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Assessing capacity of faith-based organizations for health promotion activities

Erin Kelly Tagai, PhD, MPH¹, Mary Ann Scheirer, PhD², Sherie Lou Z. Santos, MPH¹, Muhuiddin Haider, PhD³, Janice Bowie, PhD⁴, Jimmie Slade, MA⁵, Nancy L. Atkinson, PhD⁶, Tony L. Whitehead, PhD⁷, Min Qi Wang, PhD¹, and Cheryl L. Holt, PhD¹

¹University of Maryland, School of Public Health, Department of Behavioral and Community Health, College Park, MD

²Scheirer Consulting, Princeton, NJ

³University of Maryland, School of Public Health, Maryland Institute for Applied Environmental Health, College Park, MD

⁴Johns Hopkins University, Bloomberg School of Public Health, Department of Health, Behavior, and Society, Baltimore, MD

⁵Community Ministry of Prince George's County, Upper Marlboro, MD

⁶Westat, Rockville, MD

⁷University of Maryland, School of Public Health, Department of Anthropology, College Park, MD

Abstract

Background—Faith-based organizations (FBOs) are important venues for health promotion, particularly in medically underserved communities. These organizations vary considerably in their structural capacities, which may be linked to variability in implementation success for health promotion initiatives. Lacking an existing validated assessment of organizational capacity specific to FBOs, an initial prototype assessment was developed.

Methods—The FBO-CI (Faith-Based Organization Capacity Inventory) assesses three structural areas of capacity: Staffing and Space, Health Promotion Experience, and External Collaboration. The multidisciplinary team, including FBO leaders, co-developed the initial instrument. The initial reliability from a convenience sample of 34 African American churches including descriptions of FBOs representing three capacity levels is reported.

Results—The FBO-CI demonstrated feasibility of administration using an in-person interview format, and the three subscales had acceptable internal reliability ($\alpha \sim .70$). Most churches had an established health ministry ($n = 23$) and had conducted activities across an average of seven health areas in the previous two years.

Conclusions—This initial FBO-CI prototype is promising, and future work should consider validation with a larger sample of churches and domain expansion based on the conceptual model. The FBO-CI has a number of potential uses for researchers, FBO leaders, and practitioners working with FBOs in health promotion initiatives.

Keywords

community assessment; needs/assets assessment; health research; community organization

Faith-based organizations (FBOs) are those that maintain a religious identity through their activities, decision-making, and staffing (e.g., church congregations, national networks of religious denominations; Bielfeld & Cleveland, 2013). FBOs have become important vehicles for health promotion, particularly in underserved communities (Campbell et al., 2007). These activities may originate internally through health ministries or external partnerships such as health departments or university-led research projects, and range from distribution of print health education materials to church-based health clinics. African American churches are one type of FBO that often incorporate health promotion into their mission—especially in the context of reducing health disparities (Holt et al., 2009; Parrill & Kennedy, 2011).

Health promotion initiatives in FBOs experience varying degrees of implementation and outcome success among populations they are intended to serve. With experience over the past 12 years in partnering with over 70 African American churches in several health behavioral intervention trials (see Holt et al., 2009; Holt et al., 2014), considerable variability in such outcomes and among the churches themselves has been noted. FBOs vary widely in their characteristics such as size, staffing, physical plant, and leadership (Austin & Claiborne, 2011; Kearns, 2006). Based on these observations, and viewing FBOs as organizations, the literature and theory around organizational factors and the growing dissemination and implementation literature focused on capacity suggests organizational capacity in FBOs could—and should—be assessed.

