Published in final edited form as:

J Health Care Poor Underserved. 2017 ; 28(1): 378–388. doi:10.1353/hpu.2017.0029.

Health ministry and activities in African American faith-based organizations: A qualitative examination of facilitators, barriers, and use of technology

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Abstract

African American faith-based organizations (FBOs) can play an important role in addressing health disparities. Increasingly, churches offer health fairs, screenings, or education within their health ministries. However, little is known about how to link these organizations with the many evidence-based interventions (EBIs) developed by research. This study explored 1) factors that facilitate or impede health ministry activities, including the adoption of EBIs, and 2) opportunities to use technology to support/enhance the capacity of FBOs to sustain health-related activities. We conducted 18 key informant interviews with African American pastors and FBO leaders and six focus groups with members. A popular health ministry strategy was distribution of print materials. There was limited awareness of EBIs and how to access them. Challenges included maintaining qualified volunteers, financial resources, and technical assistance needs. Participants used technology and social media but older adults did so less often. Findings have implications for dissemination/implementation research in FBOs, in relation to the translational continuum.

Keywords

Minority health; evidence-based; health disparities; health education; health ministry; faith-based; translational research

African Americans are disproportionately affected by health problems,¹ often referred to as *health disparities/inequities*. In response to these inequities more faith-based organizations (FBOs), such as churches, are offering structured health promotion activities including health fairs, screenings, or education, sometimes termed *health ministry*. African American churches strive to attend to the spiritual, mental, and physical needs of their members.² In

working for the advancement of the community in all avenues of life, African American pastors have led the charge serving as teacher, politician, preacher, and as an agent of health-related change.^{2,3} From the public health perspective, evidence-based interventions (EBIs) developed for use in African American FBOs now exist for a broad range of issues including heart disease, HIV/AIDS, cancer, obesity, smoking cessation, and flu vaccines.^{4–10} With few exceptions (such as Body and Soul^{11,12}), however, most of these interventions have been tested in efficacy trials without further dissemination.

A significant gap between research and practice has been documented.^{13,14} Kreuter and Bernhardt¹⁴ note that the responsibility for distribution systems for public health interventions remains “largely unassigned” (p. 2124). Further, they maintain that researchers who conduct efficacy trials are often not in the best position to facilitate intervention *dissemination* (actively spreading EBIs using planned strategies)¹⁵ or *implementation* (putting EBIs to use within a setting)¹⁵ once they do become evidence-based¹⁴.

Institutionalization, or “the extent to which the evidence-based intervention is integrated within the culture of the recipient setting or community through policies and practice¹⁶(p27)”, may be a key way to achieve sustainable health promotion activities in FBOs, yet such processes are relatively unresearched particularly in community settings.¹⁷ In summary, there is an opportunity for public health to partner with FBOs in the effort to reduce health disparities by disseminating, implementing, and institutionalizing the many evidence-based health promotion interventions that are available through research discoveries.

Concomitantly, health information technology is playing an ever-increasing role in health communication and promoting health equity.¹⁸ However, certain groups—including many racial and ethnic minorities—have historically had lower rates of access to technologies, a circumstance often referred to as the *digital divide*.¹⁹ Learning how to get EBIs disseminated to FBOs, and the potential for use of technology, are key questions with greater implications for translational research. However, despite the growing prevalence of health ministries in African American FBOs we actually know very little about health activities in these central organizations in African American communities. While a considerable number of studies have been devoted to developing and testing the efficacy of disease-specific interventions in FBOs, very few studies have examined the processes by which health ministries are established and maintained.²⁰ The current study makes a unique contribution by examining health ministry activities, including the awareness and use of EBIs, and the potential for use of technology in African American health ministries, situating health ministry within the translational continuum^{21,22} (see Figure 1). Conducting this research in a community setting provides an extension of the translational continuum (e.g., T0 – T4), which has traditionally been applied to biomedical research. Though we believe that FBOs have a role to play in all phases of the translational continuum through community engagement starting with problem identification at T0, the current study focused on implementation of EBIs and the potential for use of technology for health promotion activities in these settings (see Figure 1). We conducted individual interviews and focus groups with African American FBO leadership and members in order to: 1) explore the factors that facilitate or impede health activities, including the adoption of EBIs, and 2) identify opportunities to use technology to support/enhance the capacity of FBOs in their health ministry activities.

