.

Research Questions

With this study I sought to understand the experiences of female African American faith leaders who participated in faith-based health promotion programs in their churches or places of worship. My aim was to understand the perspectives and experiences of these female pastors using an in-depth interview protocol to answer my research questions. I constructed the following three questions to guide this study:

- RQ1**:** What is the role of female African American Christian pastors in influencing, motivating, and building health promotion programs?
- RQ2**:** How do spiritual and religious beliefs guide and influence congregational health promotion activities of female African American Christian pastors?

- RQ3**:** How do female African American Christian pastors associate feminist theory characteristics with their success in the pastorate and in health promotion among their congregations?

Answering these three research questions allowed me to explore and understand congregational health promotion by female African American Christian pastors and the influence of liberal feminist theory in how they built their health promotion programs.

Theoretical Framework

A theoretical framework is a theory that provides a basis or rationale for predicting and conducting research. It is a navigation tool, a means to steer the research from the beginning of a process to the end (Creswell, 2013). Qualitative researchers use theoretical frameworks to back their research arguments, create sound study questions, and explain the choice of methodology for a study (Bradbury-Jones, Taylor, & Herber, 2014). Theoretical frameworks involve the overall direction for the study of questions concerning gender, class, and race (Creswell, 2009, 2013). The continuous rise in chronic diseases, poor health, and health disparities among African American residents of the United States has driven government agencies to collaborate with African American churches to initiate health promotion activities that will bring social changes in congregations. With this qualitative case study, I focused on female African American pastors of Christian congregations and their experiences and perspectives in implementing congregational health promotion activities in their churches. I explored these perspectives and experiences through the theoretical lens of feminist theory and its impact on female African American pastors' decisions to implement CBHPPs in their churches. Liberal feminist theory highlights violations of women's equal rights in society such that women are mainly restricted as a group instead of as individuals (Munson & Saulnier, 2014). Feminist theories originated in

1792 with Mary Wollstonecraft's publication "A Vindication of the Rights of Woman," which dominated feminist thought (Donovan, 2012).

Nature of the Study

I conducted qualitative case study, which is used to describe in depth the experiences of one person, family, group, community, or organization in natural settings; a case study places an individual, a group, or an activity as the research subject (Creswell, 2009). Case studies are linked to real-life impressions and situations and are buttressed by considerable resources (Creswell, 2013). Case study theory is founded in examining how an issue is revealed through one or more cases in a research study (Creswell, 2013). Case studies focus on discrete events during precise time periods.

Qualitative case studies can take one of three aspects—explanatory, exploratory, or descriptive—and they are also holistic and either single or multiple in nature (Yin, 2014). For this qualitative case study, I analyzed the phenomenon of congregational health promotion by African American female pastors in Christian faith churches. I interviewed 13 female African American pastors to explore and describe their perspectives on congregational health promotion in their ministries and the initiatives they used in implementing health promotion activities.

I used a feminist theoretical perspective as a lens through which to view how female pastors were able to affect health promotion in their congregations. I conducted in-depth interviews with open-ended questions to collect the data for qualitative analysis in the female pastors' natural settings either in person or by telephone. I selected this methodology African American pastors' self-described experiences, leadership characteristics, and perceptions of health promotion in the ministry.

Operational Definitions

African American (Black) church: An organization where group of individuals attend a Christian-based church of a historically African American denomination and/or congregation, for example, African Methodist Episcopal, Baptist, or Pentecostal (Church of God in Christ). The church has been a cultural sustainer in the African American community for a range of issues including social, political, health, and economic issues. The African American church has been defined as a mixture of common beliefs, rituals, and experiences that can determine processes and plans to address pressing social problems in the community (African American Registry, 2013).

African American Christian faith pastors: People who affirm their unity and oneness in God through dynamic happenings in the Holy Spirit. They preach only what they hear from God through the Holy Spirit by believing in prayers, faith practices, and revival, which plays a crucial and powerful role in their congregations' growth (Booth, 2011).

Christian faith: refers to the experience of living a new personal relationship with God by the transformation and indwelling power of Jesus in believers' bodies and lives (Sherbondy, 2006).

Church-based: Programs or activities that include faith practices such as prayer, scripture reading, and/or praise and worship (Sherbondy, 2006).

Congregation: An organization formed for the purpose of providing for worship of God and religious worship and services (Merriam-Webster, 2014).

Congregants: Groups of individuals who together to worship God, for religious teachings/services, and for other church activities (Merriam-Webster, 2014).

Experience: All that is perceived, understood, or remembered from undergoing or encountering an occurrence (Booth, 2011).

Health disparities: Differences in health outcomes between populations (Healthy People, 2016, 2020). I use the terms *health disparities* and *health inequalities* interchangeably in this manuscript.

Health promotion: Refers to the process of allowing people to control and enhance their health, focusing on individual behaviors through a wide range of social and environmental interventions (World Health Organization, 2016).

Pastors: People whose work involves leading church services and providing spiritual or religious guidance to other people; they are licensed or ordained to oversee church bodies (Payne, 2014). In short, pastors are spiritual shepherds who tend to the personal needs of their congregants. They are responsible for weekly worship services, Bible study, and pastoral counseling (Hardy, 2014).

Phenomenon: A single concept or idea, which could include an emotion, a relationship, a program, an organization, or a culture (Creswell, 2013; Patton, 2002).

Social injustice: stated as doctrines regarding the causes, social, political, and economic, of human inequality (Merriam-Webster, 2014).

Assumptions

This study, I assumed that the female African American pastors who participated would provide honest and sincere responses and perspectives about their experiences with health promotion initiation in their churches. Research has revealed that female African American pastors' influence in health-related program like CBHPPs can increase participation among their congregations and contribute to successful outcomes (Butler-Ajibade et al., 2012). Therefore, it seems safe to assume that CBHPPs in African American churches succeed because of the influence of their African American pastors, specifically *female pastors.* However, I did not plan to explore the outcomes of these programs and therefore**,** I did not attempt to verify this second assumption.

Scope and Delimitations

For this qualitative case study, I sought to understand female African American pastors' perspectives on congregational health promotion and the role of spirituality and religion in health. In addition, I used feminist theory to explore these women's perspectives as pastors delivering the message of health from the pulpit. The scope of the project was thus delimited to female African American pastors of churches in the Chicago, Illinois, area including surrounding South suburbs who had initiated health promotion programs in their churches.

Limitations

Because I sought to understand the perspectives of female African American pastors in their settings, there was a limitation in that the women's experiences differed across settings and thus could not be simplified or generalized. However, though the results cannot be generalized, this study was conducted to help readers understand the experiences of female African American

pastors regarding congregational health promotion. Health program creators who want to initiate similar CBHPPs and health policymakers who want to create policies for health organizations to collaborate with female African American pastors on congregational health promotion may use this data.

Significance of the Study

Women have played crucial roles in the church; the Bible acknowledges women as vital to the prophets and ministries (Resane, 2014). Wiele (2015) also mentioned the significance of women in the church and their contribution of vitality to the church as pastors. According to Hankerson & Weissman (2012), health promotion programs by nonprofit organizations, government agencies, health organizations and professionals, and communities have been successfully performed in partnership with African American churches. Lumpkins et al. (2013) also indicated that female African American pastors are role models for their congregations, not only on but also off the podium. These women use their spiritual and religious beliefs as pastors to implement health initiatives in their congregations, which is significant in bringing wellness and health and in turn promotes social change in their communities. (Butler-Ajibade et al., 2012; Rowland & Isaac-Savage, 2014; Williams et al., 2012). Even though more women are becoming pastors in African American churches than before, there are few studies highlighting their contributions, experiences, and perspectives on leading their churches, especially regard to CBHPPs for their congregations. The intent of this study was to show female African American pastors' mother natures, emotional aspects, valuable gifts such as encouragement to both males and females, and ability to bring vitality to the church (Wiele, 2015). The specific aim was to show how female pastors from three African American Christian denominations have provided benefit to their congregation through health promotion activities. These women's perspectives on

implementing health promotion programs could provide other female African American pastors and congregations as well as communities and even African American male pastors with information about how to conduct these and related activities in their churches.

Summary

Church-based health promotion programs have been useful for introducing healthy behaviors in African American communities in collaboration with nonprofit organizations and government agencies. The initiation of CBHPPs by African American pastors, specifically female pastors, reflects their aptitude in influencing and promoting healthy behaviors among their congregations from the pulpit. Because of the scope of these female pastors' impacts in the African American community, it is imperative to understand how they view their experiences with CBHPP initiation and social change among their congregants and African American communities at large. Researching this topic was important for understanding women's experiences and roles in implementing the CBHPPs. Additionally, gaining insight into female African American pastors' experiences could also contribute to social change by updating health organizations and health policymakers on how to cooperate with more churches to increase awareness of African Americans' high risk for chronic diseases.

In Chapter 2 I present a detailed review of various research findings pertaining to church-based health promotion (CBHP) of female African American pastors in the Christian faith; I highlight the current literature gap regarding CBHP by female African American pastors for their congregants. Further, I reveal the impact of feminist perspective theory (FPT) on female African American pastors as women in the ministry. In Chapter 3 I present details on the study methodology, in Chapter 4 I highlight study results, and in Chapter 5, I discuss study findings, make conclusions, and provide some recommendations.

Chapter 2: Literature Review

Introduction

Nonprofit organizations in African American communities are known to be forerunners in addressing health issues concerning excluded populations. One of the reasons for this is that African Americans suffer from more chronic diseases than other ethnicities in the United States (Butler-Ajibade et al., 2012; Lumpkins et al., 2013; Williams et al., 2012), and they are also more likely to die from chronic disease (Lott-Collins, 2015). Additionally, more adults with diabetes in the African American community develop diabetes complications than White adults (Murphy et al., 2013). However, African American churches can address these health disparities as Frazier, Lincoln, and Mamiya (2001) stated that African American churches influence and support their congregations and communities with social support and outreach in economics, politics, spirituality, health, and social welfare (as cited in Lotts-Collins, 2015).

The backing and participation of pastoral leaders of African American churches are influential in instituting the ways, missions, and administration of health promotion programs. African American leaders and pastors are expected to follow up with current health issues in their congregations and initiate programs to meet those health problems in their communities (Lott-Collins, 2015). In addition, pastors can serve as facilitators for behavioral and social change due to their positions and roles in the church; pastors address issues beyond the religious and spiritual communication with their congregations and communities (Lott-Collins, 2015). Pastors also play crucial and influential leadership roles that can motivate their congregations and communities with regard to health and lifestyle. Although they are occupied and busy with being full-time pastors, they can use their positions to initiate wellness and health promotion from the pulpit (Lott-Collins, 2015). Other authors have emphasized the participation of Black

pastors and how the amicability between members of congregations creates trust and success in staging health promotion programs within their churches (Butler-Ajibade et al., 2012; Rowland & Isaac-Savage, 2014). Furthermore, other authors found that African American church leaders and members were receptive to the expansion to health-related programs (Patel et al., 2013) and that health promotion was culturally compatible with African American clergy and congregations (Lott-Collins & Perry, 2015).

Additional research has revealed the pivotal roles African American churches and communities have played by initiating health promotion programs that target African American congregants and communities (Austin & Harris, 2011; Butler-Ajibade et al., 2012; Parrill & Kennedy, 2011). However, this research lacked studies regarding the roles of female African American pastors in church health promotion programs. Thus, this study addressed congregational health promotion among African American female pastors in the Christian faith. It is important to comprehend the roles of female pastors in initiating and implementing health promotion programs in their churches. Having faith-based leaders, pastors, researchers, social workers, and health care professionals involved with community-based interventions can influence and assist congregants in health promotions that can bring about social change and health behaviors in the church and communities (Lott-Collins, 2015).

The purpose of this study was to investigate African American female pastors' perspectives on congregational health promotion in the church. For this study, I explored the role of women pastors in their churches' congregational health promotion. The goal was to explore the steps these pastors use in Christian African American ministries in influencing, motivating, and building congregational health promotion. I also explored the female pastors' perceptions regarding health, spirituality, and religious beliefs in a qualitative approach that allowed for in-

depth related thoughtfulness regarding how these pastors affect future health actions in their congregations for social change.

Literature Search Strategy

Walden University Library was the main library I accessed for this study because of its availability of large amounts of peer-reviewed journals, articles, and research studies. I also searched Google Scholar. I searched and gathered literature no older than 5 years that were relevant to my study. I searched the multiple Walden University Library databases (Thoreau Multi-Database Search), multidisciplinary databases (Academic Search Complete; ProQuest Central, and ScienceDirect), CINAHL, Medline Simultaneous Search, PubMed, ProQuest Health & Medical Complete, both MEDLINE and CINAHL with full texts, and dissertations and thesis databases for literature. I also reviewed information from government agencies such as the CDC, DHHS, the National Institutes of Health, Healthy People 2020, and other programs. My searches were aimed at pertinent literature focusing on the character and deeds of African American churches, pastors, and congregations using search terms such as *Black churches, health promotion programs, health determinants, health promotion 2020, African pastors and congregations, African American female pastors and churches*, *feminist theory and female pastors*, *liberal feminism/feminist theory*, *African American pastors*, *feminist theory*, and *pastors and spirituality*.

Theoretical Foundation

A theoretical framework is a theory that provides a basis or rationale for predicting and conducting research. It is a navigation tool, a means to steer research from the beginning of the process to the end (Creswell, 2013). The theoretical framework guides the researcher in what to look for, including the boundaries of the research, and guides the researcher in the direction that

should be followed (Rockinson-Szapkaw, 2013). Such frameworks guide research in two ways: determining if research fits or is already known and if a developed theoretical framework makes a vital contribution to the research (Rockinson-Szapkaw, 2013). Qualitative researchers use theoretical frameworks to back their research arguments, create sound study questions, and explain their chosen methodologies (Bradbury-Jones et al., 2014). Theoretical frameworks guide the overall direction of study questions concerning gender, class, and race (Creswell, 2009, 2013).

Feminist Perspective Theory

I investigated the topic for this dissertation through the lens of FPT. Feminist theories originated in early 1792 with Mary Wollstonecraft's publication "A Vindication of the Rights of Woman," which dominated feminist thought (Donovan, 2012). However, there were earlier expressions of feminist thought. Four month earlier, Olympe de Gouges had issued a pamphlet in Paris entitled *Les Droits de la femme* ("The Rights of Woman"; Donovan, 2012). Furthermore, in 1790, Judith Sargent Murray, an American, published "On the Equality of the Sexes" in Massachusetts (Donovan, 2012). Feminist theory is equated with conflict theory in studying gender, patriarchy, and the persecution of women (Boundless, 2016).

There are three waves of FPT. The first was in the 19th and early 20th centuries and was concerned with women's suffrage, their basic right to vote (Boundless, 2016). The second wave was in the 1960s and 1970s, when women's liberation efforts were focused on inequalities such as employment place, family, and reproductive rights (Boundless, 2016). The third feminist wave has been from the 1990s to the present and has been focused on the feminist perspective regarding gender, converging on diversity and change, multiculturalism (tolerance of different

cultures and tolerating cohabitation with different others), poststructuralism (efforts to review or challenge traditional arrangements), and postmodernism (Boundless, 2016).

Feminist theory and ideology have evolved through the years and have much in common. Though there are several types of feminist thought, and liberal feminist theory was created out of liberal political philosophy so that women could modify laws and accomplish gender justice (Sarikakis, Rush, Grubb-Swetnam, & Lane, 2008). Liberal feminists focus on respecting all people, defending equal rights and equal opportunities for both women and men (Sarikakis et al., 2008). Okin (1989) considered that liberal feminists' lack of autonomy is due to the so-called gender system. The *gender system* is defined as the autonomy of gender (male and female) and is inherited, and some women are working to rectify it (Baehr, 2013). Most liberal feminists adhere to the feminist political philosophy of the gender system. These women state that personal autonomy is prevented by unfriendly social arrangements that hinder women's lives (Baehr, 2013). Liberal feminist theory is chosen because the pastoral system is a male dominated profession, so it could help to describe how female pastors viewed their work.

A case study is defined as the investigation and description of an unclear phenomenon and its framework in an in-depth study; it can be a person or group of people focusing on discrete events to methodically study in a precise time (Creswell, 2013; Yin, 2014). For this dissertation, I conducted a qualitative case study of congregational health promotion by female African American pastors' in their ministries. I used feminist theory as the theoretical lens to address the challenges and barriers these women face and expound on their knowledge in the ministry, including their experience, knowledge of the Bible, emotions, and intuition (Patton, 2002). My rationale for applying FPT was to study the views of female African American pastors in the

Christian faith view and the impacts of their views on their health promotion activities in their congregations.

Liberal Feminist Theory

From FPT I used liberal feminist theory to address these dissertation research questions: What is the role of female African American Christian pastors in health promotion in their congregations? How do these ministers' spiritual and religious beliefs guide and influence their congregational health promotion? Liberal feminism involves the belief that men and women are equal and that through government oversight in the public sphere, equality of opportunity will occur (Banks, Murry, Brown, & Hammond, 2014). FPT support that no one has power over another person and that the obligation is shared by both sexes to preserve the planet (Swanson, 2015). Female African American pastors have the potential to be as effective as their male counterparts—in this case exhibiting leadership roles in congregational health promotion (Swanson, 2015).

There is a considerable amount of support for CBHPPs as the solution to church congregations' poor health outcomes and increased morbidity and mortality (Lumpkins et al., 2013; Williams et al., 2012). For example, health-related program can help African American women who are subject to eminent decisions they have to make regarding breast health as well as social practices that influence whether they pursue optimal breast health (Toomer, 2012). Church health promotion interventions are mainly coordinated by church leaders, who should be recognized as the most influential voices for successful CBHPPs (Webb, Bopp, & Fallon, 2013). Female African American pastors can serve as facilitators for behavioral and social change due to their positions and roles in the church; African American leaders and pastors are expected to promote their congregations' health, which responds to African American community needs as

well. However, there may be a difference in female pastors' approaches versus male pastors' approaches as feminine approaches to problems tend to involve relationships and interdependence, where masculine approaches address problems with judgments, reasoning, and principles (Swanson, 2015). With this dissertation, I aimed to understand female African American pastors' perspectives and experiences in health promotion among their congregations (see Butler-Ajibade et al., 2012; see Lott, 2015; see Lumpkins et al., 2013).