There are several reasons why a health-focused organizational capacity assessment for use in FBOs is needed. *For researchers*, such a tool will help those working with FBOs to understand how contextual/organizational factors influence outcomes across the implementation and translational continuum. Such an assessment will help researchers identify (a) FBOs most prime for partnership on health promotion initiatives and (b) the types and amount of technical assistance that an FBO may need. *For FBO leaders*, a capacity assessment tool could help them identify their strengths and areas for future investment, as well as appropriately plan their health promotion initiatives based on identified capacities. *For practitioners working with FBOs*, it may help optimize FBOs with evidence-based interventions based on their initial capacity. A capacity assessment tool can also help practitioners involved in capacity building initiatives track changes in FBO strengths over time. Such an instrument needs to be brief and practical to ensure feasibility for multiple stakeholders (Lewis, Weiner, Stanick, & Fischer, 2015). The purpose of this article is to describe the development, feasibility testing, and utility of an organizational capacity instrument specific to FBOs—the Faith-based Organization Capacity Inventory (FBO-CI).

Defining Organizational Capacity

The current literature is inconsistent in its definitions of capacity—the terms organizational “capacity” and organizational “readiness” have been used interchangeably (thus references to “readiness” are also made). However several researchers suggest that these terms are in fact discrete (Rabin & Brownson, 2012; Weiner, Amick, & Shooou-Yih, 2008). A previous model draws a useful distinction where organizational readiness reflects the *perceptions* (e.g., attitudes, beliefs, intentions) of *individuals* in organizations and is comprised of motivation and their perceived self-efficacy to implement change (Gagnon et al., 2014; Weiner et al., 2008). In contrast, organizational capacity is defined by the structures of the *organization* as a whole. Rabin and Brownson (2012) define capacity building as “any activity...that builds durable resources and enables the recipient setting or community to continue the delivery of an evidence-based intervention...” (p. 27). Consistent with the definition of readiness provided by the aforementioned model and with Rabin and Brownson (2012), capacity is defined as the *observable, structural elements of organizations, assessed at the organizational level (unit of analysis)*.

Previous Capacity Assessments

Literature describing how to systematically assess organizational capacity is infrequent (Jarpe-Ratner et al., 2013), particularly in FBOs. In a recent review of readiness/capacity models (Castañeda et al., 2012), it was noted that measurement was still at the early stages (Foster-Fishman, Cantillon, Pierce, & Van Egeren, 2007), characterized as underdeveloped, and a priority for implementation science (Newhouse, Bobay, Dykes, Stevens, & Titler, 2013). Several instruments from the secular literature informed the current work (see Finney & Moos, 1984; Lehman et al., 2002; Marguerite Casey Foundation, n.d.). However, due to lack of FBO-specific factors such as the unique role of the pastor none could be used directly for the FBO-CI. Finally, most existing instruments are not particularly user-friendly for FBOs due to their complexity, use of jargon, or response burden.

A number of previous instruments are indeed available to assess characteristics of FBOs (see Berkely-Patton et al., 2012; Carter-Edwards, Jallah, Goldman, Robertson, & Hoyo, 2006; Christian Reformed Church, n.d.; Leake et al., 2007; Trinitapoli, Ellison, & Boardman, 2009; United Church of Christ, n.d.; Whitt-Glover, Porter, Yore, Demons, & Goldmon, 2014). These instruments assess domains such as leadership, financial operations, membership, program evaluation, marketing, and ministries. However, these instruments were atheoretical, not focused on health, or missing data about psychometric properties. While none of the instruments reviewed were found to be optimal for the current purpose, they helped inform the FBO-CI development.

Conceptual Framework of Organizational Capacity in FBOs

FBOs have unique characteristics (e.g., volunteer staff, fiscal resources) that tend to vary considerably from one organization to another. Such contextual factors may influence health promotion activity success differently than secular organizations (Leake et al, 2007). Guided by previous instruments and conceptual models (Greenhalgh, Robert, Macfarlane, Bate, &