Methods

Church recruitment

Churches in a Mid-Atlantic state were recruited using the following criteria: a) African American pastor, b) majority African American congregation (vs. Black Caribbean, Black African immigrants, etc.), and c) at least 75 adult members. A purposive effort was made to sample different denominations and sizes of churches. Churches were invited by phone or through a visit and investigators gave the pastor a letter summarizing the project. Sixteen churches were approached and 10 agreed to participate. Additional data on the churches that declined to participate are not available.

Key informant interviews

A total of 18 key informant interviews were conducted (nine pastors, nine health ministry/other leaders). Trained interviewers scheduled 1.5-hour interviews with participants conducted in church settings. The interviews were audio-taped and transcribed verbatim. The interview guide covered church priorities including health, how health priority issues are identified, previous/current health activities, *health ministry*: structure, plans, successes, challenges, opportunities, and resources; and *technology*: current use, types of technologies used, how used, successes, challenges, opportunities, and resources. Each key informant received a \$30 gift card.

Focus groups

Following completion of the key informant interviews, seven of the 10 churches were invited to host a focus group comprising eight to 10 congregants and six agreed. Using mainly church announcements and personal contacts, members were asked to participate in a group discussion about health ministry activities to be held at the member's church. The focus group interview guide covered topics similar to the key informant interview guide. Trained moderators and research staff members led the focus groups. The groups were audio taped and transcribed. Each focus group participant received a \$30 gift card.

Qualitative data analysis

An inductive process was used, employing an open coding method. All six project team member co-authors independently reviewed all transcripts for initial themes and patterns. The team had a discussion where we developed a preliminary consensus list of themes, which was used to derive the codebook. Two interviews were used for codebook training and then codes were applied independently. Coders divided the labor by working in pairs. Discrepancies were resolved through discussion in a process of constant comparison.²³ Inter-rater agreement for the codes was high (Facilitators of Health Ministry Activities = 97.17%; Adoption of EBIs = 97.73%; Barriers to Health Ministry Activities = 92.14%; Using Technology to Build Capacity = 99.24%), likely due to the broad nature of the codes and clarity of the codebook.

Results

Church characteristics

Denominational affiliations for the 10 churches included six Baptist, two non-denominational, one Seventh-day Adventist, and one from the Church of God in Christ (COGIC). Average weekly attendance at the churches ranged from 50 to 1,000 with most of the churches (seven out of 10) serving 125 members or less. On average the pastors had an age of 55 (SD = 12.3), with an average of 17 years on their current post (SD = 12.2).

Participant characteristics

A total of 77 individuals (18 key informants and 59 focus group members) participated in the project. Participant age ranged from 20 to 86 and the mean age was 56 (SD = 15.1). The majority were female (69%). Participants had an average of 14 years of education (SD = 2.3). Almost half were employed full-time (37; 48.1%), while retirees and the disabled (6) constituted another 31% of the sample. The median annual household income for study participants was in the \$50,001-\$60,000 range.

Facilitators of health ministry activities

Every church in the study reported health-related activities at some level. Distributing print materials and bringing in expert speakers were frequent health promotion activities. Members also described events organized around monthly health themes. Exercise activities and health fairs were other common offerings.

Seven of the 10 churches had a formally established health ministry comprised of volunteers from within the congregation. All of the health ministry leaders were women (six were nurses and one social worker). Pastors chose their health ministry leaders based on a number of factors including professional background, length of time involved with the ministry, and demonstrated leadership capacity. To get people involved in health activities, health ministry leaders depended heavily on church announcements, the pastor's influence, and incentives/giveaways:

We recently did a menopause session, and so we were able to get, like, 50 pairs of purple shoes -- purple high heels [to give away], I encourage [them with] an incentive or some kind of token that they walk away with...the women in red is fun. We sort of do like a red cosmetic bag or whatever, and they also look forward to it...So we'll do like the first 50 women.

—Participant 2 (Health ministry leader, Baptist church)

Current health ministry strategies—including promoting monthly health themes, exercise opportunities, and health fairs—also populated the list of health ministry future goals. Where events had been successful in the past, health ministry leaders hoped to offer them again. Mental health and substance abuse prevention were mentioned frequently as new activities to be added in the future. Concerns about addiction, and the risks of needle-sharing, led to discussions of serving those with HIV/AIDS. Communication goals centered on more consistent dissemination of health information to the congregation using established

ministry departments (e.g., men's ministry, women's ministry, youth ministry) and targeted communication strategies.