Literature Review

The literature I reviewed reflected how African Americans receive poor quality health care and unfair treatment from U.S. medical systems (Smedley, 2012). This portion of the U.S. populace are often are disproportionately unemployed, uninsured, low income, and on state-issued insurance, which shows how social injustice among African Americans contributes to this population's mistrust toward health care professionals and access to care. Social injustice creates economic burdens for the health care system (Smedley, 2012).

African American pastors can implement health promotion programs among their congregations to create positive social change within their communities (Austin & Harris, 2011). Lumpkins et al. (2013) asserted that Black churches provide environments of empowerment, and their positions in African American communities are significant in understanding the many health problems that exist in the African American community. They showed the importance of health ministries in the African American churches, which provided easy access for the congregations and community, so that members could monitor and control their health issues themselves (see also Austin & Harris, 2011). African American pastors also assist in reducing their communities' disbelief toward health care professionals and members' involvement in health promotion programs (Butler-Ajibade et al, 2012).

Equity in health, health care, and population health outcomes are imperative to the well-being of any nation, especially this minority group, African Americans (Frieden, 2014). Generally, African American pastors' influence their congregants' health. Nonprofit organizations in general are known to be forerunners in addressing health issues concerning excluded populations (Butler-Ajibade et al., 2012; Lott-Collins, 2015; Lumpkins et al., 2013; Rowland & Isaac-Savage, 2014). Leadership is vital in nonprofit organizations such as ministries, and female pastors are more than capable of affecting their congregation's spiritual, physical, and emotional lives (Rowland & Isaac-Savage, 2014).

Churches' Roles in Health Promotion Initiatives

Church and community health programs play a significant role in reaching out to the public. African American churches use Community Health Awareness and Monitoring Program to implement and provide education, screenings, and prevention plans (Butler-Ajibade et al., 2012). Churches are where information can effectively be disseminated, and African American churches can be vehicles and models for health promotion in their congregations. Pastors in African American churches play crucial roles in the successful launching of cardiovascular health, mental health, and social programs in the church (Butler-Ajibade et al., 2012). These pastors have a long history of taking the initiative in addressing critical social, economic, political, and health issues facing the African American population.

African American pastors and the church have collaborated with many health departments to conduct health fairs, transportation to medical appointments, exercise programs, meal assistance, and many other vital programs to prevent heart disease, diabetes, and strokes among African Americans (Butler-Ajibade et al., 2012). Although these partnerships with black churches can prove vital, Rowland and Chappel-Aiken (2012) stated, "delicate partnerships

require people who possess strong strategic planning skills and sensitive facilitation and negotiation skills" (p. 23). Clearly the current literature lacks any discussion exclusively of female pastors' influence on congregational health promotion, which was the reason for my study of congregational health promotion by female pastors in their congregations.

Pastors and church congregants have proved to be vital in implementing cardiovascular disease health programs (Butler-Ajibade et al., 2012), and African American Populations are influenced and supported by African American pastors' health promotion in their congregations. Those authors encouraged pastors to take the lead in these initiatives in reducing cardiovascular disease by adding dietary plans, nutrition and exercise, group activity/cooking classes, medications trainings, and scriptures to link the values of a healthy lifestyle with the Bible (Butler-Ajibade et al., 2012). One of the characteristics of Christian pastors is to be available 24-hour every day, week, month, and year for their congregants (Chatters et al., 2011). As stated above, men and women pastors are equally capable of performing the duties of ministering to their congregants (Chatters et al., 2011).

Authors have found that health disparities for African Americans continue to increase compared with for other ethnic groups in the United States (Derose, Gresenz, & Ringel, 2011; Lumpkins et al., 2013), and the CDC and DHHS work closely with African American pastors in churches and communities to enhance and expand health programs (Lumpkins et al., 2013). Lumpkins et al. (2013), in their article "Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church," demonstrated the perceptions of African American pastors about health promotions in their churches and how these perceptions have guided the pastors to improve congregational health (Lumpkins et al., 2013). The article permits deeper contextual understanding of the phenomenon

of how African American pastors perceive themselves from the altar concerning health promotions (Lumpkins et al., 2013).

Lumpkins et al.'s (2013) utilization of open-ended interviews and natural settings of six male African American pastors set the background for continuous study in specific cultures (Lumpkins et al., 2013) and for female African American pastor participants to disseminate health promotion information through community-based participatory research (Lumpkins et al., 2013). According to Lumpkins et al., Black churches are seen as trusted organizations by African American communities, as such African Americans seek spiritual guidance, counseling and directions in their daily lives. The research allows further study to be conducted amongst African American female pastors' to explore their perceptions and beliefs of health promotion. Church-based health promotion (CBHP) and church-based health promotion program (CBHPP), which according to Lumpkins et al. have shown substantial influence on several health behaviors among African American populations.

Williams et al. (2012) investigated African American pastors' beliefs regarding health promotion and speaking about health from the pulpit as part of their sermon messages. The authors used interviews with pastors from 33 rural African American churches to highlight the pastors' perceptions about church health promotion; the 30-minute interviews covered (the church leaders' characteristics, beliefs, church health-related programs, health messages indices, and other health-related indices (Williams et al., 2012). Church-based health promotion programs require pastors to take initiative in health promotion. The pastors are perceived as gatekeepers or agents of change, and therefore, understanding how their health beliefs influence their congregants is significant (Williams et al., 2012). In their article, "A Study of Rural Church Health Promotion Environments: Leaders' and Members' Perspectives," Williams et al.

demonstrated how pastors believe that their church members' receptivity to health is correlated to health messages, programs, facilities, and policies and that it is appropriate to discuss healthy lifestyle, eating, and weight loss from the pulpit in their sermons. The authors focused on the ministers' health messages, which they delivered from the pulpit because they connected biblical messages to health- related issues (Williams et al., 2012). The study sample consisted of full-time male pastors, not a larger population of church leaders such as female pastors who initiated and implemented congregational health promotion programs.

Pastors' Roles in Church Health Promotion Programs

Churches have consistently been places where African Americans seek health care intervention and social help, more than other institutions (Rowland & Isaac-Savage, 2014). Rowland and Isaac-Savage, 2014) investigated African American pastors' perceptions of health care, wellness, and health education in African American communities, and the pastors continuously supported health promotion among their congregations and in their communities as a whole. Pastors in this article were educated on health promotion, which they acknowledged was beneficial to their congregation members with high blood pressure high and diabetes (Rowland & Isaac-Savage, 2014).

Rowland and Isaac-Savage, (2014) pursued their study because of the incidence of African American community members' not receiving the same treatments for pain as whites, which incited Black churches to intervene (Rowland & Isaac-Savage, 2014). The authors interviewed the pastors of these Black churches to examine their perceptions of health issues that affected their congregations and communities and to gain their insights. Most of the ministers had some form of educational materials for their congregations to improve their health, but Rowland & Isaac-Savage, 2014recommended additional studies to further explore pastors'

perceptions health promotion and behaviors. To reduce these disparities, Rowland & Isaac-Savage, 2014asserted that "mini-medical school" programs in Black churches would highlight the problems for African American community members so that they could be better prepared to navigate the health system.

Black churches serve as religious and spiritual pathways for the development and growth of congregations and communities, and Hardy (2014) posited that African Americans still seek counseling through their churches when they are in crisis, suffering difficulties, and having challenges. In addition, African American churches are seen as the connection between the African American population and health care (Green et al., 2014). Green et al. (2014) focused on black community members suffering from cancer and found that the assistance of Black churches helped improve cancer survival rates and reduce disparities through early detection and information dissemination. Furthermore, the authors determined that people suffering with cancer have limits physically, spiritually, and emotionally and that emphasizing the relationship between Black churches and medical care can change aspects of cancer and survival (Green et al., 2014). The pastors in this study reported that their relationships over time with their cancer patient congregants had been close, which had made a significant difference with these congregants and with the community (Green et al., 2014). In addition, "pastors reflected on exploring and tapping into the diversity within church membership itself as a source for new partnerships for effective supportive care program," (p. 1394). However, again the pastors in this study were male and not female. Therefore, for this study, I explored female pastors' opinions about congregational health promotion in African American churches.

Female Pastors' Roles and Influence on their Congregations

Study findings showed that churches are ideal sites for health promotion interventions that reach the general population, and in one U.S. survey of 811,895 adults, church attendance was highest in African American communities (Newport, 2010). However, research on the expanding body of awareness among church leaders is limited, and the subject needs further study (Webb et al., 2013). Newkirk and Cooper (2013) validated the need to understand the practices of female African American pastors in the Baptist Convention and the trials they encountered as leaders in churches customarily ruled by men. Black female pastors are increasingly answering the call to ministry, and they are not only spiritual leaders; they are expected to be ready to teach, counsel, and preach to their congregants (Newkirk & Cooper, 2013). Black male pastors and other church leaders have often presented ideas regarding equality of Blacks in American society, but their female counterparts have been largely ignored in the African American community (Newkirk & Cooper, 2013).

As outlined in the research studies I reviewed, there is a literature gap regarding solely female African American pastors working with health promotion programs in their churches; studies included only male African American pastors or both, but not women only.

The objective for this research was to have female pastors tell their stories as pastors in male-dominated profession, including how they have been able to carry out health promotion programs in spite of their many likely challenges. Swanson (2015) supported the feminist perspective on women's leadership in the ministry in "A Feminist Ethic that Binds Us to Mother Earth." In this study I focused on gaining an understanding of how female pastors have the potential to be as effective as their male counterparts, in this case in the context of their leadership in the ministry and their roles as leaders for congregational health promotion (Swanson, 2015).

Strengths and Weaknesses of Methodological Approaches

Health promotion and prevention programs—educational and lifestyle strategies—influence health behaviors in African American communities, and churches have been appropriate settings for health promotion and prevention programs in these communities (Lott-Collins, 2015). Lott-Collins (2015) determined that African Americans practice and express their faith in the church in different ways—worship styles, cultural traditions, and religious practices. The author posited that from slavery through the Civil Rights movement and still now, the African American church has been significant in leadership roles, spiritual influence, and hope for African American congregations and communities alike.

African American pastors and congregations are major sources of support for chronic diseases, and CBHPPs are most successful when church leaders have available resources and the knowledge of community needs (Campbell et al., 2007). Buildings with kitchens and conference rooms provide access for a steady influx of people who partake of church health programs and activities (Campbell et al., 2007). In addition, churches are less affected by economic conditions and globalization than are other institutions, thus making them ideal and feasible places to recruit and retain participants (Campbell et al., 2007).

Continued health disparities have left health care practitioners and lawmakers searching for ways to promote health with new conceptual and theoretical frameworks to reach African Americans and other disenfranchised groups in society (Daniels & Archibald, 2011). As such, church-based health promotion was conceptualized as a public health modality that could close health care gaps among ethnic groups, reduce health care disparities, and increase health promotion and disease prevention in the African American population (Daniels & Archibald, 2011). Church-based health programs can be generally conceptualized on a socio-ecological

model, which studies the historical significance of the church's place in people's lives and the multifaceted nature of the church as a community (Daniels & Archibald, 2011).

In addition, this model offers framework for many levels of inspiration with regard to health behaviors and practices (Daniels & Archibald, 2011). The church-based health promotion model takes into consideration where and how people live daily, culturally, and contextually, while giving the kind of education that is needed to encourage optimal and healthy lifestyles (Daniels & Archibald, 2011). Daniels and Archibald (2011) cited Aquili and Newberg and Pert in finding that on an intrapersonal level, the church-based model recognizes that for some people, spirituality and faith are significant parts of their health treatment. Programs under this model take into consideration that attitudes and beliefs, based on people's backgrounds, do affect health outcomes, and their aim is to develop and increase connections on that cognizance while feasibly disseminating needed data (Daniels & Archibald, 2011).

On an interpersonal/social level, church-based health promotion builds on the trustworthiness that exists in and around people's lives and finds what inspires them as agents of social change to support healthy behaviors (Daniels & Archibald, 2011). On an organizational level, this promotion model aims at enriching existing ministries by providing essential resources that validate healthy lifestyles (Daniels & Archibald, 2011). On an environmental level, this model seeks to advance community supportiveness and access to healthy decisions through policies and advocacy resources (Daniels & Archibald, 2011).

Research Questions

Hankerson and Weissman (2012) identified that successful health promotion interventions have been performed in partnership with African American churches. My aim with this study was to examine the following research questions: What is the role of female Christian

pastors in health promotion and prevention in their congregations, and how do spiritual and religious beliefs guide and influence congregational health promotion, according to female Christian pastors? In conducting this research, I aimed to elaborate on the dissertation questions and examine female pastors who are involved with their congregational health promotion.

I explored and examined the significant roles of these African American female pastors during interview sessions to highlight their participation with congregational health promotion; how their spirituality and religious beliefs affected their congregational health promotion decisions as female African American pastors; and the influence of feminist perspective theory on these pastors in their congregational health promotion. As asserted by Lumpkins et al. (2013), female African American pastors are role models for their congregations not only on but also off the podium. Furthermore, these women utilize their spiritual and religious beliefs as pastors to implement health initiatives in their congregations, which is significant in bringing wellness and health and in turn promotes social change in the pastors' communities (Butler-Ajibade et al., (2012); Rowland & Isaac-Savage, (2014); Williams et al., 2012).

Summary

The church is the ideal setting for health promotion programs that African Americans could participate in for health information, and African American pastors see themselves as trusted voices in conveying health behavior to their congregations. These pastors' teachings have centered on their leadership roles and their relationships with their congregants (Lumpkins et al., 2013). Available literature focuses on both male and female pastors' initiating congregational health promotion in Black churches, but there are no specific studies of only male or only female pastors' initiating this promotion. Thus, with this study I focused on female African American pastors who had initiated congregational health promotion in their churches.

The church, a large part of African American communities, affects not only congregation members, but community members as well. Pastors' messages to their congregations about healthy behavior should be one factor that public health staffs should contemplate when developing health promotion programs targeting African Americans (Lumpkins et al., 2013). The communication component is critical for the success of programs but must appeal to the targeted populations to be successful. Lumpkins et al. (2013) conducted a qualitative case study with a semi-structured interview approach that allowed for a deeper understanding of the phenomenon of how African American pastors see themselves as health communicators. The goal of the pastors in that study was to affect the future health behavior of their congregants (Lumpkins et al., 2013). However, future research should encompass larger samples of pastors all over the urban core to better represent the breadth of African American clergy (Lumpkins et al., 2013).

In Chapter 3 I discuss the case study methodology and the in-depth interviews I conducted with a sample of 13 female African American pastors. I provide details regarding how I explored the female pastors' experiences and perspectives of congregational health promotion programs in their churches. In the chapter I cover my research methodology, population, and sampling as well the methods I utilized to collect and analyze the data.

Chapter 3: Research Method

Introduction

One of the roles African American female pastors play is to communicate with their congregants about their health issues, which are beyond religious and spiritual connotation from the Bible. Pastors are seen as influential leaders who can influence and motivate both their congregations' and their communities' health and lifestyles. With this research study, I qualitatively assessed the beliefs and knowledge of 13 female African American pastors with the use of open-ended interview questions. The purpose of the study was to explore female African American pastors' opinions about congregational health promotion in the church.

In this chapter I highlight details of the research method I used to address the problem statement and purpose. In addition, I discuss my role as the researcher and describe my study sample, research questions, study context, and data collection and analysis; I also address issues of trustworthiness and ethical considerations. To conclude, I cover the implications of social change, which will provide an avenue for ongoing research.

Research Design and Rationale

In this section I share the strategy I used in my research for this qualitative case study. Qualitative research depends mainly on examining individuals or groups in specific human settings (Creswell, 2009). Occurrence allows researchers to explore individuals or groups through simple to complex scenarios, communities, organizations, or programs and the support of deconstruction and reconstruction (Yin, 2014).

In a qualitative case study, the researcher's focus is on exploring a phenomenon by (a) focusing the study on how and why questions, (b) not coercing participants, (c) boundaries are unclear between phenomenon and context, and (d) contextual conditions are studied for their

relevance (Yin, 2014, pp. 9-14). For this study, a qualitative method was suitable because of my need to understand the participants' experiences through open-ended questions. Open-ended questions can be used during in-depth interviews, which are useful for obtaining detailed information about a person's experiences (Creswell, 2009, 2013).

With this study, I sought to understand the experiences of female African American pastors whose churches or places of worship participated in faith-based health intervention programs. Understanding the role of female African American pastors' opinions about health promotion ministry in their churches is imperative for understanding their impacts on their congregants' health. With that in mind, I constructed the following three research questions that guided this study:

- RQ1**:** What is the role of female African American Christian pastors in influencing, motivating, and building health promotion programs?
- RQ2: How do spiritual and religious beliefs guide and influence female African American Christian pastors' congregational health promotion activities?
- RQ3**:** How do female African American Christian pastors associate feminist theory characteristics with their success in the pastorate and in health promotion among their congregations?

These three research questions allowed me to explore and understand congregational health promotion by African American female pastors in the Christian faith and how liberal feminist theory influenced them in building their health promotion programs.

The Phenomenon

With this dissertation, I explored the phenomenon of health promotion in African American churches by female pastors. The purpose of this study was to explore and understand

the congregational health promotion activities of female Christian African American pastors in Chicago, Illinois, and its surrounding South suburbs. These pastors are active in preventive medicine through planning and delivering health promotion messages in Black churches and communities (see Rowland & Isaac-Savage, 2014). These African American pastors have multiple roles in Black churches, and as such, they play crucial roles in congregants' lives as leaders of health behavior change (see Rowland & Isaac-Savage, 2014). The health behavior change agent role of these pastors is important in communicating health issues in the church setting and in turn helping to reveal trust and credibility in health promotion materials aimed at African Americans (Rowland & Isaac-Savage, 2014).

Research Tradition

A qualitative case study inquiry was appropriate for this dissertation study because I was exploring female pastors' opinions on congregational health promotion from the pulpit and the possibility of the amount of information to be gathered (Patton, 2002). According to Yin (2014), qualitative case studies have at least one f three aspects—explanatory, exploratory, or descriptive—and are also holistic, single, and multiple in nature. Furthermore, Yin asserted that case studies are most appropriate (a) for answering "how" and "why" questions, (b) when contextual conditions are applicable to the phenomenon under study, and (c) the limits are not clear between the phenomenon and context (Yin, 2014, pp. 9-14).