Kyriakidou, 2004; Weiner et al., 2008), the structural organizational characteristics of FBOs were grouped into three major categories of *Staffing and Space*, *Health Promotion Experience*, and *External Collaboration*. The three categories were informed by three components of the conceptual model proposed by Greenhalgh and colleagues (2004): *System Antecedents for Innovation* (Staffing and Space), *System Readiness for Innovation* (Health Promotion Experience), and *Outer Context* (External Collaboration). These categories were re-named in a lay-friendly manner for wide implementation by researchers, practitioners, and FBO leaders. Staffing and Space are the stable components of FBOs that do not readily change with the introduction of an innovation (i.e., *membership, building, leadership, and staffing*). FBOs' previous *health promotion experience* includes *health ministry-specific* activities (e.g., health-related activities, an existing health ministry). External Collaboration includes *collaboration/partnerships, involvement in research, and technical assistance* from outside organizations or individuals. Other capacity characteristics that the research team found to be relevant for success in health promotion activities and were prominent in previous capacity and related readiness models are shown in an overall conceptual framework of organizational capacity in FBOs (Figure 1). However for reasons previously mentioned these are not assessed in this initial version of the FBO-CI.

Present Study

The present study worked closely with local FBO leaders to develop an initial prototype of a capacity assessment for health promotion activities. This paper discusses the development of the FBO-CI, provides illustrative descriptive data from a convenience sample of 34 African American churches, and discusses both feasibility and lessons learned from collecting organizational data from African American churches. The current work was conducted in the context of the research team's ongoing research program in Maryland (Graham-Phillips et al., 2016; Holt et al., 2014; Saunders et al., 2013). A capacity assessment for use in FBOs would fill a gap in the current literature and currently available assessments, and would have a number of potential users and uses. Researchers may find such a tool helpful when planning health promotion activities in FBOs, to identify those organizations with more limited capacity, which may require greater technical assistance. FBO leaders could use a capacity assessment when planning new initiatives including health promotion.

Methods

Instrument Development

The research team reviewed available organizational capacity instruments, consistent with the areas reflected in the conceptual model. The multidisciplinary research team included three community partners with leadership experience in African American churches representing FBOs. All team members, including the community partners, participated in all phases from instrument development through interpretation of the data, which helped when considering the sensitivity and cultural competency required in these settings and the feasibility of asking particular questions, including pastor employment outside the church. The team identified existing items from available capacity instruments, and in cases where no existing items were available, the team drafted items using an iterative process. Our

community partners provided critical input after instrument development. During initial administration of the survey, it was found that several items initially included were not feasible for the pastor or other church administrators to complete given available data at the church level and were later removed, including the percentage of members employed. Table 1 details each FBO-CI section and its corresponding items and organizational factor (e.g., Staffing and Space). The FBO-CI is available from the authors upon request.

FBO-CI Administration

The FBO-CI was completed by pastors or designated key informants from 34 African American churches in Prince George's County and Baltimore City, Maryland enrolled in one of three research projects. Two of the projects involve cancer early detection interventions (Holt et al., 2014; Saunders et al., 2013), and the third involved African American churches not previously engaged in research or university-led partnerships (Graham-Phillips et al., 2016). Church recruitment was completed by African American interfaith community partners that had established relationships with FBOs in Prince George's County and Baltimore City, Maryland. The community partners approached the Pastor of each church and described the research project. If interested, the church information was then provided to the research team who obtained written informed consent from the respondents. Churches were eligible if they self-identified as having a predominantly African American congregation, were a Christian denomination, and were located in the study region.

The FBO-CI is a paper-and-pencil survey completed by the pastor and returned to the research staff or completed in an interview format. The FBO-CI took an average of 30–60 minutes to complete. Early administrations of the FBO-CI were self-administered by pastors or pastor-nominated key informants. However, participants had difficulty responding to some items, including specific church membership counts, delaying survey return. The research team determined that an interview format would yield higher quality and more timely data collection. The data collection protocol was revised to first distribute the survey to the church and then schedule a subsequent in-person interview to complete the FBO-CI. This gave pastors time to review the survey and collect any information they may not have readily available before the interview, such as the total number of adult members. Most of the churches ($n = 29$) completed the survey in the interview format, while five churches completed the FBO-CI in the self-administered format.