Adopting EBIs

When key informants were asked whether they were familiar with the term, “evidence-based” nearly half were not. Only two offered a definition congruent with the public health use of the term. Once the interviewer defined the term key informants were asked where they might look for an EBI that had been designed specifically for African American FBOs. Three key informants had no ideas. The remainder said they would look to health professionals who attended the church, ask their personal physician, or look for information displayed in health facilities including hospitals and community health clinics. Leaders emphasized a desire to be able to access such programs through a community-based agency:

If there could be a consistent, local opportunity for people to access it, I think that would really be all that would be necessary.

—Participant 3 (Pastor, Baptist church)

Focus group participants were also largely unfamiliar with the term evidence-based however unlike the key informants, when asked how they would go about finding an EBI, Internet searching was the dominant response. The following search terms were frequently mentioned: health ministry, African American health, prevention, and the name of a specific condition of interest. Focus group participants also suggested that, in addition to health-related facilities, faith-based EBIs be publicized in announcements on religious radio and television and through posters on public buses and trains.

None of the health ministry activities conducted by the churches included the implementation of EBIs. However, Pastors and health ministry leaders were concerned about delivering reliable information. To design health ministry activities leaders reported depending on trusted websites, church partnerships, or denominational offices.

Your national health agencies or organizations like American Heart Association; you know those kinds of organizations where you can access that information on the computer.

—Participant 7 (Health ministry leader, Baptist church)

Barriers to health ministry activities

Challenges to conducting health promotion activities in the churches were described at both the organizational and participant levels. Maintaining a sufficient volunteer base was frequently cited as a major organizational challenge. All of the health ministry leaders volunteered in multiple church departments and burnout was a common concern. Pastors expressed frustration with recruiting fresh volunteers:

I have not found the answer of how to motivate volunteers. That is my biggest challenge as a pastor right now...I try. I try. It's discouraging when you're trying to motivate people...it's a constant struggle.

—Participant 8 (Pastor, Seventh-day Adventist church)

Lack of financial resources was another key organizational challenge. Only the two largest churches had funds earmarked for health ministry activities. Pastors also expressed a need for technical assistance if health promotion programs are to move forward:

I can mention a few volunteers that would be able to do it. The question is I don't know how to get it implemented.

—Participant 9 (Pastor, Baptist church)

At the participant level, health ministry leaders were often discouraged by low attendance at events that had been well planned and properly promoted:

I've found that it's hard to get the membership to take advantage of the things that you're offering.

—Participant 1 (Pastor, COGIC church)

Focus group participants indicated that health-related fears may contribute to low turnout, however, when describing their own reasons for poor attendance, overwhelming time demands were most often cited along with child care and transportation issues.

Using technology in health ministry

All of the churches had a general website however the extent of use by both leadership and congregants varied widely. Overall, email and text messages were considered the most successful strategies for electronic communication with members. Church leaders also reported using group voicemails in order to reach all segments of the congregation. When asked about social media, six of the 10 churches reported having a Facebook page. The two youngest pastors in the study, both in their thirties, also had a Twitter account. However, only two churches reported using technology specifically for health-related activities.

Lack of Internet access was a frequently reported barrier to technology use. Age and finances were seen as closely linked to Internet access. Leaders and members alike believed that older adults avoided technology due to fear. Conversely, older adult participants described it as an issue of preference and disliked the extent to which electronic communication undermined social relationship connections/experiences:

Just don't try to take the easy way out...What about people who just prefer to call?
I think that's the biggest thing, to have that personal contact.

—Participant 9 (Pastor, Baptist church)

Older adults recognized that electronic communication was necessary at times and some reported depending on younger family members to help them bridge the digital divide when needed. Church leaders were concerned with sending out unwanted volumes of information. Leaders were also concerned that technology users would be disgruntled by ministry messages sent at a cost to the recipient:

I think it may be a challenge for people who are inundated with messages from everywhere...It could be disregarded. It could be information overload...and you forget or you just don't...give it the importance that it needs.

—Participant 6 (Health ministry leader, COGIC church)

Financial concerns also existed at the organizational level. Pastors and church leaders expressed a desire to obtain computer equipment, offer Internet access at the church, and conduct classes to increase computer literacy but the costs of these efforts was viewed as considerable:

Technology, not only costs money but changes so that what you purchased last year [becomes obsolete]; churches can't keep up...Churches are not going to do that. They can't afford to do that.