Study data collection activities must be well planned for researchers to gain access to participants' chosen settings, give the research study sufficient resources while in the field, set a defined schedule of data collection activities, and address unanticipated events if and when they occur. Yin (2014) and Stake (1995) asserted that interviews are one of the most important means of data collection in case studies. According to these authors, case study researchers use open-

ended interviews to ask participants questions that require specific insightful answers about certain events (Stake, 1995; Yin, 2014).

A case study places an individual, a group, or an activity as the research subject. These case studies are linked to real-life impressions and situations and are buttressed by a considerable amount of resources (Creswell, 2013, pp. 97-98). I followed a qualitative case study design for this research; qualitative case studies allow researchers to analyze within each setting and across settings. Mine was a multiple case study because I examined female African American pastors from churches in three denominations, which offered me the potential to look for similarities and differences across denominations.

The Role of the Researcher

Qualitative researchers play a significant role in their research. Clear objectives, goals, and methods are the researcher's main responsibilities (Yin, 2014), and thus, researchers are the primary study tools and are personally involved in every step of the research process; in contrast, quantitative researchers are independent from the studies they are conducting (Kothari et al., 2016). Qualitative researchers also want to confirm that their prior knowledge, experience, and beliefs about the phenomenon under investigation do not compromise either the process or the final study findings (Lee et al., 2014).

Methodology

Participant Selection Logic

Lincoln and Guba (1985); Marshall, Cardon, Poddar, and Fontenot (2013); and Patton (2002) asserted that there are no set rules for adequate sample size for qualitative studies; instead, qualitative researchers should continuously recruit participants until they reach saturation point. Saturation is participant data begin to be repeated or redundant (Lincoln &

Guba, 1985; Marshall et al. 2013) or when where there are no new data emerging from the sample (Lincoln & Guba, 1985).

The case study approach supports the inquiry of socially complex phenomena and their circumstances, thus offering a rich, holistic understanding of the phenomena (Kothari et al., 2016). For this study I targeted female African American pastors in Christian faith ministries in Chicago, Illinois, and surrounding South suburbs; I chose these neighborhoods based on the numbers of African American community members and African American churches present. I also targeted African American ministries from three different denominations, each constituting a separate case. These institutions are all of Christian faith, but they have different beliefs, values, and interpretations.

The criteria for study participation were

- female African American pastor
- actively ministering full or part time in a church in Chicago, Illinois, or in the surrounding south suburbs
- pastors for more than 3 years
- active in church-based health promotion among their congregations
- signing a consent form before participating in the study, as required by Walden University's IRB

Recruitment

For this qualitative case study of congregational health promotion by female African American pastors in the Christian faith, I initially intended to have fewer than 10 participants; however, based on the sample sizes in the studies above, I interviewed 13 female pastors who met the criteria above. I recruited participants by searching the Internet for African American

churches from different denominations using search words such as *Black church* and *African American church*. I used the initial screening questionnaire (Appendix B) to recruit potential participants via telephone. Those that answered the asked questions correctly based on African American female pastors, used CBHP in the church, live in Chicagoland and surrounding South Suburbs, willing to participate in the study sharing their experiences and are willing to sign consent form for the study were chosen.

Instrumentation and Data Collection

For this dissertation study I used open-ended interviews questions to comprehend a small group of female African American pastors' perspectives on implementing health promotion programs in their churches; for my purposes, it was best to have these women express their positions in their own words. I audio taped the interviews, used field notes, and reviewed the literature about the topic (Creswell, 2009). Field notes assist researchers in gathering data that other collection techniques may not capture, such as personal reflections, reactions, and insights (Creswell, 2009). They are written, detailed, nonjudgmental, tangible descriptions of what the researcher observes in the field.

Summary

The purpose of this chapter was to provide the methodology of this research study. The essence of the study was to explore the phenomenon of congregational health promotion by female African American pastors of the Christian faith. I described my methodology, role, participant selection logic, and data collection process with regard to how I used a multiple case study design to narrate female African American pastors' opinions and experiences from the pulpit of their congregants' health promotion programs in their churches.

Chapter 4: Results

Introduction

The purpose of this inquiry was to (a) explore African American female pastors' perceptions about congregational health promotion in the church; (b) explore these women pastors' roles in their churches' congregational health promotion programs; (c) explore the steps these pastors use in their African American Christian faith ministries in influencing, motivating, and building congregational health promotions; (d) explore these pastors' insights into health, spirituality, and religious beliefs from the perspectives of different African American churches; and (e) explore the influence of feminist perspectives on these women as pastors. I conducted in-depth, face-to-face interviews with 13 female African American pastors using semi-structured interview questions (Appendix D) to gather detailed data needed to answer three research questions:

- RQ1**:** What is the role of female African American Christian pastors in influencing, motivating, and building health promotion programs?
- RQ2**:** How do spiritual and religious beliefs guide and influence congregational health promotion activities of female African American Christian pastors?
- RQ3**:** How do female African American Christian pastors associate feminist theory characteristics with their success in the pastorate and with health promotion in their congregations?

The three research questions allowed me to explore and understand congregational health promotion by African American female pastors in the Christian faith and the influence of liberal feminist theory in the building of their health promotion programs. This chapter includes details pertaining to the pilot study that preceded the main study, study setting, demographics of the

participants, data collection, data analysis, and research study results. In this chapter, I also described how research quality and trustworthiness were retained.

Pilot Study

After I received IRB approval, I collaborated with churches and female pastors in Chicago and the South suburbs to recruit study participants. After each interview with participants, I asked if they knew Black churches with African American female pastors and if they could share the names and information of other African American female pastors with me. They said yes but that they would speak with these pastors before sharing their information with me. I was able to recruit two of the participants by this means after they met the initial screening questionnaire criteria. I completed a pilot study with the first three study participants I recruited. Pilot studies enable researchers to examine the feasibility of the methodologies they intend to use in their studies (Whitehead, Sully, & Campbell, 2014). This pilot study helped me to test the quality of my study methodology, including the participant recruitment plan, the data collection tool (Appendix D), and my data analysis techniques. Results of the pilot study indicated that the interview guide could generate the data I needed to accurately address the study questions.

The recruitment process was identical for the pilot study and the main study; the pilot study participants met all eligibility criteria detailed in the study invitation flyer (Appendix A). Flyers were placed in churches with secretaries and in community centers. I sent out flyers and demographic checklist via emails and U.S. postal service. I called the African American pastors who were interested using the initial screening questionnaire for recruiting potential participants. I screened participants using the initial eligibility screening questionnaire (Appendix B), and I requested that participants complete a demographic checklist (Appendix C). At the start of each interview, I read the consent form to each participant and obtained her signature as an indication

of full approval and consent to participate in the pilot study. The three pilot study participants answered all interview questions with responses that explicitly addressed the three research questions.

The responses of the pilot study participants confirmed that the study flyer, demographic checklist, eligibility screening questionnaire, and consent form aligned well with the study problem and purpose; participants did not ask for further explanation during the recruitment and interview process, a sign that all study documents were understandable. The voice recorders produced good sound and I identified no unwanted noises, which established discretion of the interview setting. Although detailed results are not reported herein, the pilot study was successful; I needed no major modifications to any of the study processes or documents. There were no changes to the interview questions and thus no need for changes to the original IRB approval. The hands-on experience of completing a pilot study enhanced my interviewing skills, which increased my confidence during the main study interviews

Study Setting

The responses to the interview guided questions by the participants formed the primary source of data used in this study. I conducted face-to-face interviews with each of the study participants in their chosen settings, either at their churches or in their homes. As argued by Irvine, Drew, and Sainsbury (2013), face-to-face interviews in private settings enable researchers to create optimal encounters to develop normal connections that allow participants to spontaneously share their experiences and perspectives. I maintained a journal for my personal self-reflections to guard me from bias so that I could maintain flexibility and alternative plans to deal with any sudden or unforeseen problems (see Jacob & Ferguson, 2012).

Discretion is one of the core elements that enhance participants' trust in qualitative interviews (Brandimarte, Acquisti, & Loewenstein, 2013). The private setting provided a comfortable and relaxing atmosphere, so the participants could share their experiences and perspectives. I accepted every one of the participants' chosen settings as the interview venues because they were given the option to choose their own venues; the venues were easily accessible. Days before each of my scheduled interviews, I drove to the location to familiarize myself with the neighborhood, so I could get to these interviews on time.

On my arrival to each church location, the receptionist received and escorted me to the participants' office; in the private homes, the participants welcomed and invited me in. Before and after each of the interviews, the participants gave me a guided tour and introduced me to those around. Of the fifteen of the participants, seven honored their appointments and eight cancelled their appointments. However, of the eight that cancelled, six of them rescheduled. The remaining two participants permanently cancelled due to unforeseen personal issues. They did not participate in the study.

The interview rooms in the churches had several seats and desks; I gave participants the opportunity to choose where to sit. Before each interview took place, I used a few minutes to interact and build rapport with each participant to make her feel comfortable and relaxed, which helped build trust for them sharing their experiences and perceptions during our interview sessions (see Irvine et al., 2013). At this moment, I gave participants $25 Visa gift cards as an assurance that they did not have to complete the interview to be compensated. One participant refused the card, stating that it is "God's work I am doing." I reminded her that she could also refuse the interview because she refused the $25 gift card, and she insisted, "I agreed to this interview not because of you paying me for my time but because I'll do anything for my God."

As was the case with the pilot study participants, before the interviews began, each participant filled out the demographic form and signed a consent form that highlighted (a) the study background and purpose; (b) the voluntary nature of the study; (c) sample interview questions; (d) possible benefits and risks; (d) privacy, confidentiality, and rights of study participants; and (e) the expected time frame to complete the interview process. After obtaining the participant's consent, I started to record the conversation and began to administer the interview questions outlined in the interview guide (Appendix D). In addition, I used other data collection tools, including field notes and memos to record additional data from observing and listening to participant responses throughout the interviews. These data permit the researcher to triangulate data during analysis to enhance the quality of study findings (Guo, Reimers, Xie, & Li, 2014; Tessier, 2012). After obtaining responses to all the research-guided interview questions, I informed participants of the next steps after data collection and thanked them for participating in the study.

Participant Demographics

By filling out demographic checklists (Appendix C), participants provided relevant demographic information used in this study, including their ethnicity, current place of residence, level of education, employment status, number of years as a minister, and religious affiliation. Table 1 highlights the key demographic information of participants in this study. The ethnicity of the participants were African American, approximately 31% of participants lived in Chicagoland, 31% lived in the Southeast suburbs, and 38% lived in the far South suburbs. By education level, 23% of participants had bachelor's degrees, and 38.5% each had master's or doctoral degrees. A slight majority of the pastors worked full time at 54%; the majority had been

ministering for 5 years or over. After initial eligibility screening and scheduling interviews, I decided to represent each of the participants with numbers and churches with alphabets.

Table 1

Demographics of Study Participants (N=13)

Participants	Ethnicity	Education	Employment	Years of Ministry	Affiliation
P1	AA	D	FT	17	BC
P2	AA	M	FT	5	AC
P3	AA	M	PT	20	BC
P4	AA	M	PT	12	PC
P5	AA	D	FT	10	NC
P6	AA	B	FT	19	PC
P7	AA	B	PT	4	PC
P8	AA	B	PT	8	MC
P9	AA	D	FT	25	PC
P10	AA	D	FT	15	PC
P11	AA	M	PT	3	BC
P12	AA	D	FT	17	PC
P13	AA	M	PT	5	AC

Note: African American, B = Bachelor's, M = Master's, D = Doctorate, FT = Full time, PT = Part time, AC = Apostolic church, BC = Baptist church, MC = Methodist church, NC = Nondenominational church, PC = Pentecostal church

Participant Profiles

In this section, I provide brief profiles of the 13 female African American pastors I interviewed in this study identified only by the numbers assigned to them. Each profile highlight details of the participant's demographics: including ethnicity, sex, residence, education level, years in as a pastor, and church affiliations.

P1 has been a pastor for 17 years at Church A. She is married and living with her husband in Southeast suburb of Chicago. She identified herself as African American and a senior pastor who had started as a youth pastor before starting her own church in Chicago. P1 has a doctoral degree in family/marriage counseling and is currently a full-time pastor. She initiated health promotion activities in her church in conjunction with members of the congregation.

P2 has been a pastor for 5 years at Church B. She is married and living with her husband and three children in a far South Chicago suburb. She identified herself as an associate pastor and an African American, although she was a counselor for over 10 years before becoming a full-time pastor; she has a master's degree in pastoral counseling. P2 is proud to be one of the pastors who started health promotion activities in a church.

P3 is an associate pastor at Church C. She is married and living with her husband and one older child in Chicago. She identified herself as an African American. She has a master's degree in nursing. P3 has been an associate pastor for 20 years at Church C and still works part-time as a nurse. She loves her job as an associate pastor, so she is going to become a full-time associate pastor next year. This pastor did not initiate health promotion activity, but she was on the committee that oversees the yearly health promotion activities in the church.

P4 has been an associate pastor for 12 years at Church D. She identified herself as African American. She is a married mother of four children living with her husband in Southeast suburb. She has a master's degree in education and was an educator for 15 years before becoming an associate pastor; she still teaches part time online at a junior college. She loves being a minister, and she took part in implementing a health promotion event at her church that takes place every year.

P5 from Church E lives alone in Southeast suburb. She identified herself as African American, she has a doctorate in pastoral counseling, and she is engaged to be married. P5 has been a full-time pastor for 10 years and is the senior pastor of Church E; she trains pastors and strategically sends them out to other churches to lead. P5 initiated CBHP activities at her church and in the community, and she makes sure these activities are held three times every year.

P6 is a full-time associate pastor at Church F in a Southeast suburb. She is married with three adult children, and she lives in Chicago with her husband. She identified herself as African American. She has a bachelor's degree in nursing and has been a minister for 19 years. P6 trained for more than 5 years at Church F. She initiated health promotion activities in her the church and is happy with her accomplishments of these yearly health promotion activities.

P7 has been a part-time associate pastor at Church G for 4 years as well as being a social worker; she has a bachelor's in psychology. She identified herself as African American. P7 is married with two children and lives with her husband in Chicago, and she says her first love is serving people; P7 is part of the committee that initiated health promotion activities at her church three years ago. She loves helping her congregation members register for health insurance and take care of themselves.

P8 from Church H identified herself as of African American and an associate pastor; she is engaged and is not rushing to be married yet. She lives alone with her two dogs and has a bachelor's degree. P8 has been in the church all her life; she started as the children's department teacher at Church H, moved on to be a youth pastor for three years, and has now been an associate pastor for 8 years. P8 is a nurse by profession and was one of the initiators of health promotion activities at the church 6 years ago. She enjoys working on these activities, and she says she wants to make an impact by helping people not just emotionally but both physically and spiritually.

P9 is a full-time senior pastor at Church I who identified herself as African American. She is married, living with her husband in a far South suburb, and she has three older children who are living outside the home. P9 has a doctorate in marriage counseling and has been a pastor

for 18 years. She initiated health promotion activities for her congregation and has been involved in these activities for the past 8 years along with several church members and associate pastors.

P10 is a senior pastor at Church J. She identified herself as African American, and she lives with her husband in Southeast suburb. P10 has a doctoral degree in theology/pastoral counseling; she became a full-time pastor after working for a hospital and a high school for 25 years. She has been a full-time pastor for 15 years, and she now has seven associate pastors and two deacons. P10 was one of the pastors who initiated health promotion activities, working with her associate pastors and deacons. She holds these activities every year and is pleased with the turnout every year.

P11 is an associate pastor with Church K. She identified herself as African American. She lives with her husband in Chicago, has a master's degree in education, and was a full-time school teacher at the time of this interview. P11 is new at being a pastor. She had been active in the church before, but she was only ordained 3 years ago. She was, however, part of the team that initiated health promotion in the church 6 years ago. P11 enjoys being a minister and participating in the health promotion activities. She wants to become a full-time pastor soon so she can continue caring for her congregation and community with these activities.

P12 identified herself as African American and a senior pastor in the Baptist Convention at Church L in a far South suburb. She has a husband and two adult children, and she lives with her husband in the far South suburb. P12 has a doctorate in theology, entered the ministry immediately, and has been a pastor for 17 years. She initiated CBHP activities 5 years ago with the help of some of the associate pastors and members.

P13 from Church M identified as African American. She is married and lives with her husband of 7 years in a far South suburb. She has a master's degree in social work and works 3

days as a social worker and 2 days as an associate pastor. She was part of the team that initiated health promotion activities at her church, which have been in existence for 3 ½ years.

Data Collection

I collected data from 13 female pastors who identified themselves as African American; they willingly and openly volunteered their experiences and perspectives by answering the interview questions listed in Appendix D. The interviews took place over six months between May and October 2017.

All participants recruited in this study answered the invitation flyers (Appendix A) and emails. I distributed the flyers to 30 churches, 10 community centers, and 15 grocery stores, and I emailed 40 churches; I also visited 10 different churches' Sunday services. After identifying these churches via internet in the chosen areas, most of them responded back via internet. Majority of them said no, but I called and scheduled some appointments with the churches willing to participate. I visited the churches during their Sunday services so that I could distribute my flyers personally to the pastors. I spoke with church representatives privately after service and asked to be given the opportunity to speak with female pastors. All but two of the churches gave me permission to interview their female pastors. The rest denied me access because their senior pastors, who happened to be male, wouldn't allow it. When contacted by prospective participants, I gave them a brief introduction to the study and completed an initial screening questionnaire (Appendix B) that lasted 5 to 15 minutes to determine eligibility. When prospective participants failed to meet the initial screening criteria, I thanked them for showing interest in participating and expressed my regret that they did not meet the requirements to participate. After identifying eligible participants and affirming their interest in participating, we worked together to schedule convenient dates for face-to-face interviews at their chosen location.

During the interviews, I asked the study participants the semi-structured questions in the interview guide pertaining to the phenomenon of church-based health promotion activities. The interviews lasted between 40 and 83 minutes, during which study participants voluntarily shared stories of their experiences and perspectives on congregational health promotion activities.

Both my dissertation committee and Walden University's IRB approved the content of the data collection tool, the interview protocol (Appendix D). The interviews took place at locations and in settings chosen by the participants, which ensured their privacy and the confidentiality of the information they shared during the interviews. Also, as I noted above, in documenting and reporting on the data, I emphasized the participants' privacy and confidentiality by not using their real names. Instead, I assigned each participant a number that I used during the data collection and analysis and the reporting of study findings.