Data Analysis

Descriptive statistics were calculated for each survey item or question. Items were standardized into z scores before reliability and validity analyses, as they did not have uniform response options. Cronbach's alpha and item-total correlations were used to assess initial reliability for each of the three subscales. Each subscale with a Cronbach's alpha $\sim .70$ was characterized as having acceptable internal consistency (Nunnally, 1978).

Each subscale was scored by first calculating the mean of the individual items' z scores and then transforming each mean into t scores with a mean of 50. This process ensures that all subscales and the total score can be uniformly interpreted. An FBO-CI total sum of the subscales was calculated. While the analyses presented used the t scores, those utilizing the

instrument in practice may find it useful to divide the subscale scores to tertiles reflecting organizations with “low,” “medium,” and “high” capacity. SPSS 22.0 was used for all analyses. All means were calculated using all valid, nonmissing values for each case. This work was approved by the University of Maryland Institutional Review Board. Informed consent was obtained from all study churches and participants.

Results

FBO Demographic Characteristics

The 34 FBOs were primarily Baptist ($n = 15$) or Non-Denominational ($n = 7$). t scores on the Staffing and Space subscale ranged from 35.89 to 59.48 ($SD = 6.41$), the Health Promotion Experience subscale ranged from 32.21 to 61.19 ($SD = 8.12$), and the External Collaboration subscale ranged from 36.21 to 65.50 ($SD = 8.11$; Table 2). Within each subscale, 95% of the t -scores range from 30 to 70. The FBO-CI total score had a mean of 150.17 ($SD = 16.22$) and ranged from 114.69 to 178.72.

Reliability—All three of the FBO-CI subscales had an internal reliability greater than or approaching .70 and most item-total correlations were reasonable (Table 3). Some items were retained due to their content or theoretical significance (e.g., pastor education; Odulana et al., 2014) despite low item-total correlations. Removing the items did not result in meaningful increases in the internal reliability of each scale. The Staffing and Space subscale contains eight items, the Health Promotion Experience subscale contains four items, and the External Collaboration subscale contains three items.

Descriptive church profiles—Descriptive profiles of the churches with the highest, median, and lowest overall FBO-CI scores at baseline were examined from the pool of 13 churches that were enrolled in Project HEAL to illustrate the application of the FBO-CI to three churches of variable capacity. Project HEAL is a church-based cancer early detection intervention with a three-workshop series delivered by two trained Community Health Advisors from each church (Holt et al., 2014). The Project HEAL protocol includes (1) Community Health Advisor training, (2) the three-workshop series attended by eligible congregants, and (3) 12- and 24-month workshops led by research staff to report back study findings to participants (for full description of the intervention see Holt et al., 2014 and Santos et al., in press).

The church with the highest overall FBO-CI score (t scores: Total score = 176.15, Staffing and Space = 52.96, Health Promotion Experience = 59.08, External Collaborations = 64.11) had a congregation size of 420, owned their building, had one paid full-time staff member, and a volunteer staff of 75. The church had a health ministry and previously collaborated with one organization. Additionally, this church had a comprehensive website that details the church's 24 ministry activities as well as a history of their church and lead pastor, the year the church was established, total number of congregation members, service times, and calendar of events. In Project HEAL, this church trained and certified their Community Health Advisors in 20 days and completed their three workshop series in 70 days. The church enrolled 20% of eligible congregation members in Project HEAL, and 25% of enrolled participants attended their 24-month follow-up workshop.

The church with the median total FBO-CI score (Total score = 148.38, Staffing and Space = 47.16, Health Promotion Experience = 53.90, External Collaborations = 47.33) had a congregation size of 300, a volunteer staff of 32, and a health ministry. However, the church did not provided information on building ownership and did not have any paid staff or a history of collaboration with other organizations. Additionally, the church had a similar comprehensive website providing the same type of information as the church with the highest overall FBO-CI score. This church trained their Community Health Advisors in 19 days and they completed their 3-workshop series in 56 days. This church enrolled 20% of eligible congregation members in Project HEAL and 32% were in attendance at their 24-month follow-up workshop.