—Participant 16 (Pastor, Baptist church)

Discussion

The current project aimed to describe health ministry practices, facilitators and challenges, and use of technology in African American FBOs, and lay the foundation for future successful dissemination and implementation of EBIs in these organizations, including institutionalizing health promotion activities in FBOs. This study makes a unique contribution by considering the intersection of health ministry in FBOs and the translational continuum²², given the proliferation of EBIs generated by research and not reaching further dissemination and implementation. We discuss the qualitative findings and conclude with study limitations and recommendations based on the current findings.

Overall, the current findings indicate that, in this modest sample of African American FBOs, there is considerable interest and activity around health promotion and health ministry to serve the membership. These activities capitalize on the strengths of the volunteer base in the churches, who are often women and those who have a previous health background frequently through their employment. However, the interview and focus group data suggest challenges in keeping that volunteer base engaged and getting members involved in the health activities, as well as time and budgetary limitations. We find that FBO leaders often have high interest in promoting the health of their memberships but may lack the specific knowledge as to the best way to go about doing that. This was reflected in the limited awareness of EBIs and where to find them, and that no churches reported using EBIs in their health ministry activities. These findings underscore the opportunity for public health to partner with FBOs and provide access to appropriate EBIs for faith communities to implement, based on their identified priorities. The findings do not, however, provide the answer to the question raised by Kreuter and Bernhardt¹⁴ as to whose responsibility it is to provide a distribution system for EBIs once they become available. This is still an issue and it was clear from the current data that while FBOs may benefit from such a system, they are not in a position to lead the effort.

However, our findings also indicated we need to make it as easy as possible for FBO leaders and those involved in health ministry to access and implement evidence-based health programs, as both time and financial resources are limited. Due to the overwhelming amount of information on the Internet, lay individuals may need assistance in navigating to trusted health information, preferably in a “one-stop-shop” format. This is consistent with Kreuter and Bernhardt's¹⁴ recommendation around building distribution capacity for EBIs, in which distribution of all types of programs regardless of disease focus would be coordinated

through a single system, in the case of an FBO, their health ministry. These researchers also recommended that interventions should be worthy of inclusion, packaged to facilitate ease of use, and include comprehensive user support. FBO leaders indicated continuing concerns around financial barriers faced by people who do not have computers, Internet access, and/or smart phones. Additionally, some older adult members expressed a desire for more personal contact. Taken together these results indicate that while technology may play an important role in furthering the reach and adoption of EBIs in FBOs, implementation may best be supported by a “hybrid” design in which human contact is supplemented with technology.

Several limitations should guide the interpretation of these findings. As is common with qualitative research, this study utilized a modest convenience sample. The FBOs were recruited from a single mid-Atlantic state. As such, the results may not be generalizable to other geographic regions such as the South or West. In particular, the current sample consisted of a middle class, largely college-educated group of African Americans with health insurance and this is reflective of the study region.^{24,25} Findings may reflect greater use of technology given the socioeconomic aspects of the sample.²⁶ Had the study been conducted in a disadvantaged sample, it is possible that greater challenges may be reported with regard to barriers to health ministry activities in the churches.

In conclusion, this study revealed factors that facilitate and impede health ministry activities in a sample of African American FBOs as well as their use of technology in these initiatives. Those working with FBOs need to understand each organization’s individual strengths and capacities as contextual factors, which are critical for health promotion activity planning, implementation, and sustainability. We believe that public health should play a role in supporting FBOs by providing them straightforward, centralized access to EBIs based on their identified health priorities, and technical assistance with implementation and institutionalization of health promotion practices. It is likely that with the amount of work that such an initiative will take, partnerships will be a critical approach to achieving such a goal.

Acknowledgments

This work was supported by a grant from the University of Maryland Clinical Translational Science Institute, and in part by a grant from the NIH-National Center on Minority Health and Health Disparities (PG60MD000207, S.B. Thomas, PI).

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Figure 1.

Translational continuum

Adapted from: Khoury MJ. et al.²¹ The continuum of translation research in genomic medicine: how can we accelerate the appropriate integration of human genomic discoveries into health care and disease prevention? *Genet Med* 2007;9(10):665–674.