After each interview was complete, I immediately transferred all recorded interviews from the recording devices to a single file folder on my computer secured with a strong pass code. I used this same computer to send the recorded interviews to a transcription service, and I received each transcript by computer within three days. I stored the transcribed data in multiple places in my computer, and I also utilized an external storage device for the interview transcripts, both with strong pass codes. In addition, I kept my field notes, which tracked and captured the nonverbal communications that transpired during the interviews, including facial expressions, gestures, and pauses, in a secured pass coded locker that was only accessible to me.

The participant recruitment took six months because I encountered challenges. Potential participants from six churches did not respond to the emails or flyers they received from me; instead, their senior pastors and assistant male pastors replied on their behalf. These pastors explained that their churches' senior pastors were males and that only these male pastors could

answer my questions. Although they apologized and wished me well, they were very concerned with me interviewing just female pastors and not both. I explained to them that the study only focused on female pastors, but they were still not satisfied, and ultimately I did not get interviews from those six churches. In a specific incident, one of the most interesting challenges that occurred during recruitment was when one male pastor tried to disrupt an interview. The potential participant was his wife, and he requested that he be present during the interview session. I quickly and respectfully declined his offer and did not get the chance to interview that female pastor.

Data Analysis

I first manually coded the data I collected to familiarize myself with the coding process and with the data. I repeatedly studied each sentence in the participants' responses to identify code patterns; I then grouped these patterns to form categories that I then used to identify themes. All this was done to capture direct quotes from participants that buttressed the interpretation of the data and to create themes or concepts (Gioia et al., 2013; Rudestam & Newton, 2001). Each of the female African American participants provided comprehensive data that related to their experiences and perspectives with organizing church-based health promotion activities in their respective churches. I searched for both commonalities and differences in the pastors' responses.

The overall goal of this analysis was to make the association between the data gathered and the research questions. I synthesized the descriptions of the study phenomenon from the study participants, conceptualized fundamental structures, and validated findings with the original collected data. I asked the same interview questions of each participant, and this consistency allowed me to auto code most of the transcribed data into NVivo 11 data analysis

software; the NVivo software allows researchers to collect, organize, and analyze data from interviews, observation of focus groups, discussions, surveys, and audio recordings (Creswell, 2013). Interview questions (IQs) generated consistent responses that addressed study questions, which helped me to organize and arrange the collected data according to RQs and corresponding IQs. I analyzed and interpreted the organized data using constant comparison, the theoretical framework that guided this study.

Evidence of Trustworthiness

Credibility

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Transferability

Lincoln and Guba (1985) wrote that transferability can be used as a thick description of procedures, context, and participants in an ample facet to allow others to determine the resemblance and restructure research findings. The participants in this study, female African American pastors who implemented health promotion activities in their respective churches would be transferable to a comparable population that meets the same measure. To attain transferability, I utilized analysis between participants to generate themes to define the scope of this study. Thus, results from this study may be pertinent to related studies conducted by other researchers investigating related problems, in similar settings, on similar populations. During the entire process of carrying out this study, I preserved impartiality and controlled possible researcher biases from swaying the study process and findings because of my religious beliefs as a Christian.

Dependability

To enrich dependability, I scientifically applied the methodology approved for this study. For example, I consistently used the IRB-approved study guide to recruit and interview participants and during data analysis. Miles, Huberman, and Saldana (2014) assessed that audit trails offer a step-by-step overview of each stage of the research process that can be repeated by researchers who want to duplicate a study in a similar setting with similar study populations. I

used a research journal and audit trails to protect my study records, and I recorded how I maintained neutrality as well as the stages I took to address potential researcher biases, which confirms dependability. The readers of this study interested in performing their own research should be able to replicate this research study.

Confirmability

Confirmability refers to the degree to which the results of this study could be substantiated by other potential researchers for data's accuracy, relevance, or meaning (Elo et al., 2014). The rationale for doing this is to show the transparency of the study methodology, so readers, including those who may not share my interpretation, can discern the means by which I reached my study conclusions. I kept audit trails, as highlighted in Miles et al. (2014), to systematically track the contextual background of the data and the incentives and rationales for all methodological decisions taken throughout the study. Audit trails also made it possible for me to organize, document, and keep track of the data on an ongoing basis and to summarize and synthesize data on a frequent basis during the research study process.

Results

In this study, I sought to present the voices of female African American pastors as they narrated their experiences and perspectives of congregational health promotion using the 13 themes and 10 categories that emerged from analyzing the participants' responses to interview questions. I selected the themes based on the statement, phrase, and word similarities as they emerged during data analysis using NVivo 11. Interview questions IQ2 (b/d), IQ3 (b/c/d/e/f), IQ4 (b), IQ7, IQ8, and IQ9 did not directly address the study research questions but were useful in gathering data on the female African American pastors' experiences and perspectives concerning congregational health promotion activities.

Research Question 1

To generate responses to RQ1, I developed the following six IQs that the study participants answered:

IQ1. What is your role as African American female pastor in health promotion and prevention in your congregation? What were your expectations for your congregation in church-based health promotion intervention?

IQ2. What was the reason for starting and participating in church-based health promotion?

IQ3. How are you able to support your congregation from the pulpit?

IQ4. Based on your leadership and counseling experience with your congregation, what do you believe to be the high health risks of your congregation?

IQ5. What was the best experience you had as an African American female pastor in CBHP? Please give examples of things that made it good experience or a bad one?

IQ12. How do you perceive your role and that of the church as advocates of positive social change in your congregants or community?

All participants responded to these questions, except that one did not respond to IQ1b and three did not answer IQ12. Seven themes emerged from the answers to RQ1: (a) church to have healthy congregations, (b) God called me, (c) health insurance, (d) health problems in the church, (e) health promotion, (f) pastoring, and (g) support for health promotion. In addition, two categories were created.

Table 2 below summarizes the themes and categories that emerged from the answers to RQ1.

Table 2

Emergent Themes and Categories for Research Question 1

Research Question 1	Themes	Categories
What is the role of African American female Christian pastors in influencing, motivating, and building health promotion programs?	• Church to have healthy congregations • God called me • Health insurance • Health problems in the church • Health promotion activities • Pastoring • Support for health promotion	• Ministry • Social change

Theme 1: Church to have healthy congregations

The participants felt their position as pastors made them responsible for caring for their congregations; all of the participants were truly concerned with the well-being of their church members. The majority of the participants' answers were similar to each other, but three answers were memorable during the interviews:

> **P9**. I really wish for my congregation to be healthy. I love to exercise every morning, so I want the same for my congregation. For my congregation, I really pray they remain healthy and take good care of themselves.
>
> **P10.** Starting this program was easy for me because I want all my members to live their full lives. I do not want premature deaths in the church … My expectation for the congregation is that they would love life and live it the fullest as intended by God … I am happy if my members are healthy and happy.
>
> **P11.** Our expectation from the congregation is to have them involved in one form or the other. They must come and help even if they feel they are healthy… We are very serious

about eating healthy foods and exercising, so we encourage the congregation to come and be part of it.

I specifically remember the answer one of the participants gave when asked of her expectations for the congregation; her answer had nothing to do with her congregation's health. It was surprising to me that she saw the congregation as not being honest with her, straightforward with their health issues, or truthful about their health when asked. She used certain words to express her feelings of disappointment, such as "facading, dishonest, and masking the truth about their illness and disease" of the congregation. During the interview she revealed that she was not pleased with this behavior because she wanted to help and assist her congregation but could not.

Theme 2: God called me

I was surprised at the participants' responses regarding their roles as female African American pastors and their experiences in implementing church-based health promotion to their congregations and communities. All the participants responded with a sense of calling, a duty to be servants of God, or a responsibility to care for their congregants, God's children. They responded as pastors who were leaders and who had experience in their profession representing God and emulating Jesus Christ. They expressed why it was important to care for their congregations by implementing health promotion in the church for those who could not afford health care on their own. Data analysis revealed three of the participants' answers to be more direct and specific regarding their calling as God's servant:

P8. I am an assistant pastor, but with more responsibilities. As a servant of God, I work for God in the church.

P10. I am a senior pastor of this church. I started the church with three families in my basement in 1999; I have almost 600 members now in the church. It is a Pentecostal church, and we believe in God, Jesus, and the Holy Spirit. I oversee most of the events in the church. I have seven pastors, two deacons, one elder, and ten leaders in the church. I am the shepherd, and I am responsible for all the members in the church because God has given me the job to do. I enjoy being a pastor of the church. I love my members and want the best for them. The church is growing and work is getting harder too. To whom much is given, much is expected.

P13. Well, I am one of the assistant pastors of our church. My responsibilities include women ministry and church health promotion. As a servant of God, I am responsible to God's work in the church; I work for God's people in the church. I also participate in the initiation of church based health promotion in the church. I am a social worker by day for three days and two days as an associate pastor. I believe I was created by God to care for His children not just spiritually but emotionally and physically.

To my amazement, one of the participants opened up to me about her feelings and her role as a pastor. She said that she felt she was not given the opportunity to turn down her present position as a pastor; she said she would remain as a pastor for one more year and go back to her old profession, where she would triumph and be fulfilled. The participant stated, "I was asked by my senior pastor to take part in this study. He got the mail and asked me to partake in the study….To tell you the truth, I really do not want to be a pastor. I was not given the option to decline this position because it was presented to me that God wants me to be a pastor."

Theme 3: Health Insurance

When participants were asked why they wanted to implement health promotion in their churches, they spoke of poor health and no insurance. The majority of the participants expressed how having health insurance is one of the ways people could obtain good health care from hospitals and clinics. The participants stated that having insurance made a big difference for their congregation members, but unfortunately, many people do not have the necessary insurance to take proper care of their health issues. Participants P1, P7, P9, and P12 shared the importance of health insurance for their congregations:

> **P1.** We try … even though we don't provide insurance, we try to provide information for various insurance. I have families that had Harmony Health Care. Because they were on general assistance, they qualified for the additional benefits of Harmony Health Care for themselves, for their children… I felt comfortable as a pastor that in the event there will be a medical crisis, everyone in that family had the opportunity to have general health insurance.
>
> **P7.** Most of them are without insurance, so this is the only means for them to check their blood pressure and other tests.
>
> **P9.** For those who do not have health insurance or had before but don't at this time do not want others to know they need help. To them, it is a stigma, and they want to trust the pastor and the program not to air out their lack and needs to other members of the church. All these concerns to me relate to trust. I want my congregation to trust me and know that I will not share their secrets with other members.
>
> **P12.** With the health promotion activities in the church is one way of introducing health care to some of our congregations that have no insurance, so can get the proper help at a reasonable time.

Theme 4: Heath Problems in the Church

The data analysis of health promotion activities in African American congregations revealed that these participants were truly concerned about chronic health diseases and early deaths in their congregations. The female African American pastors influenced, motivated, and built health promotion activities in their respective churches to assist their congregations in receiving health care. Participants wanted to improve the health of their congregations and reduce the continuous chronic health issues in their churches. They saw that members of their congregations were living poorly, and they wanted to implement health promotion for their congregations and communities. According to the participants, most of their congregation members had been battling chronic diseases for years and were not getting better. All the participants spoke of high blood pressure as the major health problem among their church members; however, three of them added more conditions in their answers regarding high-risk health problems among their church members:

> **P11.** When we look around the church, the congregation do have chronic diseases that must be addressed. There are members who have diabetes, high blood pressure, obesity, prostate problems, and heart diseases. What better way to have church-based health promotion to help address these problems?
>
> **P12.** The program was initiated also for the chronic health problems in the congregation. The members have hypertension and diabetes. Some of them suffer from arthritis and mental problems.
>
> **P13.** The church addresses high blood pressure, mental issues, diabetes, heart diseases, obesity, and so on. Obesity is common in the church, and addressing it is one of our goals

for the congregation. During our monthly mini-health promotion educations, nutrition is also discussed and encouraged.

Two of the participants had different health problems as their answers:

P5. Well, I'm looking at everything from physical to mental health issues. I'm looking at diabetics, I'm looking at people facing kidney issues with dialysis, I'm looking at teen pregnancy and young women who are not caring for themselves. And of course, among our congregation, it's obvious that there are people who really could use some attention in terms of mental health.

P1. I have dealt heavily in abuse. I've had in the congregation, not just the congregants, I've had a lot of the leaders that were with me having to deal with very severe domestic abuse. What do I do when I miss them at church? I'd have to call many times. I've even gone to people's house unannounced and say I'm kind of nosy.

P2's answer related more to not knowing the health problems in her church because congregants would not divulge their health problems openly to the pastors or other congregants:

P2. I don't think African-Americans are as open to disclose a lot of their health challenges. Number one, because they don't know for sure, and number two, they're probably embarrassed. I can look and see that a lot of our people in organization, in our congregation, are obese—they're grossly overweight. Usually, when you have obesity, it is coupled with something else, high blood pressure and diabetes and other little things that probably go along with it that we might not attribute to health challenges but they are.

Theme 5: Health Promotion Activities

Participants saw health promotion as a way of addressing the health issues and curbing early deaths of their congregants. As female African American pastors, the participants were very serious in discussing how health promotion activities had helped their congregations to be serious about their health and understand why it is important to lead a healthy life. They also felt that the health promotion activities had given them the chance to be close to the members of their congregations. Participants wanted to use this avenue of health promotion to change their congregants' behaviors and lifestyles. All the participants' answers were very specific regarding they had initiated or helped to implement health promotion activities in their churches. Among the participants who were senior pastors (5/13), four of them had initiated and one participated in health promotion activities:

> **P1**. We are bringing the resource, we're bringing awareness, and we're bringing institutions into the church to better educate us. I think that was the biggest issue with me is that, when you don't acknowledge there's a need, you don't feel a need to get the resources. That is why a lot of these churches right now are falling, because they don't have the resources to meet the health needs of the people. Be it cancer, be it lupus, and be it immunization for our young people, researching what we have, bipolar disorders, and mental health disorders.
>
> **P5.** This is just a part of what we do three times per year; we make sure health is promoted to the congregation and community three times a year. We believe for lack of knowledge, the sooner they get to get help for their health issues, the better those situations will be handled. Making sure the congregation get the right and appropriate information for what they need the better.

P9. The church-based health promotion activities are held because of the increasing high blood pressure, diabetes, heart diseases, prostate, and breast cancers. Apart from our yearly health fairs, every first Monday of the month, I have different people in health fields come speak with the congregation about health. So far, it has been successful. Most of the invited speakers speak about nutrition, stress, sugar, salt, and exercise.

P10. I would say as an African-American pastor and a female is not easy. I have been a pastor for fifteen years, and I have participated in the church's health promotion program now for almost five years. I was one of the initiators of the church-based health promotion programs. I am the senior pastor of this church.

P12. My role as a pastor does include initiating health promotion. I make sure the congregation hear me announce different health activities from the pulpit that can change their lives for the better; I want to see the congregation living their lives to the fullest. With the health promotion activities in the church is one way of introducing health care to some of our congregations that have no insurance, so cannot get the proper help at a reasonable time. We have our health promotion events twice a year, May and September.

Of the remaining participants who were assistant pastors, seven participated in and one had initiated their churches' health promotion activities:

P2. What we do, we do health promotions. We do … sorry, health screenings as a part of the outreach effort along with, of course, music and school supplies, things of that nature. This is our main outreach effort where we do PSA screenings, we do education as far as mental wellness, mental illnesses and things of that nature. We also do immunizations, we do high blood pressure screenings, we do dental screenings, and we do, I believe

diabetic screening as well. After that, once we do the screenings and of course, medical personnel they're available to talk with the guests.

P3. My expectations from the congregation when we have any kind of health promotions is to get the congregation involved. We have a bulletin that every Sunday has information in it, and we have different information in our bulletin, but sometimes everything does not get in the bulletin. Like here tomorrow, we have our panel discussion on adverse childhood experiences and trauma of adult well-being.

P4. We are participating in church-based health promotion for people to know themselves. Individuals are supposed to know themselves better than the second person. They should go for the yearly physical. It just to create awareness about their level of own health and wellness. They don't wait until the last minute until something happens.

P6. I am not the senior pastor of our church, so it makes some of my work in the church easy. I am fortunate to have a female as a senior pastor, who is also the general overseer of the church. The job given to me is very dear to me. Health is everything. I do initiation for all the ideas for each health fairs, but I do have other pastors and members join in the participation of health promotion activities and programs in the church every year.

P7. We have people come speak to the congregation about health, nutrition, lifestyle changes, and diseases. Now all members of the church must have their health physicals every year if they are healthy, and those with chronic diseases must always be ahead of their promotion of health. Because of the church-based health promotion activities in the church, we now discuss about many other health problems. Because many without insurance don’t even know they have health problems, so they wait till it is too late. In the church, we had someone who was in a coma for almost two days because of high

sugar. My senior pastor does not want this to happen again, so the health fairs started … After the first church-based health promotion activity, we had survey done to get the opinion of the congregation.

P8. Health problems like prostate and breast cancers are in the church. In the U.S. more of African American female are dying from breast cancers than other nationalities, so having experts to come speak about women's health is one of the improvements the church has made from feedbacks. As the church continues to hold these health promotion health fairs in the church, we have been effective in making sure everyone's concerns are handle with respective.

P11. There are some prevalent diseases that are addressed in these training sessions. When we look around the church, the congregation do have chronic diseases that must be addressed. There are members who have diabetes, high blood pressures, obesity, prostate problems, and heart diseases. What better way to have church-based health promotion to help address these problems?

P13. We have early strokes and heart attacks that made the pastoral committee implement church-based health promotion in the church. We have a yearly health fair, and every month education from different health professional from the church and outside the church. The congregation is happy to have these available assistance that are scarce outside the church.