Lastly, the church with the lowest total FBO-CI score (Total score = 131.94, Staffing and Space = 35.89, Health Promotion Experience = 51.78, External Collaborations = 44.26) had a congregation size of 53, owned their building, and a volunteer staff of 32. However, the church did not have any paid staff. The church had a health ministry and previously collaborated with two organizations. Additionally, while the church had a website, it did not have as much detail as the other two churches. However, this church had the highest participant reach of the three churches described here as 74% of eligible congregation members in Project HEAL and 56% were in attendance at their 24-month follow-up workshop. This church trained their Community Health Advisors in 16 days and they completed their 3-workshop series in 63 days.

Discussion

The FBO-CI is a practical tool that can be used as a front-end assessment for FBOs and those working with them, for planning and selecting health promotion interventions optimized to the FBO's existing capacity. It fills a gap in organizational assessment tailored for the unique context of FBOs. During the course of this initiative, similar work was being done in Catholic churches by Allen and colleagues (2015), who also identified a lack of existing instruments suitable for this purpose. Their CRUZA initiative developed an instrument assessing parish leadership, financial resources, Hispanic Ministry, and health and social service offerings. The reluctance of our churches to provide financial information illustrates important cultural nuances between these two initiatives. Both projects expended considerable human capital in the collection of the data, largely through interviewer contacts and efforts.

The FBO-CI has several potential users and uses in research and practice. Researchers may use the FBO-CI to assess FBO capacity before implementation of health promotion interventions to identify capacity levels that may indicate a need for greater assistance. FBO leaders may use the FBO-CI to complete a self-directed internal assessment of their capacity to implement new health promotion interventions. Finally, practitioners may use the FBO-CI to identify suitable existing health promotion interventions that best fit the current capacity of an FBO. This initial prototype provides a starting place to assess the structural capacity factors of FBOs. Further, the FBO-CI provides a foundation that can be built out with FBO-specific assessments of leadership support and church readiness through validation with a

larger sample of FBOs. These initial three FBO-CI subscales have reasonable initial internal reliability even with their variation in item content and brief nature.

Staffing and Space

This subscale includes the FBOs' membership, building, leadership, and staffing. Greater church size (Austin & Claiborne, 2011), leadership, and staffing have been associated with successful implementation of new information and activities in an organization (Greenhalgh et al., 2004; Leake et al., 2007; Trinitapoli et al., 2009). Clergy are often seen as "gatekeepers" and as trustworthy, authoritative figures within the African American community (Parrill & Kennedy, 2011). FBOs with supportive leadership that dedicate time to implementation and sustainability are more successful with implementation of a health promotion activity (Austin & Claiborne, 2011). Pastors that work outside of the FBO in addition to their pastoral role may have less time to devote to partnerships and collaborations in health research (Corbie-Smith et al., 2010). The building characteristic includes the facility itself, ownership (Owens & Smith, 2005), and sufficient capacity to house the current program (Campbell et al., 2007). FBOs may not have the appropriate facilities to deliver health promotion activities without an adequate building or autonomy over building space.

While size has been positively associated with implementation success (Austin & Claiborne, 2011), the church descriptions illustrate participant reach seemed to be greater in the example church with the lowest overall FBO-CI score and lowest Staffing and Space subscore. This may be related to smaller churches having a tighter social network than larger churches, which may foster greater feeling of accountability for attending a health promotion program when asked to do so by a pastor or a Community Health Advisor. Similarly, a negative association between church member size and bonding between members was found among Chinese churches (Cheung, Hui, Lau, Cheung, & Mok, 2015). This finding supports the idea that larger membership size does not always translate to a more successful implementation of health promotion programs in FBOs. Future research should assess Staffing and Space among a larger population of FBOs with greater variability in church membership size.