Theme 6: Pastoring

The participants saw their duties and responsibilities as a direct calling from God. They wanted to make a difference in the lives of the members of their congregations. The majority of the participants revealed their caring and pastoring abilities toward the health of the church

members. However, one participant felt pressured to accept the position as a pastor. She said her senior pastor told her God asked him to ordain her as a pastor and she was not given the chance to either accept or reject the offer, and she did not want to disappoint the senior pastor. This is the reason she would love to go back to her old job as a counselor. Participants stated that they influenced their congregations by showing interest in how church members lived through the words of God. Below are some samples of their words on being a minister in an African American church:

> **P1.** My first position I think to assist the congregation in areas of health is to be very in tune with what the family needs are. When you pastor a church, you pastor primarily four generations of people. One family can consist of a grandmother—grandparents—their daughter and son, which is marital in-laws, and their biological children. Some blended family, one may have had children prior to the marriage.
>
> **P2.** I'm actually the most senior pastor out of all of the pastors. One of our role is to provide the church with information and promote things that are and that will benefit the church holistically…Personally it means a lot because I have been trained; I'm a trained counselor. I received a master's at Loyola in pastoral counseling, I received a master's from Adler University in military psychology. As a counselor, I try to deal with the whole person; if you are unhealthy physically then everything else is going to be unhealthy, mentally, emotionally, and spiritually. I believe because I used to work with the VA. I do miss my job. I will love to go back to the VA; I enjoyed taking care of the veterans. I know whenever we have our health fair, some of them come to have their health tested but never follow up.

P3. I came to Trinity in 1999 and when I came I was a nurse. I've been a nurse since 1974. I went straight from high school to nursing school and became a nurse. Then in 1980, I went back to get my… I think 84, no, 85… I went back to get my BSN and then I got my master's degree. So when I came here, I was a nurse, and naturally being a nurse in a faith congregation, people will always pull on you, ask questions, whatever… so I did educational net level about different diseases, even Deacon Ministry, different diseases.

P4. It's also a privilege to be interviewed by you, and I thank you for this opportunity. I am an associate pastor for almost twelve years. My senior pastor is a female, and I am privileged to work under her. I have several duties in the church, and I am respected by the congregation. I participate in our yearly health promotion activities, which is usually in August.

P5. My role of course as the leader is to make sure that health issues are included in our focus in our ministry and to promote those issues the pulpit. I have an outreach church where I train pastors and disseminate them into different denominations. I also make sure they are from ready to bring not just spiritual beliefs to the world but emotional and health.

P6. I am not the senior pastor of our church, so it makes some of my work in the church easy. I am fortunate to have a female as a senior pastor, who is also the general overseer of the church. She is the visionary, and we take directions from her. I take the job given to me very dearly. Health is everything.

P7. I'm the associate pastor to a pastor who started this church from the beginning. She was called into the ministry by God, so she was then ordained to be part of the ministry

by the senior pastor. I have been a pastor for four years now, and I love being a pastor. I do work also outside the church as a social worker. I work closely with the senior pastor and oversee the youth ministry also. As a church, health has been a problem for us. We are no different from most African-American churches where chronic diseases are prevalent. Can I say that the biggest problem we face is obesity? It is a basic health issues, especially among us from African descent.

P8. Counseling the congregation fulfills my purpose in life. I love people, and I make sure they are loved by me as their pastor. If the congregation cannot get love from the church, I wonder where they can find one. It has God move in mysterious ways.

P9: Since I am the senior pastor of our church, I really wish for my congregation to be healthy. I love to exercise every morning, so I want the same for my congregation. I have four other pastors that work with me in the church. They have other jobs, but I am full-time pastor. I started church-based health promotion in the church eight years ago.

P10. I would say as an African-American pastor and a female is not easy. I have been a pastor for fifteen years, and I have participated in the church's health promotion program now for almost five years. I was one of the initiators of the church-based health promotion programs. I am a senior pastor of this church. I started the church with three families in my basement in 1999. It is a Pentecostal church, and we believe in God, Jesus, and the Holy Spirit. I oversee most of the events in the church. I have seven pastors, two deacons, one elder, and ten leaders in the church. I am the shepherd, and I am responsible for all the members in the church because God has given me the job to do. I enjoy being a pastor of the church. I love my members.

P11. I am an associate pastor in a Baptist church. I love being a pastor. I have been at least three years as a pastor. Our senior pastor is a male. I am planning to become a full-time pastor of our church. I am a high school teacher by profession. I did not initiate the church-based health promotion by myself, but I was one of those who initiated the health promotion in the church six years ago. It was a collaborative effort by a group of pastors and members interested in helping others and strangers.

P12. My first position I think is to serve my congregation as God asked me to. I also assist the congregation in many ways including health. I pray to God to guide me and tell me what I should tell the congregation every time I am to speak the word of God from the pulpit. I also call my congregation whenever God asks me to call and warn them of dangers. I am basically the spiritual mother of the congregation. God has given them to me to take care of, so I am responsible as long as they are still the member of my church. I am their senior pastor and I must do my job from the pulpit and outside the pulpit.

P13. Well, I am one of the assistant pastors of our church. My responsibilities include women ministry and church health promotion. As a servant of God, I am responsible to God's work in the church; I work for God's people in the church. I also participate in the initiation of church-based health promotion in the church. I am a social worker by day for three days and two days as an associate pastor. I believe I was created by God to care for His children not just spiritually but emotionally and physically…The health promotion is about three and half years old now. We are a medium-size church, and we are ready to make impact in the community. My senior pastor is a male, but he is not intimidated by the female pastors.

Theme 7: Support for Health Promotion

Participants expressed their concerns with funding church-based health promotion activities; all their answers were similar in the sense that they looked outside for support. The pastors were very aggressive in pursuing the success of health promotion activities in their churches; they expressed how important it is to have things in place for each year's health promotion activities. Participants were able to influence and motivate their congregations and communities alike as they implemented health promotion activities in their churches. Some of them had fund raising within the church and community to be able to fund their health promotion activities. The participants worked hard and used different ways to acquire funds for health promotion activities in the church:

> **P1.** When you start a program, you never know where you're going to get the money from. You try to deal with people in your congregation that are resourceful, that will dig a little deeper and find intervention programs free or general to the public that you can bring into your church; that's the best way to do it. However, many times for me, I was fortunate enough to have clinical psychologists in my congregation, lawyers, and a few doctors. So, I too, knowing the congregation, would allow them to have an expression and share their information free.
>
> **P2.** We have Walgreens, University of Chicago hospital, CVS, different health insurance companies, and so on come to help us present our yearly health fair. Every year we have more than 500 people come through the health fair; we have more than 50 booths with different vendors. I hope you can come and witness this. We do have donations from local companies and individuals.
>
> **P3.** So Walgreens gives us, when you are talking about resources, we get the blood pressure machines, the glucose theaters, we get flu shots, and then we have other vendors

coming in and do things like mini massages. Doctors come in and they do conferences on different things. University of Chicago, we just have different health facilities that comes there, and that's a biggie. On that day we serve about 500 people that comes through. Well, I'll say 500 people that we have forms on that get screened, but it's more than 500 that just comes through and picks up information.

P4. Usually, we write companies; we have some of our members who work for this. There are some pharmaceutical companies. We have the Home Health. We invite companies who will come. They'll support the church. We always create that awareness amongst our members for them to come and be checked out, and mostly we don't pay, because it is highly subsidized. We've had a lot of people coming to get their blood pressure to do the blood sugar, they would check their heart rate. This has been effective, and we find a lot of responses.

P5. There's a combination of things. I think the physical health issues we do focus on more because we have an older population. My focus is in a very low-income community. We spread out various health issues; we have booths and workshops that cover all of the health issues. Sometimes, we have support from private donors, nonprofit organizations, hospitals, and state grants. Just to get the word out. To express my personal concern, my love for the people and my desire to see us live fully.

P6. We use different organizations to assist us for our health promotion fairs. We have CVS, Walgreens, hospitals, nursing homes, Home Health, different health insurance companies, and some private health organizations that attend our health promotion activities. We have more than thirty erected booths for vendors to exhibit their products; we also have blood pressure, blood sugar, cholesterol, prostrate, and other health issues

addressed. The church do have a yearly budget for the health promotion activities; sometimes, outside donations also help with the health promotion activities. The church members do arrange for foods and snacks for the events and also have home health agencies arrange for snacks and drinks.

P7. We get support from health agencies, nonprofit organizations, pharmacies, Home Health, hospitals, and so on are companies that contribute to our health fairs. We also have other churches visit us during the health promotion activities. We've had two banks support us also. We always create the awareness amongst our members for them to come and be checked out, and mostly we don't pay because it is highly subsidized.

P8. The health promotion programs have been difficult, but we manage with what we have. We raise funds by selling baked goods and taffy apples. We also have organizations and companies willing to support us during the health fairs; we have had Walgreens come give flu shots during fall. We lobby health organizations and agencies to come participate during our health fairs, and in turn, they recruit patients that fits their company objectives. All these really help the church carry out church-based health.

P9. Each health fairs have been expensive since we have yearly increase of members and visitors from the neighborhood. We are able to raised funds selling candies, caramel apples, raffle tickets, bake sales, and concerts. We also have donations from the congregation and outside organizations. We also have volunteers from different hospitals, pharmacies, home health agencies, and random helpers from the community.

P10. Usually, there are some pharmaceutical companies and health organizations that do assist us with blood pressure, blood sugar, cholesterol, and BMI checking during the health fair. They support the church monetary also; some nonprofit organizations do help

us also with money donations. We create awareness amongst our members for them to come and be checked out.

P11. What we do is send letters to different organization for donations or their health service each year; this is one of the ways we sponsor health promotion activities. Different health facilities and vendors come to our events. They pay for the booths and pay for tables to exhibit their products and businesses.

P12. I am aggressive in what I want, and I do not take no for answer. The Bible says we should keep on praying and asking till the door is opens. Once I come to realize this, I became bolder in asking for help all the time from these people. It's uneasy at first, but gets easier each year. Every year there's four places we try to get support from for our health promotion program: hospitals/health agencies; church raffle tickets sales/bake sales/donations from members; non-for-profit organizations; and private donations. We do not wait till the event is close before asking. We started with the church contribution and effort; the congregation is a very useful resource.

P13. Supporting the health promotion programs have been difficult, but we manage with what we have. We raise funds by selling raffles tickets and holding concerts. We also have support from neighborhood organizations, health agencies, and companies. Vendors that want to showcase their products do get booths during our health fairs too. All these really help the church carry out church-based health promotion activities. We have CVS and Walgreens come during the health fairs to promote the services they offer in their pharmacies.

In addition to the seven themes that were generated, analysis of the female African American Christian pastors' interview responses regarding their roles in influencing, motivating,

and building health promotion programs also revealed their roles in three categories that did not fit into the themes and will be discussed separately: Illness, ministry, and social change.

Ministry

All the participants were asked if they had health ministry as part of their health promotion activities in their churches, and all but three did not: P6, P9, and P11. RQ1 is focused on female African American pastors' roles in their churches as they implement health promotion activities; Health ministry helped most of the participants to continue these yearly health activities. Participants stated how health ministry was important in reaching most of their goals in helping congregations have access to health promotion activities all year round. P1, P2, and P5 had outreach ministries that they said were equivalent to health ministries; these ministries continued health promotion activities all year round at the churches. P3, P4, P7, P8, P10, P12, and P13 had health ministry in their churches, and they assisted their participants in keeping up with health promotion activities. Health ministry helped participants to assist church congregants with health promotion activities such as screening for high blood pressure, blood sugars, health promotion activities workshops, and other health issues. Some of the participants in their own words were serious about the health of their congregation:

> **P4.** Yes. Basically I've already answered that we have a health ministry, a health ministry in the church, and also we have some diseases as I said earlier that are peculiar to some people, especially the female. We know very well in this country, they will say hypertension is a very great killer. Sometimes people don't even know that they have high blood pressure until something happens. That is one of the reasons why we created this.

P8. Under the leadership of our senior pastor, I and some other pastors and health ministry came up with the idea of having health promotion in the church. We were losing members to illnesses that can be prevented.

P10. In the church today, we have diabetes, hypertension, heart diseases, and obesity. The church does have health ministry; the ministry attract those members that are in the health profession. We are participating in church-based health promotion for people to know themselves. It is our expectation that the members of the church will understand the most important thing in life, their God and health. There's always ways to prevent and even if they have it how to overcome.

Social Change

Health promotion activities in the church led to social changes among congregants and communities. The participants in this dissertation initially sought to bring social changes in the church and eventually curb the increasing death rates among their congregations. IQ12 centered on participants bringing social change to the congregation. It gave meaning to the participants and the incentives to continue with health promotion activities all year round for their church congregations. Data analysis of the participants' responses revealed that social change related to RQ1 with the responses participants gave to IQ12 but did not relate to RQ1 themes. All the participants used statements, phrases, and words for their responses to social change of health promotion activities in the church with their own knowledge and understanding of what social change meant to them:

P1. When you say political positions, social positions, I again go back to what I said earlier: It is that pastor's responsibility to know. You make two decisions: I'll share my resources because that's how you grow, sharing; I'll share my resources to increase your

resources. When you have greater resources I can now leave you accountable to share your resources.

P2. Most of our congregation have changed the way they eat. They exercise more now. The obesity in the church is getting less, and many are starting to understand that most of their health problem stems from being fat. My senior pastor wants to change the behavior of the members, and all the activities we are having is helping in that way. We will continue to hold these activities in the church because it is helping the members greatly. Those without insurance are helped to get into the Affordable Care Act (ACA) and many have their own doctors now. Really these health promotions in the church have been wonderful. I am so proud of the church that is doing this for church member and I am part of this good thing in the church.

P3. The most important thing is you got to be out there, and you've got to hear what the community is saying, and you've got to allow them to say what they feel. You can't put words in their mouth because if I come into your community trying to find out what things I can do in your community, I have to hear from your perspective. When we first start the family caregivers, there was one thing we asked the attendees: What was it they wanted or what was lacking?

P4. Well we were able to ordain three female pastors and three male pastors this summer because they have proved and shown the qualities of pastor in the church and outside. We do have many who have changed their eating habits and losing weight also. Some of our neighboring church are now doing their own health fairs from participating in one of our own health promotion activities. We are working to have a clinic opened to the public to help the poor.

P5. My focus is taking the ministry to the people and doing the work that needs to be done, meeting practical needs. We have the spiritual needs and we have practical needs. I believe that our evangelism effort when we go into the community, we should go not empty handed. We can go with the word, and that's necessary and is needed. We also need to tap into what are your needs. Housing? Health care? Are you having problems with family issues? Are you hungry? Did you need clothing? Those things. Our job is to connect people to those resources to make sure they get there, make sure that there's follow-up. Then we have our case management where we have our clients follow though. We go with them and we call, we contact to make sure that those things happen.

P6. Well social change in my opinion is having our members register for health care services; have them get health care insurance; have them be employed as people who advocate for health care in the community; having more of our female members register in the community college to become nurses; have some of the females become assistant pastors because of their faithful contributions to the church activities; have the youths in the church both males and females register as pastors in theology schools.; and finally we have more of the female members volunteer as counselors to the youths and other members in the church.

P7. We have the evangelism team; we go out to minister to people. People who attend the church for the first time tell us that they are drawn to the church because we care and love. We still strive to reach out to as many as possible this remaining part of the year… The health promotion activities is a great tool for bringing social change to the congregation's health behavior and community. It also helps to encourage female pastors from other churches to stand firm and believe themselves as pastors.

P8. They also are happy to participate in the health fairs. They're calling and they are willing to withstand mediocre comments. My goal is to have more female pastors in church. The community is learning how to eat right learning and be serious about their health, the same time having females in the church as pastors.

P9. This chance has brought social changes to the community and congregation. We had feedbacks that encourages the health promotion committee. We are happy to bring behavioral changes to the community. Many of the community and congregation members have changed the way they eat. They go for checkups and maintain weight loss to stay healthy. Apart from the church members, we have community members that come to volunteer during our health fairs.

P10. We do outreach and health fairs in the community, so we reach people outside the church and make social change in their lives. They get healing, diagnosis, knowledge and behavior change from out activities. Because of this activities we hold in the church every year, we have been able to have more female pastors ordained.

P11. The most important thing is that lives are changed for the better. The congregation is getting healthy each year, and it reflects on the community as a whole. We are not losing members to early death and terminal diseases. Health attitudes and behaviors change each year. There are few potentials amongst female church members that want to become pastors.

P12. I am satisfied that young females are going to have it a little easy being pastors in African American churches. I say this because initiating church-based health promotion is not just to improving congregation members' health but to encourage future young

female pastors that they can be multitasking from the pulpit and changing lives that are entrusted to them.

P13. Yes. Since I have been female pastor, I have helped some females become pastors in the church and outside… That was my goal to have more female pastors in church to bring compassion and emotion. The community as a whole are learning about their health, and encouraging more females into pastoring is awesome.

Research Question 2

I developed four IQs that participants answered to generate data to answer RQ2:

IQ7. How do spiritual and religious beliefs guide and influence your congregational health promotion activities?

IQ8. What ways does your beliefs or perceptions influence your congregation in CBHP?

IQ8b. What are the connections between spiritual beliefs and health of your congregation and God?

IQ9. How important is the role of prayers for the congregation in healing the sick?

Three themes emerged from participants' responses to RQ2: (a) church encourages us (pastors) to pray, (b) faith in god, and (c) prayer is a way. In addition, two categories emerged from RQ2.

Table 3

Emergent Themes and Categories for Research Question 2

Research Question 2	Themes	Categories
How do spiritual and religious beliefs guide and influence congregational health promotion activities of African American female Christian pastors?	• Church encourages us (pastors) to pray • Faith in God • Prayer is a way	• Pastors • Religious beliefs

Theme 1: Church Encourages Us (Pastors) to Pray

The participants' responses about how spiritual and religious beliefs guided and influenced their congregational health promotion activities differed from one another. Some of the participants were very sure prayers changed things in the congregation, including their health. P4 said, for example:

> **P4.** In fact, for most members that has been diagnosed, some of them they don't even go back to the hospital for follow-up treatment. Prayers meet them at home and when they go back to the hospital for follow-up checkup, the doctor will be surprised and will say "Where did you go? I can't find this illness again." It is the power of prayer. I would know it is God that healeth all our diseases.

Some believed prayers with professional help would solve the issues they might have in the church. Participant P8 answered:

> **P8.** My belief is that when any one is not feeling well, they should seek medical help, but pray first. Those who know me understand that I pray about everything, and they do respect that. Some see me as an example to them, and they are willing to listen to my advice; they trust me not to deceive them but tell them the truth. Either good or bad, I am happy I come straightforward in my dealings with them. God created all things in Heaven

and on earth, so we are to make use of what he created. We must believe that God made professionals to help us when we need them.

P3. You know that whatever is going on, God is able, but God uses the physician assistance: the nurses, the doctors. That's God being able. It's not sometimes you, "Well, look, God, I'm just going to wait." No. God uses the intelligence of His people to help us.

Others did not answer the question asked but spoke of things outside prayers and health. For instance, participant P3 responded:

P3: You may be, one day you may be happy, sad, depressed, whatever, there are emotions that surround whatever it is that we're doing. When we go to a job, you're not always on happy number ten at a job. Just like when you come to church, sometimes you come in church and you may not really feel like coming but you just come. But when you come you get something out there, the experience that takes you to a happy ten level. We just teach people to be aware of your emotions and how you're feeling and then be aware of the physical things that you feel going on in your body and go and get a diagnosis for whatever it is that's going on and then also stay in tune with your spiritual body.

The majority of the participants were very sure prayers changed things in the congregation, including their health.

Data analysis revealed that participants believed prayers bring them closer to God and that without praying for the congregation they are not fulfilling their calling as pastors. They gave answers that God sent them, and they must fulfill the assignment of educating members to pray. Some of the participants used the Bible to buttress their individual answers:

P2. Don’t get me wrong—I believe in prayers, but God has put people on this earth to help us when we are sick and so on. Personally, I pray then seek help from doctors. I

normally tell anyone who come to me for counseling to pray for healing but must seek help outside the church. I also do not condemn anyone who wants to do the holistic approach to their healing. I pray with them, and they continue to trust God for their healing.

P3. Of course. Every service that we have, we have what's called an altar call prayer. One of the pastors does an altar call prayer, and there's space in our bulletin for to write down the names of people who are sick, and we're encouraged to write down at least one name. If we can't get all the names down, write down at least one name, and then the pastor will pray for the concerns of our congregation, whether they be physical illness, it could be financial illness, it could be societal illnesses, but we do pray.

P4. I will tell you we're a faith-based church. We believe in God. We pray. We know that God answers all prayers. God is the greatest physician. He is the healer. With him nothing is impossible. I believe, and our spiritual background when people come in no matter how naughty, no matter how difficult it may be, we've seen examples of people who have been diagnosed with cancer and they have been healed because they went back with prayers…We believe very much in prayers, and our prayers has helped to cure even what people thought it was incurable.

P5. I believe people look to me as a spiritual leader. My faith is strong and I tell people that they must pray and believe, but we must be proactive about doing things to help ourselves. I believe it does play a role.

P7. We are a Pentecostal church. We believe in the Holy Spirit and miracles. We live by faith and the word of God. We believe in God. We pray. We know that God answers all prayers. God is the creator of all things living and non-living. We see God as the greatest

God. We believe in the healing power of God. With Him nothing is impossible. I believe in the spiritual faith in God and his powerful gift of Holy Spirit that we as a church live by. We have some members in the church who have been healed completely from deadly diseases without treatments. All these are accomplished by faith in the healing power of God… Going to the hospital is always encouraged from the pulpit by our senior pastor and I. We believe very much in prayers, and our prayers has helped to cure cancers and other incurable diseases. There's awareness on the power of prayer, because God is the owner of our bodies.

P8. Spiritual and religious beliefs really matters in this church. We pray and expects God to move for us. Prayers are answered and we give thanks to God for this. Don't get me wrong, we believe also in science health care. I and all members must visit the doctor once a year to monitor our health and health status. Personally, I pray for God to make me useful in his kingdom, and I also belief medical doctors are created by God to keep people alive. Usually when I counsel any congregation member, I make sure they follow up with their personal doctors. The religious beliefs of the members is strong, and they are ready to do anything after praying to God for help. The Bible says our help comes from above and God is the giver of life. What better way to seek the owner of your life for healing and guidance?

P10. Helping the congregation get to their utmost health is a challenge, and God has made it easy after praying and fasting. The members know that they are to fast and pray at least two times a week to be close to God all the time. Staying closer to God keeps us out of trouble and health. Introducing health promotion in the church is becoming easier with prayers and listening to God all the time. The church encourages members to pray,

but visit hospitals when necessary. For us to have the utmost health, we must pray constantly to God for good health.

P11. Spiritual and religious beliefs guide the congregation is that we pray most of the time to reach our fullest potentials. Like the congregation, the community worship God all the time. We go to church regularly and pray regularly. We speak about God in all we do and pray the congregation follow the true meaning of faith in God all the time. The church belief that God loves us first, so we live like Him by loving others. Loving the congregation is a start for us, and we love the community by having these church-based health promotions.

P12. Jehovah Rapha is our Healer and we must pray to Him for this. No father wants their children sick all the time. Prayer is communicating with God our Father. Without prayers we can't do anything right. I pray for members when they are sick for healing. I can't heal them, but God can.

P13. It is important to pray before anything in life including when we are sick. We pray so that God can intercede and cure us. God cures diseases and humans treat them. Only God can cure our ailments, so take them to him. We must also have faith that He only can help us when every other thing has failed. We need God and not the other way around. We talk to God in prayers and he listens to us. So prayers play important role in our congregation's getting healed. The Bible says, "By his stripes we are made whole," so we seek help from doctors and pray at the same time for our total healing.

Theme 2: Faith in God

Participants responded to questions about spiritual and religious beliefs influencing congregants in their churches by having faith in God. They are very sure that God is the reason

they are doing what they do, being pastors. Some of the participants correlated faith in God and spiritual and religious belief as evidence of their Christianity. Some said for Christians to believed God is the one to turn to for everything; some believed that God uses people to accomplish things in the world.

The responses of participants P3, P4, P5, P6, P7, P10, P11, and P12 were similar. They had the spiritual and religious beliefs in God's ability to do all things. They also said faith in God leads to things impossible to human beings. These participants would pray to God first and keep the faith in God to come through for them.

> **P3.** I think just verbalizing the prayer concern that lets us know that our parishioners and our congregation has a lot of needs for prayer. Then the other thing is when we hear the praise reports, it lets us know that God does answer prayers, and then it also… When we hear the prayer concerns, it gives us a chance to go to the deacon or go to the member and say, "Remember that God is with you. He will never leave you alone." That's hope. I don't go and say, "You're mom's going to be healed, " but I just say, "Just know God is with you."
>
> **P4.** Our faith in God is strong enough for us to know that when we pray, we receive everything we ask for. Illness gone, cancer gone and so on.
>
> **P5.** I tell people that God is able and we have to believe that. That He's willing and He's able. Then He will give us a spirit that we know we have to fight, we know we have to help ourselves, but God is at the head of everything.
>
> **P6.** Again, my belief in God's healing power is stronger than medical care. I sometimes encourage members to seek God before running to any medical doctor. God has the manual book of everyone's life. Go to the creator of the world and humans ask for

whatever and he listens and faithful in all things.

P7. We believe very much in prayers, and our prayers has helped to cure cancers and other incurable diseases. There's awareness on the power of prayer because God is the owner of our bodies.

P10. It is the power of faith in God that all these have occurred in the church. God only is glorified by this. God has promised us that "By His stripes we are healed" in the book of Isaiah 53:5. Many of the congregation have been healed through or by their faith in God. I will believe that prayers heals the sick my church.

P11. God being God can do all things that are impossible to us humans.

P12. As a church, we want to go back to God for everything that includes healing, marriages, work, businesses, and so on. God is our healer, Jehovah Rapha.

The following participants all believed in God but thought God made use of human beings on Earth to accomplish things on Earth. Though they believed spiritually and religiously in God's abilities, they made sure their congregation members know God created health professionals for their benefits.

P1. You know that whatever is going on, God is able, but God uses the physician assistance: the nurses, the doctors. That's God being able. It's not sometimes you, "Well, look, God, I'm just going to wait." No. God uses the intelligence of His people to help us.

P2. We must believe in God and know that God created doctors, nurses, teachers, and so on for us to benefit from.

P8. We must believe that God made professionals to help us when we need them.

P13. We talk to God in prayers and he listens to us… God created all things in Heaven and on Earth, so we are to make use of what he created.

Although participant P9 believed and has faith in God, she responded differently from the other participants when asked about spiritual and religious beliefs in influencing her congregation:

> **P9.** God says we should not worry about anything because we cannot add a single day into our lives… God sees and knows everything. I must have a room to ask for forgiveness of sins

Theme 3: Prayer is a way

Most of the participants during the interview sessions were very sure that their positions and professions were as a result of their praying daily. They also believed their communications with God have made ways for them to influence congregations their spiritually and religiously. The participants believe that Christian pastors must incorporate prayers into their daily lives to be close to God. They believe strongly that prayers are communicating with God, who called and made them become pastors.

> **P1.** I think prayer is a power that most people don't tap into, and it is incredible power that it does just what you tell it to do.
>
> **P2.** It is important to pray before anything in life including when we are sick. We pray so that God can intervene… So prayers play important role in our congregation's getting healed.
>
> **P3.** It lets us know that God does answer prayer… Remember that God is with you. He will never leave you alone. That's hope don't go and say.
>
> **P4.** God is not even a general God. When we pray to God, you have to be specific. When you know what is wrong with you, you can pray and God will answer. In our church, we believe in so much prayer, and God answered them all.

P5. God is going to take care of everything. We've got to pray and believe in our faith as an action word. We have to move forward in doing the things we need to do. We don't have to help God, but we have to help ourselves.

P6. It is important to pray before anything in life including when we are sick. We pray so that God can intervene. There are times prayers is all we need, and there are times prayers are needed in the beginning, middle, and end. So prayers play important role in our congregation's getting healed.

P7. God promise us in the book of Exodus that is "we worship the Lord our God that his blessings will be on our daily necessities. I will take away sickness from among you." God is the creator of all things living and non-living. We see God as the greatest God. We believe in the healing power of God. With Him nothing is impossible.

P8. We talk to God in prayers, and he listens to us. So prayers play important role in our congregation's getting healed. The Bible says, "By his stripes we are made whole," so we seek help from doctors and pray at the same time for our total healing.

P9. I think just verbalizing the prayer concern that lets us know that our parishioners and our congregation has a lot of needs for prayer. I let my congregation know that God never sleeps or slumbers, so it is good to know that God is with us and that he will never leave or forsake us.

P13. When every other thing has failed, God will be there to answer his children. We talk to God in prayers, and he listens to us, so prayers play an important role in our church. We seek help from doctors when we are sick, but God we seek at all times in prayers and praises.

Although participants P10, P11, and P12 all spoke about prayers, their answers did not reflect prayers for participants getting healed but for healing themselves. In analyzing the data for RQ2, two categories were revealed that did not fit with the themes.

Pastors

The majority of the participants considered themselves pastors and not female pastors. This category relates to RQ2 because the participants were African American female pastors trying to influence their congregation with their beliefs. Participants P3, P4, P5, P7, P9, P10, P11, and P12 did not respond like the others; they focused more on lifestyle changes and creating awareness through health promotion. All of the other participants wanted to be respected and given the opportunity to exhibit their God-given talent. The participants wanted to help their congregations to improve their health with health promotion activities. Participants P2 and P8 believed that they have influenced their congregations through valuable counseling sessions; they both stated they influenced their congregations with their advice.

> **P6.** I have some influences because most of the congregation respects my opinion. I tell it as it is. I will be sixty years old next year, and I am willing to go into prayer and fasting for any members who come to me for support with God's purpose for their life.
>
> **P13.** I do believe I have certain influences because majority of the congregation come to me for health issues and assistance.

When P1 responded to IQ8b, she addressed herself as a spiritual instructor and later spoke of pastors too as spiritual instructors:

> As a spiritual instructor, I would say that pastors are spiritual instructors. You have to be able to take the trust of that person and begin to build their mind. If they're only using five percent of it, challenge them to come out more for prayer.

Religious beliefs

The participants' religious beliefs varied, but they were confident that their beliefs came from the Bible. They believe they are pursuing what the Bible wanted them to do, care for the children of God. However, following the data analysis, the participants' responses to RQ2 did not have enough similarity to form a theme. P9 did not believe religious beliefs influenced health promotion activities for the congregation. Rather, she felt her beliefs as a call from God to care for those in need in the church:

> **P9.** I will say there are no spiritual or religious beliefs that influence the health promotion of the congregation… For this reason, it is always good to help our fellow Christians in need. The Bible says it is good to help someone if we can and not say we cannot at that moment."
>
> **P6.** Our spiritual beliefs has been to trust in God for all things and give thanks all the time.
>
> **P8**. Spiritual and religious beliefs really matters in this church… The religious beliefs of the members is strong, and they are ready to do anything after praying to God for help. The Bible says our help comes from above and God is the giver of life. My belief is that when any one is not feeling well, they should seek medical help, but pray first.
>
> **P11.** Spiritual and religious beliefs guide the congregation is that we pray most of the time to reach our fullest potentials.

Some participants spoke about prayers, faith in God and his ability to change things in the church through faith, and the Bible. However, Participant P3 did not address her spiritual and

religious beliefs in her response to RQ2, and P1 spoke of medications, spiritual programs, and mental responsibilities. These participants' answers did not fit the data analysis results for RQ2.

Research Question 3

Participants answered four interview questions related to RQ3:

IQ10: What influence does FPT has on your role as a female African American pastor?

IQ10b: Give examples of FPT that influence your decision to become a female African American pastors.

IQ11: What are the challenges you face as a female African American pastor in your denomination utilizing FPT?

IQ11b: Did FPT have any influence in addressing these challenges?

Three themes emerged from participants' responses: (a) experiences with male pastors, (b) female pastors, and (c) God does not discriminate. In addition, two categories emerged from data analysis of RQ3 African American female Christian pastors associate feminist theory with their success in the pastorate and health promotion in their congregation).

Table 4

Emergent Themes and Categories for Research Question 3

Research Question 3	Themes	Categories
How do African American female Christian pastors associate feminist theory characteristics to their success in the pastorate and in the health promotion of their congregation?	• Experiences with male pastors • Female pastors • God does not discriminate	• Challenges • Female perspective

Theme 1: Experiences with Male Pastors

I did not expect, during my data analysis for RQ3 that experiences with male pastors would emerge to be a theme, but participants' responses to IQ10 and IQ11 were related to their experiences working with male pastors rather than their experiences based on feminist perspectives. Almost all the participants were felt they were discriminated against and looked down on by male pastors. They did not hesitate to speak their minds about their male counterparts' behavior towards them. P1, P5, P7, P8, P9, P10, P12, and P13 had negative experiences with male peers and some male congregants:

> **P1.** The male pastors to me are not as detail oriented; they're very surface. This is what I call tradition. Everything runs on a time: It's time for the choir; it's time for tithes and offering; it's time. They never are willing to just break up the service and say Stop, somebody here is hurting, and I feel, i.e. was going to preach on Moses and Sarah, but today I'm going to preach on healing. I'm going to preach.
>
> **P5.** As a woman, female, I always have had issues when males don't want a woman to be in the lead of an issue. We're overcoming that.
>
> **P7.** When God called me to be a pastor, he knew I was a female, so the male pastors just have to accept me for who I am.
>
> **P8.** I do tell our senior pastor about things said to me by either the male pastors or male congregation. I have struggled with this since in theology school. Sometimes the male pastors thinks they should always be heard and we female pastors should be silent. In the Old Testament, the first book, Genesis 5:2 states, "Male and female created he them; and blessed them, and called their name Adam, in the day when they were created."
>
> **P9.** Male pastors cannot understand women have motherly instinct that foresee things and work hard to make it right. It is on this ground I would say I am making sure the old men

club feel threaten and uncomfortable knowing that a woman is making it in the ministry by themselves with the grace and mercy of God.

P10. When I started the ministry, there were times some male pastors tried to discourage me, but I stood my ground because God is with me. With God in front, at my sides, and behind me no one can defeat or change my mind.

P2, P6, and P11 had positive experiences working with their male pastors:

P2. I thank God for our senior pastor who always reiterate to the male pastors and members to respect me and see me as a pastor in the church.

P6. I thank God for our senior pastor for being supportive and encouraging the male pastors to see me as an individual rather than a female.

P11. I must say this that my senior pastor is the best male pastor who is so comfortable in his skin and profession. He is not threaten by us female pastors. In fact he ordained us in this church. I know there are some few male pastors and congregation members that are not comfortable with me as a pastor, but I do not let it deter me and my calling as a pastor.

Theme 2: Female Pastors

The participants spoke of God as the one in charge of their profession, not men. They quoted from the Bible to support their beliefs that women should be pastors like their male counterparts. Participants were ready to fight for what is rightfully theirs.

P1. I don't know if it's theoretical but I think as a female pastor and I think as female pastors, we're more effective for the reasons that the way that we're developed as females is an extremely caring role in a family if it's done properly.

P2. Since I did not volunteer or seek God to appoint me as a pastor, I cannot say this theory [feminist theory] had an influence on me.

P3. As a female, I've always thought that we have this motherly instinct in us, even when I was a nurse and even before I was a nurse.

P5. Female pastors are looked down on. I have been stood up by male pastors and male congregations many years ago and I never gave up. Instead, I continued to work hard to be the best female pastor. I think I am still working hard, but they are now slowly turning around to meet me at my level.

Participant P8 gave an example from the Bible about women in the ministry of Jesus. She said she saw herself as one of the women in the Bible who followed Jesus because of her services in the ministry of God:

P8. In the Bible, women made the ministry of Jesus easy for him. The women were always with Jesus to care for him and listen to him preach. Jesus acknowledged the women and was very pleased with them and their services in the growth of the kingdom.

P12. Well, as a female pastor, I am more effective in areas in and out the church. I care for the congregation, their families and so on. I care for grandparents, parents, brothers and sisters, in-laws, and children… Females are more into God than men. The Bible has shown how women support men of God to be the best in their calling. Jesus had several women in the ministry that supported Him in many ways to accomplish His purpose on earth.

P13. As a female pastor, I believe in what Jesus said about being able to do greater works than Him, so regardless of being a woman, I'm strong in Christ and am able to perform just as well as any male pastor. As a matter of fact, the more that I was met with

opposition, it only fueled my passion to serve the Lord and lead by example. By doing so, I feel that it will encourage women within the congregation to never give up or sell yourself short just because you're a woman.

Theme 3: God does not discriminate

Under this theme, the participants responded with God as the main reason for their being pastors and helping the congregation and community. God does not discriminate because He created all things on Earth. Participants spoke more of God not discriminating against anyone who has been called to serve his children:

P1. To say, Why is it that we can't have a voice? I understand how you taking your position, but with every male God gave them a female. We have purpose in this body, no less no more.

P4. In the kingdom of God, there's no he Holy Ghost or she Holy Ghost—we have one. That one has never crossed my mind for once, because our senior pastor in the church, she's a woman. When God calls people, God does not say… there's no gender. This is female. This is male. He called that and we all heeded to the call. I don't see myself even as a female in the gospel.

P10. In the kingdom of God, there's no male or female Holy Spirit, so we are one. Since I am a female pastor and the general shepherd of God's people, I am blessed not to have encountered this, but I know it is out there.

P8. God sees us as one human being. God does not discriminate and has no favorites in the kingdom.

P11. I know we are equal before God. He has no favorites in the kingdom. He made us equal, so I know I am equal to my male counterparts in the ministry.

P12 referred to the Bible when God chose a female leader:

> **P12.** Remember God chose Deborah as the first woman warrior in the Bible. Why did God do that?

Challenges

The participants' challenges as female pastors emerged as a category across the themes in RQ3. Most participants cited male pastors as their challenge as female African American pastors. Although experiences with male pastors was a separate theme in this question, important to point out that the participants recognized and called it out as a challenge in their work.

As stated above, the majority of the participants' responses focused on male pastors who were at times disrespectful and rude to them as female pastors, and six participants mentioned male pastors as challenges. Some observed that male pastors did not want them to be seen or heard from as female pastors. P8 and P13 praised their male senior pastors for coming to their aid whenever they sense disrespect from male pastors and congregation members. Participant P12, on the other hand, stated,

> Being a female in the ministry intimidate some of the male pastors, so they try to discourage you and demeaning your ability to be an effective pastor. To empower my mind I do things before they could think of it. I pray and God directs me and my thoughts towards the goal, caring for His children in the church.

P3 felt her church gave her chance to grow as a female pastor and believed the men never felt threatened by her: "This Church is fertile grounds, whatever gifts you have, they help cultivate those gifts that you have and there is no fear." P5, meanwhile, said that her challenges were from both sexes because they could not understand how she was able to accomplish works:

P5. Seeing the barriers is seeing the spirit to overcome and then having a strong faith and not believe in any of the negative reports, "You can't." "You shouldn't." "That won't happen." But moving forward, as I move forward, people move forward with me. They saw the work that God was doing in my life, and I believe they took that as an example of what He would do for them.

All but one of the remaining participants said that they had no challenges because they or other women were senior pastors:

P4. I don’t see the gender side of me. I’ve not seen the challenges, because we all come to church we worship God, and we all take instruction and guarantees from God Almighty through the Holy Spirit. Our church is directed and guided by the Holy Spirit. We have a senior pastor. She herself she will tell you that she takes instruction from God. She will tell you clearly that the church belongs all to God. It’s not her personal property. Thank you. The challenges, I don’t even see myself facing challenges.

P9. My main challenge is having more time to complete my daily chores at home. I spend practically all day in the church and feel tired when I get back home. It doesn't matter whether I sit in by the pulpit or within the congregation, I feel welcome and accepted by my wonderful members.

Feminist perspectives

With RQ3 I aimed to address feminist perspective. The participants were careful not to address themselves as feminist because they were still fighting to be respected by their male counterparts. Unfortunately, data analysis did not reveal this as a theme because it lacked enough supportive data.

P12. Feminist theory believe in many things, and I can truly say they influence me per se, but I see that knowing about this theory did give me the boldness to pursue my passion for the ministry of God. You may say it is an influence, but I will call it an awareness.

P4 and P10 responded similarly that feminist theory had not influenced them as pastors:

P10. The issue of the feminist theory is not in my church. We are all one and no discrimination at all. When I started the ministry, there were times some male pastors tried to discourage me, but I stood my ground because God is with me. With God in front, at my sides, and behind me, no one can defeat or change my mind.

P7 discussed the influence of her role as a mother:

P7. The only thing that can influence my decision of becoming a female pastor is that I am a mother and a female who has compassion and emotion. I love my children, family, and the church.

But P6 stated,

P6. I cannot say this theory had an influence on me but I will say after I became a pastor, the male pastors seemed like they had little respect for me. I have been able to command respect from them now since I first started.

P5 believed that God had appointed her and that feminist theory had not been a factor, and P4 expressed that her position as a female pastor had nothing to do with feminist theory, but God and the Holy Spirit:

P4. The issue of the feminist theory is not even common law. I don't see it. My senior pastor is a female, so these are not an issue for me as a female pastor.

The remaining pastors spoke of being empowered by God and guided by their true conviction of the Holy Spirit and its directions, and P8 and P9 did believe that feminist theory had influenced them to become and remain female pastors.

Summary

The purpose of this study was to explore the experiences and perspectives of female African American pastors concerning health promotion in their churches; with this case study I focused on the experiences of the research participants. The results presented in Chapter 4 were from data analysis of responses to the IQs, which eventually answered the RQs. RQ1 revealed the participants' perceptions about their roles as female African American pastors and the health promotion activities in their churches to address their congregations' health. The pastors showed the passion to help their congregations get the assistance they need through health promotion activities. They were able to initiate health promotion activities all year round. Data analysis for RQ2 showed participants' spiritual and religious beliefs to be aligned with God and their faith as Christians, and their responses to RQ3 concerning the influence of feminist theory on their becoming pastors were based on the best of their knowledge of feminist theory. Although the majority of the participants did not feel that feminist theory had influenced their decisions to become pastors, some of them did admit to at least some influence on their characters and their confidence in moving forward as pastors. In Chapter 5, I give a brief overview of the study purpose, interpret the study results, and discuss the limitations of the study, recommendations, and implications for social change.

Chapter 5: Discussions, Conclusions, and Recommendations

Introduction

The purpose of this qualitative case study was to (a) explore the role of female African American Christian pastors in influencing, motivating, and building health promotion programs, (b) explore how spiritual and religious beliefs guide and influence congregational health promotion activities of female African American Christian pastors, and (c) explore whether and how female African American Christian pastors associate feminist theory with their success in the pastorate and in their health promotion among their congregations. Campbell et al. (2007) indicated that African American pastors and churches are noted for their exceptional abilities to influence and lead church members to spiritual health. In addition, Hankerson and Weissman (2012) indicated that health promotion programs have been successfully performed in partnership with African American churches by nonprofit organizations, government agencies, health organizations/professionals, and communities.

In this dissertation, I uncovered African American female pastors as initiators in health promotion activities in their churches and identified reasons they had implemented health promotion activities in their churches. The study participants had developed, bi-annual, and quarterly promotion activities for their congregations and communities. Findings from this study could potentially lead to improved advocacy for healthy lifestyles and behavioral change through ongoing health promotion education for church congregants. For example, Baruth, Wilcox, Bopp, and Saunders (2008) identified lack of financial resources, congregants' motivation and time, and pastors' demonstrating by example as influences on implementing church-based health promotion activities.

I conducted in-depth, face-to-face interviews with 13 female African American pastors who voluntarily gave detailed information about their experiences and perspectives about congregational health promotion activities. I used semi-structured interview questions (Appendix D) designed to elicit detailed responses from participants to answer the three research questions that guided this study. I compared my results with findings in the literature I reviewed in Chapter 2 to establish whether this study added new knowledge on the phenomenon of church-based health promotion in African American churches by female African American pastors. I used the theoretical feminist perspective as a lens to analyze and interpret findings from this case study of female African American pastors.

The main finding that emerged from my analysis was that participants felt they had been chosen by God to carry out health promotion for their congregations. They felt fulfilled caring for their congregants with no insurance, poor health, and chronic diseases. The majority of the participants were pleased with their accomplishments in helping their congregations through health promotion, which in turn may lead to good health and longer lives. In this chapter, I present the interpretation of the findings, suggestions for future research, and implications for social change. The chapter ends with final conclusions and remarks about my personal experiences.

Interpretation of Findings

In this section I present my interpretation of study findings on the topic of experiences and perspectives of female African American pastors in health promotion activities for their congregations. A review of the literature revealed that there were not many earlier studies of only African American female pastors, but some authors had studied African American pastors in general regarding their health promotion activities in their churches. Findings from this study

helped to fill the gap in the literature on congregational health promotion activities by female African American pastors. The research questions that guided this entire study were: What is the role of female African American Christian pastors in influencing, motivating, and building health promotion programs? How do spiritual and religious beliefs guide and influence congregational health promotion activities of female African American Christian pastors? How do African American female Christian pastors associate feminist theory with to their success in the pastorate and in health promotion among their congregations? I interpreted results according to themes that emerged from each RQ through the lens of FPT and in the context of relevant literature reviewed in Chapter 2.

Findings and Reviewed Relevant Literature

Seven themes emerged from the participants' responses to interview questions that were asked to generate data to address RQ1 (What is the role of female African American Christian pastors in influencing, motivating, and building health promotion programs?).

The theme regarding churches having healthy congregations showed how female African American pastors had been able to implement health programs in their churches for the sake of social change, specifically, healthier congregations. The participants in this study used CBHP activities to care for the health of their congregations. They held yearly health promotion activities for their congregations and continued with either monthly or quarterly professional health education. These female African American pastors made significant efforts to meeting their congregations' needs. For instance,

> We had Harmony Health Plan to come in and assist us with high blood pressure screens and high cholesterol screens and early detection things that the adult sometimes work, stress, go to the gym but they never really do self-care. We had health fairs as a response

> to it. We had the community vans to come in, and then we had something, we had workshops. It was lunch-and-learn workshops, where we had some of the health care professionals come in and maybe on a Saturday on lunch and learn talk about the current our health today, what we can… eating better. (P1)

Most of the participants (12 of 13, 92%) believed they had been called by God to help their congregations and communities as God's servants. During her interview, one of the participants talked about what being called by God meant to her:

> Counseling has always been my first love. I worked for the VA for more than twenty years before becoming a pastor full time. To tell you the truth, I really do not want to be a pastor. I was not given the option to decline this position because it was presented to me that God wants me to be a pastor. I want to be full time here for one more year before I return to working with the VA. (P2)

Participants who believed that God called on them to serve extended their beliefs to the holistic salvation of God for his children to believe in miracles, spiritual things, and prayers in all situations; the participants were committed to working for God by any means necessary. This supports Lumpkins et al. (2013), who said that on the intrapersonal level, individuals' beliefs in God influence their health. The church and what it stands for has an unswerving effect on this information processing, as those with a belief in God will eventually take or discard health results based on that information. Each of the participants agreed that only God must receive all the glory. They made references to the Bible to support their beliefs and purpose in their daily responsibilities and caring for God's children

The third theme, health insurance, addressed the issues facing many African American communities. The participants wanted to help their congregations by implementing health

promotion for those members without health insurance to be able to get checkups during health fairs in the church. For example, participant P13 stated,

> Majority of the congregation members are without insurance for a different reason, but health disparity is one of them. Access to health and insurance has made it difficult for some of our congregation members to access health… If you ask me, initiating health promotion has been beneficial and helpful to the church and community. People in the community die early because they do not have good health insurances. (P13)

Being able to render different types of health screenings, training, and educational sessions for their congregants and communities made these participants happy with their calling as pastors. Affordable Care Act registration, mammograms, prostate screening and education, weight loss programs, nutritional guides, and other health assessments were provided to congregations and communities as parts of the health promotion activities.

The female African American pastor participants in this study reported that health problems in the church were a major reason that they had implemented CBHP activities. They spoke of poor health and early death among church members and of initiating health promotion activities as one of the ways they could help their congregants. They made mention of health problems such as hypertension, diabetes, heart diseases, mental problems, obesity, HIV/AIDS, cancer, and high cholesterol. P8 was specific about the health problems in her church: We have many of our members taking high blood pressure, cholesterol, heart disease, diabetes, and mental diseases. Since they do not have good insurances, we were impelled to create church-based health promotion. (P8)

The literature reviewed in Chapter 2 included discussions on the importance of African American pastors' health promotion activities because of health problems (Lumpkins et al.,

2013). According to the literature CBHPPs are the best means to reach African Americans concerning some of the diseases and cancers that are prevalent in the community and could have major effects (Lumpkins et al., 2013). This coincides with how more than 90% of the participants spoke about the important role of health promotion in their churches and communities, leading to the theme of health promotion activities. This study outcome also supported Butler-Ajibade et al., (2012) and Rowland & Isaac-Savage, (2014), who found that African American pastors encourage trust and success for members of their congregations by incorporating health promotion activities in their churches. Authors also found that African American church leaders and members were open to the development of health-related programs (Patel et al., 2013) and uncovered the importance of African American female pastors' gaining trust from their congregations to implement successful health promotion activities.

Rowland & Isaac-Savage, (2014) specified that pastors' perceptions, motivations, and barriers to health promotion activities and education in the church are important. In addition, the researchers acknowledged that little is known about pastors' opinions of health implementations and interventions (Rowland & Isaac-Savage, 2014). Even though there is little literature on how pastors felt about their health problems, the theme I identified in this study added some information on pastors' roles in health promotion activities.

Participants in this study spoke from the pulpit to their congregants concerning chronic health problems and early death. They indicated that if the needs of the congregations are met, it will trickle down to the community. For instance,

> This church is 18 years old now, and it is growing every day, so what better way to keep the members healthy? I hoped for the best for them all. God has given me the responsibility to shepherd them the right way, and staying healthy is also included. I did

> initiate health promotion in the church, but I had other pastors and members who also contributed to the success of our first activity. (P9)

Additionally, I identified the important position of these participants in their churches. They are able to preach and support members from the pulpit at the same time:

> Apart from mothers, pastors have the toughest job on earth. You care for so many people with different characters and attitudes. As a pastor, you listen and care for them all the time. My role as a pastor does include initiating health promotion. I make sure the congregation hear me announce different health activities from the pulpit that can change their lives for the better. I want to see the congregation living their lives to the fullest. (P12)

Participants further explained the importance of awareness for their congregation. Almost all of the participants expressed their support for health education and awareness for their members:

> We invite companies who will come. They'll support the church. We always create that awareness amongst our members for them to come and be checked out, and mostly we don't pay, because it is highly subsidized… There's that awareness, if it's high blood pressure, they will know what to do and know what to do. If it's high cholesterol, they will know the food to eat and know what to eat. If they have heart disease, they will know what to do. (P4)

The results showed that ministering and support for health promotion coincided with Lumpkins et al.'s (2013) finding that pastors live by example, adopting healthy lifestyle messages and behaviors to address the health problems in their churches. In addition, this study outcome supported Rowland and Isaac-Savage's (2014) assertion that African American pastors in general were seen as trusted messengers of God, so that their support for health promotion

initiatives exposed congregants to health promotion programs, screening, and health fairs that might encourage them to closely look at their personal health. Furthermore, this study's findings supported that pastors often work together with health organizations and government agencies as they initiate health promotion activities in their churches (Lumpkins et al., 2013; Williams et al., 2012)

Three themes emerged from the participants' responses to the interview questions for RQ2 (How do spiritual and religious beliefs guide and influence congregational health promotion activities of female African American Christian pastors?).

Study participants had varied perceptions and opinions about how spiritual and religious beliefs guided and influenced their congregational health promotion activities. All the participants believed in the living God and His ability to heal the sick; more than half strongly believed that members can pray and get healing, but must seek professional help as well. Three participants wanted their congregations to have faith only in God and prayers for their healing, such as P4 and P12:

- I will tell you we're a faith-based church. We believe in God. We pray. We know that God answers all prayers. God is the greatest physician. He is the healer. (P4)
- Prayer is communicating with God our Father. Without prayers, we can't do anything right. Although there is no reviewed literature to support prayers by pastors in this study, the outcome of the study uncovered the importance of prayer by these participants. (P12)

The second theme for RQ2, faith, in God further elaborated that prayer and having faith in God are crucial. All the participants believed that faith in God showed how any Christian

should live, especially pastors. These participants discussed how faith in God led to the impossible:

- I tell people though, quite frankly, that we just can't pray and just say, "Okay, God is going to take care of everything." We've got to pray and believe in our faith as an action word. We have to move forward in doing the things we need to do. (P5)
- I came to the point of knowing that faith is what God is looking for from us all as His children. The Bible says, “It is impossible to please God without faith. “ Most of the churches of these days are running after money, and the Bible says, “Money is the root of all evil.” Religion has destroyed what God wants for us on Earth. (P1)

There was no reviewed literature to support faith in God during my literature review in Chapter 2. I did not include faith in God as part of my reviewed literature. During my data collection, majority of the participants seemed to talk about faith in God. According to the article by Sanchez (2015), to be one with God in faith and in accordance to His will, vision, and purpose for one’s life as well as that of the church is to love. The love that is referred to is not love in word alone, but the actual act of loving one another the same way that one loves themselves as well as believing in Christ. To believe in Jesus and keep the commandments assures believers in the Christian faith that their faith in God is truly authentic and guides them in all that they do.

Separately, prayer was such a way of life for the participants in this study that they could not even express it. They truly believed that prayer kept them grounded and close to God, and some reported that they prayed all the time for everything and anything:

P13. It is important to pray for anything in life including when we are sick. We pray so that God can intercede and cure us. God cures diseases and humans treat them. Only God can cure our ailments, so take them to him.

Participants' praying for their congregants was another way of attaining the ultimate goal of healthy lifestyles using health promotion activities in the church. Lumpkins et al. (2013) supported that at the organizational—i.e., church—level, the pastor's governance is crucial because he/she has the influence to support health issues within the church and community. P10 elaborated on prayer:

P10. On prayer is our weapon in getting things done. We speak to God and he gives us ideas and ways to do things. When some members have the wrong diagnosis, they spring into prayers and get their solutions from the Almighty God who knows all things on Earth. I believe that God is ever ready to care for his children.

This study uncovered the participants' perspectives concerning feminist perspective theory (FPT). Three themes emerged from the responses to the interview questions for RQ3 (How do African American female Christian pastors associate feminist theory with their success in the pastorate and in their health promotion among their congregations?).

First, it was important to understand the challenges and barriers from men that the female African American pastors had faced when training to be pastors and initiating health promotion activities in their churches. In addition, in the literature I reviewed, Black male pastors and other church leaders regularly presented philosophies about equality of Blacks in American society, but their female pastors have been largely ignored in the African American community (Newkirk & Cooper, 2013):

P5. Well, as a female, I have a resistance of course because it was something that the males weren't accustomed to, that they hadn't done. Sometimes when it's not their idea, they resist and give you a little problem and some barriers. There's a way to finesse to get around that. My issue was within the faith community as well as from the outside.

P8. The challenges I face were from other pastors and not the congregation. I thank God for our senior pastor who always echoes to the male pastors and male members to respect the calling of God in God's servants, especially female pastors.

As the second theme, the majority of participants attributed their profession to being called by God, and they did not want to accept that FPT was a contributing factor. They saw themselves as "go–getters" whom no man could hinder from becoming pastors:

P1. I'm not a feminist but I do believe that the female pastors are necessary.

P7. When God called me to be a pastor, he knew I was a female, so the male pastors just have to accept me for who I am. In God's kingdom, there's no gender. I see myself a female pastor and a servant of God called for the gospel to be preached.

P10. The issue of the feminist theory is not in my church. We are all one and no discrimination at all. When I started the ministry, there were times some male pastors tried to discourage me, but I stood my ground because God is with me.

The outcomes agree with findings of Swanson (2015) that women's leadership in the ministry supports a feminist perspective. Majority of the participants believed in equality and wanted fare treatments for them as their male counterparts. The participants voiced how they demanded and asked for respect from male pastors and male congregations. For example, P6 said: "I cannot say this theory had an influence on me but I will say after I became a pastor, the male pastors seemed like they had little respect for me. I have been able to command respect

from them now since I first started." P8 said: "Feminist theory is vital in my case. I always want to scream. I do tell our senior pastor about things said to me by either the male pastors or male congregation. I believe we are equal before God and we are capable to carry out God's work in the same manner. I will stand by my belief and worship God as he has asked me to. No one can stop the purpose of God for me; not even male pastors." These pastors reported caring for their congregations as mothers care for their children:

> **P1.** Well, as a female pastor, I am more effective in areas in and out the church. I care for the congregation, their families, and so on. I care for grandparents, parents, brothers and sisters, in-laws, and children.
>
> **P12**. Apart from mothers, pastors have the toughest job on earth. You care for so many people with different characters and attitudes. As a pastor, you listen and care for them all the time.
>
> **P13.** Caring for people is my passion. I love people and I make sure they are loved by me as their pastor.

In this study, the majority of the participants attributed their callings to God. They maintained that they had been placed on Earth by God to fulfill their purpose as servants of God to care for the children of God. The third theme that emerged in response to the RQ3 interview questions was the belief that God does not discriminate:

> In the Old Testament the first book, Genesis 5:2 states, "Male and female created He them; and blessed them and called their name Adam, in the day when they were created." God sees us as one human being, but human being sees us as different people. In the kingdom of God, we are one, and we are all children of God.

Other participants stated: “In the kingdom of God, there's no male or female Holy Ghost, so we are one” (P10) and “In the kingdom of God, there's no the Holy Ghost or the Holy Ghost, we have one” (P4). These participants’ conclusions are supported by findings in the reviewed literature that men and women pastors are equally capable of ministering to their congregants (Chatters et al., 2011).

Theoretical Lens

A theoretical framework is a theory that provides a basis or rationale for predicting and conducting research; the theory provides navigation, a means to steer the research from the beginning of the research process to the end (Creswell, 2013). Qualitative researchers use theoretical frameworks to back their research arguments, create sound study questions, and explain the choice of methodology selected for a particular study (Bradbury-Jones et al., 2014).

This qualitative case study was about female African American pastors’ experiences and perspectives regarding implementing health promotion activities in African American churches. I explored how feminist perspective theory (FPT) had influenced the pastors’ decision to implement health promotion activities in their churches, using the theory to guide the interview question development. Many of the participants did not know the meaning of FPT, which believe that no one has power over another person and that the obligation is shared by both sexes to preserve the planet (Swanson, 2015).

One of the participants stated she wanted to believe that FPT had some influence in her decision to fight for what she wanted to be, a pastor. She went on to say we are all created by one God and that no one should be superior to another.

P12. Feminist theory believe in many things, and I can’t truly say they influence me per se, but I see that knowing about this theory did give me the boldness to pursue my

> passion for the ministry of God. You may say it is an influence, but I will call it an awareness. I am equal to the next person around me be it male or female.

Sixty-nine percent of the participants were not sure that FPT was a contributing factor in their decisions to become pastors; they addressed themselves as pastors, not female pastors. Liberal feminist theory (LFT) relates to how society violates women's equal rights by treating them as a group instead of as individuals; the determination was that are violated whenever they are judged physically and not intellectually (Munson & Saulnier, 2014). My findings confirmed this LFT perspective concerning female African American pastors; the pastors in my study were discriminated against by male pastors and congregants. The female African American pastors in my study had not been denied entrance into theology school, but they were not allowed to hold leadership positions in the church. Majority of the participants spoke about discrimination after completing their pastoral degrees and certificates. They were mainly assistants and not senior pastors of the church. They still feel they only allow male pastors to get the senior pastor positions. I also found that female African American pastors worked more to prove their abilities to lead Black churches.

Two participants (15%) said that there was nothing like feminist theory in their vocabularies because their churches had female senior pastors, and I was surprised to know that most of the participants wanted male pastors and congregants to respect them as pastors and not see them as females. These participants did not want people to think of them as feminists; they wanted to be considered servants of God doing God's work:

> **P9.** God called me to the ministry and not any man. I am using feminist perspective of equality to keep me going. I want to believe that whatever a man in the ministry can do, I can do it is not better. Jesus words in the Bible guarantees me that I can do what He has

done and even do it better. I have Jesus, I have the world, so no male pastor can discourage me to do what God called me to do.

P10. The issue of the feminist theory is not in my church. We are all one and no discrimination at all. When I started the ministry, there were times some male pastors tried to discourage me, but I stood my ground because God is with me. With God in front, at my sides, and behind me no one can defeat or change my mind

Conceptual Framework

The CBHP was conceptualized as a public health social work modality that could narrow health care gaps between ethnic groups and majority populations to decrease health care disparities and increase disease prevention in the African American population (Daniels & Archibald, 2011). CBHP can be generally conceptualized on a socio-ecological model that entails studying the historical significance of the church's place in people's lives and the complex nature of the church as a community (Daniels & Archibald, 2011).

Data analysis showed how female African American pastors were able to bring social change to their congregations. They were able introduce health promotion activities in their churches and communities that significant behavioral changes. Some of the pastors' church activities gave members without insurance access to health care; some had free health screenings and services to fill prescriptions. Furthermore, the interview question responses revealed how these female African American pastors had been able to reach many in their communities to bring awareness to early death preventions and healthy lifestyle changes.

This model offers a framework for many levels of inspiration on health behaviors and practices (Daniels & Archibald, 2011). The CBHP model considers individuals' daily, cultural, and contextual living habits while giving the kind of education that is needed to encourage

optimal and healthy lifestyles (Daniels & Archibald, 2011). Aquili and Newberg as well as Pert were quoted in Daniels and Archibald (2011) as stating that for some, spirituality and faith are significant parts of their health and treatments. CBHP reflects that attitudes and beliefs stemming from experiences do affect health outcomes, and promotion activities are aimed at improving that cognizance while practically distributing needed information (Daniels & Archibald, 2011).

Limitations of the Study

The initial limitation of this study was that my sample focused on African Americans from a specific area. Specifically, I used purposive sampling to select the study participants from Black churches in Chicago and the surrounding south suburbs, and these restrictions limit the generalizability of the study's findings; for instance, the findings might not apply to other churches or to male and female pastors from other ethnic groups.

Creswell (2013) recommends between 5 and 25 participants for qualitative studies. I planned to interview 18 participants, but the actual sample size was 13 because of potential participants' lack of interest or time. In qualitative studies, the sample size may be small if the data reach the point of saturation (Marshall et al., 2013). By the 10th interview for this study, I was not hearing any new information, indicating that I had reached saturation. Another limitation was that the responses of the 13 purposively selected participants for this study may not represent those of all female African American pastors in the United States.

As with any other qualitative study, this case study generated large and varied forms of unstructured data, which made the process of managing, organizing, storing, analyzing, interpreting, and presenting final study findings a time-consuming exercise. Nevertheless, I piloted this study single handily; ultimately I was responsible for analyzing, interpreting, and reporting the findings. Critics may debate that this study is a product of a single researcher's

lens. However, I did use consistent measures for the manual coding with notes in the margin, a code sheet, and use of NVivo 11 software for comprehensive data analysis.

Recommendations

After conducting this research and studying the data, I would recommend that future researchers expand their sample criteria to include participants from a variety of churches of different denominations and sizes. Although I reached data saturation in that responses became repetitive, a larger sample size should provide a richer picture of the experiences of female African American church pastors. Another recommendation is opening the participant pool to female pastors from other races. Many cited studies about church pastors and health promotion activities took place in African American churches and focused on both male and female pastors. I conducted my study in the Chicago and surrounding south suburbs areas, which is a small location compared with the rest of the United States. Research with other female pastors, African American and otherwise, and female pastors from other areas would provide a richer description of the views of female pastors about health promotion activities in their churches.

Ultimately, I as the researcher of this study recommend that hospitals, nonprofit organizations, and pharmaceutical companies increase their partnership and collaborative efforts with African American churches to implement health program activities such as quarterly educational training sessions for congregants. This way, other Black churches would be able to obtain funds for up-to-date health information, including innovative information on disease prevention. Churches could also make their programs culturally appropriate for their audiences.

Implications

This study revealed how participants were able to capitalize on CBHP activities and the opportunity to continue building congregational health promotion activities in their respective

churches. Through this, participants were able to reinforce their ministerial duties as spiritual/religious and prayerful leaders. I also provided more details of how participants see themselves as female pastors. These female pastors believe in themselves as having the abilities as their male counterparts to lead and direct their congregation. Leadership is vital in nonprofit organizations such as ministries from pastors who an impact their congregation's spiritual, physical, and emotional lives (Rowland & Isaac-Savage, 2014).

This study brought positive social change through creating awareness of congregants using information gathered from health promotion activities in the church. During data collection, some of the participants spoke of health education and continuous professional training that churches provided for their congregants. For example, P7 said: "We do have short and small group seminar or training 3 times per year in the church premises. These trainings have increased awareness for the congregation. At least, it has improved and addressed some of the challenges facing us." The participants understood the high-risk behaviors and diseases that exist among their congregants. Furthermore, the congregants were able to utilize the information and awareness they received from CBHP activities and continuous education from health care professionals in their churches. For example, P2 said: "He usually speaks about health improvements from the altar on Sundays. Sometimes, I talk to any member that I feel do need help, but he or she is embarrassed to let us know."

Positive Social Change Implications

Positive social change implications from this study may involve creating awareness of health promotion activities that have started in African American neighborhood churches, such as more health fairs organized by female African American pastors in their communities Black churches. Female African American pastors' disseminating health promotion activities to their

churches is important for decreasing health disparities in African American populations. Another of the implications for positive social change that influenced other churches' pastors and their roles as leaders of health promotion activities for their congregations is through using CBHPP. This study could also create positive social change through assisting Black churches in remote areas to start their own health promotion activities. This can include increasing the awareness of healthy eating, seeking professional help when needed, and educating members on positive behavioral changes they can make

I am willing to work with communities in Chicagoland neighborhoods by bringing awareness of health promotion activities to African American churches. Having extended my knowledge through these study findings I am willing to raise the idea of health promotion in community meetings, including introducing health education workshops. My study may lead to more young females becoming pastors if that is their professional interest. The physical health of their congregants is typically part of the role of a pastor. These female African American pastors' implementation of health promotion activities in their churches are examples for younger female pastors of how to care for their own congregations in the future.

Conclusion

In conclusion, with this study I have presented the experiences and perceptions of female African American pastors regarding their health promotion activities in their churches; they use these activities to maintain and care for their church members. The female pastors in this study came to appreciate the importance of caring for congregants' chronic diseases through initiating health promotion activities in their churches.

The pastors also acknowledged the vital roles they played from the pulpit in their members' lives. The information from this study can be utilized by hospitals, public and private

government agencies, schools, and health organizations to improve cultural barriers to CBHP in communities through developing partnerships to initiate health promotion activities in African American churches. Finally, this study was able to highlight various diseases in the congregations that African American female pastors had handled with CBHP activities. With CBHP, African American female pastors were able to bring awareness of these diseases and at the same time addressed them to reflect health improvements and prevention of death from preventable illnesses in the church and community alike.

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Appendix A**:** Study Invitation Flyer

STUDY INVITATION FLYER

Invitation to Participate in a Study on **Experience of Congregational Health Promotion By African American Female Pastors in the Christian Faith**

This research study is for African American female pastors who have been involved in the initiation or implementation of Church-Based Health Promotion Program (CBHPP) in their churches. My name is Arlene Obazee, and I am a doctoral student at Walden University's College of Health Sciences. I want to understand your views on church-based health promotion programs. I also want to understand the perspectives of this phenomenon from African American female pastors in the Christian Faith that are in the Chicago, Illinois and surrounding South Suburbs.

Note: Your participation would be entirely on a voluntary basis, and you may opt to withdraw at any time.

Study Eligibility:

You may quality for this study if:

a) You identify yourself as an African American female pastor.
b) You have or have been part of the initiation of Church-Based Health Promotion Program in the church for the congregation.
c) Your church is located in Chicago or the surrounding South Suburb
d) You are willing to share freely with researcher face-to-face interview that will last between 60 to 90 minutes.

Benefits to Participants:

Although there may not be any direct benefit for your participation in this study, sharing your experience pertaining to the implementation of church-based health promotion activities in the church will provide you an opportunity to contribute to availability of knowledge and scholarly information about health care challenges and issues facing African Americans church congregations in Chicago areas and the surrounding South Suburbs. You will be compensated with $25 Visa card for taking part in this study.

Appendix B: Initial Screening Questionnaire

Participant Recruiting goals:

Participants must:

- Be African American females pastors.
- Be pastors full/part time for 3 or more years.
- Live in the Chicago, Illinois and its surrounding South Suburbs.
- Be willing to be a participant, sign consent form and complete a recorded face-to-face interview that will last between 60 to 90 minutes.
- Commit to a date and time they will be available for the interview

The following questions will be used to qualify potential participants in the initial phone call screening interview:

i. Obtain caller's name and sex.

ii. Are you a resident of Chicago, Illinois and its surrounding South Suburbs?

iii. What is your total number of years in ministry?

iv. Are you a full/part time pastor?

v. Which church do you pastor?

vi. Have you been involved in the initiation or implementation of a church-based health promotion program in the past 18 months?

vii. Are you willing to freely participate and share with the researcher about your experience in the church-based health promotion face-to-face interview that will last between 60 to 90 minutes?

viii. Are you willing to sign an informed consent, which says that you voluntarily agree to participate fully in the study?

Closing Remarks for Potential Ineligible Participants:

Thank you for your interest in participating in the study and answering the screening question However, presently, I am looking for individuals who for specific criteria, and according to the information you have provided, you do not meet the study eligibility requirements at this time. Thank you very much for your time.

Closing Remarks for Eligible Potential Participants:

Thank you for your interest in participating in the study and answering the screening questions. Based on your answers, I am delighted to inform you that you are eligible to take part in this study, and I would like to go ahead and book an interview time and date convenient to you.

Do you have any questions for me at this moment? _____

Would you like to participate in this study? _____

Can we set your interview? _____

What time and day works best for you? DATE OF INTERVIEW _____ TIME OF INTERVIEW _____

Thank you for agreeing to take part in this study. I look forward to meeting you at the venue on (the agreed interview data) at (agreed interview time).

Appendix C: Demographic Checklist

Please check only one answer per question

Ethnicity: □ African American □ African descent □ Other (Specify) _____

Resident: □ Chicago □ South Suburb □ Other (Specify) _____

Education level: □ Less than high school □ High school □ Associate degree

□ Bachelor's degree □ Graduate degree □ Post-graduate degree

Current employment status: □ Full-time □ Part-time □ Unemployed

Number of years as a pastor: □ 1 - 2 □ 3 - 4 □ 5 or more

Religious affiliation:

COMMENTS:

Appendix D**:** Study Interview Guide/Question

A Qualitative Study: Congregational Health Promotion By African American Female Pastors in the Christian Faith

Introduction: I will state my name, the title of the study, research purpose, and IRB number.

Obtain demographic information of the study participant: I will ask participants to briefly tell me about themselves, their names, highest education level reached, employment status, where they live, their ethnicity, number of years as pastors, and religious affiliation. I will inform the participants that the interview may last between 60-90 minutes. I will then ask the participants if they have any questions or clarifications before we start with the interview. In the case where there are no questions, I will then go ahead and begin administering the interview questions.

IQ1. What is your role as African American female pastor in health promotion and prevention in your congregation? What was your expectations for your congregation in Church-Based Health Promotion (CBHP) intervention? What does CBHP means to you and your congregation?

IQ2. What was the reason for starting and participating in Church-Based Health Promotion? Did health access disparities amongst African Americans influenced your decision in implementing health promotion intervention in your church? What are the health issues of your congregation? Do you have health ministry in your church?

IQ3. What are the health promotion disease prevention activities held in your church? Is this a yearly activity? How are you able to support your congregation from the pulpit? What was effective and ineffective? What could be improved? What feedbacks did you receive from the congregation?

IQ4. Based on your leadership and counseling experience with your congregation, what do you believe to be the high health risks of your congregation? What factors would make any of the congregants not to participate in the CBHP of your church?

IQ5. What was the best experience you had as African American female pastor in CBHP? Please give examples of things that made it good experience or a bad one? How did the experience affect your relationship with the congregation?

IQ6. What are the challenges in carrying out CBHP in your church? What have you done to address these challenges?

IQ7. How do spiritual and religious beliefs guide and influence your congregational health promotion activities?

IQ8. What ways does your beliefs or perceptions influence your congregation in CBHP? What are the connections between spiritual beliefs and health of your congregation and God?

IQ9. How important is the role of prayers for the congregation in healing the sick?

IQ10. What influence does FPT has on your role as African American female pastor? Give examples of FPT that influence your decision to become an African American female pastors?

IQ11. What are the challenges you face as an African American female pastor in your denomination utilizing the FPT? Did FPT have any influence in addressing these challenges? Please be specific and give examples.

IQ12. How do you perceive your role and those of the church as advocates of positive social change in your congregants or community?

Are there any questions you want to ask me or contribute to this study?

Conclusion: Thank the participants for taking their time to participate in the study and then provide the participants with a description of what will happen next after data collection. Also, at this moment, I will explain and assure the participant that the privacy of their collected data will be protected.