Health Promotion Experience

FBOs that have strong organizational structures, such as health ministries, assisting the promotion of various health behaviors and advocating for new health innovations (Greenhalgh et al., 2004) may be better equipped than FBOs without strong organizational structures to implement and sustain new health promotion activities (Campbell et al., 2007; Greenhalgh et al., 2004). While the descriptive church profiles did not support the highest Health Promotion Experience subscore having the greatest reach and implementation, the range between the highest and lowest subscore was only 2.12 demonstrating little variability. Additional research is needed to identify the relationship between the Health Promotion Experience subscale and health program success.

External Collaboration

FBOs with strong inter-organizational networks are often better equipped to implement health promotion activities due to additional support from other organizations throughout the community (Ayton, Carey, Joss, Keleher, & Smith, 2011). A history of research involvement may equip FBO staff and congregation members with the necessary skills for program implementation, including data collection, intervention implementation and sustainability, and evaluation (Campbell et al., 2007; Trinitapoli et al., 2009). Technical assistance has been shown to facilitate implementation success for health promotion activities (Campbell et al., 2007). FBOs may require various forms of technical assistance to provide basic health-related services, particularly when located in neighborhoods with insufficient resources (Kearns, 2006). However, the descriptive church profiles found the church with the largest External Collaboration subscore had the lowest reach and—similar to Health Promotion Experience—further research is warranted to identify the relationship between External Collaboration and program success.

Limitations

There are a number of limitations to consider when assessing the current findings. The current study has a limited sample size, convenience sampling through existing community partner relationships, and focused on African American churches in a relatively small geographic area already engaged in some form of health-related research. As a result, our experiences may not be transferrable to other populations or to FBOs with the most limited capacity. Additionally, even though the FBO-CI focuses on objective, structural capacity factors, with only one observation per organization, inter-rater reliability could not be verified. Further, there is missing data for some items due to the initial challenges in FBO-CI administration before the interview format protocol changes. Lastly, some of the item-total correlations and reliability estimates were modest. Future analyses with a larger sample size would have the ability to examine the factor structure of the FBO-CI.

Conclusions

The FBO-CI is a promising initial version of a brief practical assessment that researchers, practitioners, or faith leaders can use to assess structural aspects of capacity of FBOs for health promotion activities. Additional refinement, potential expansion, including additional domains focusing on health program/ministry implementation skills, and the more perceptual aspects of capacity, and readiness, as well as validation with a larger sample is warranted. Future work with the FBO-CI should consider use with increased heterogeneity of FBOs (e.g., mosques, temples), populations, and geographic regions. Additional assessments could consider gathering multiple perspectives on the items within each FBO such as pastors or other key informants. As the dissemination/implementation science research agenda continues to develop, the FBO-CI will be useful for assessing the important role of context in health disparities research and practice.

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Figure 1.
Capacity conceptual framework in faith-based organizations

Table 1

FBO-CI items and corresponding organizational factor

FBO-CI section	Survey items	Organizational factor
Cover page	<ul style="list-style-type: none"> FBO and pastor contact information Denomination 	None
Profile of congregation	<ul style="list-style-type: none"> Total membership size Demographic composition (e.g., predominant race/ethnicity of members) 	<i>Staffing and Space</i>
Congregational characteristics	<ul style="list-style-type: none"> Pastor characteristics (e.g., employment, education) Building information (e.g., ownership, adequate space for current program, Internet/computer access) Theological/faith stance Services provided (e.g., food pantry, shelter, computer classes) Staffing (e.g., full-time, volunteers) Evaluation of services (e.g., type, frequency) 	<i>Staffing and Space</i>
Technical assistance	<ul style="list-style-type: none"> Technical assistance received in last 6 months Technical assistance currently needed 	<i>External Collaboration</i>
Health ministry activities	<ul style="list-style-type: none"> Current health ministry and length of existence (if any) Health areas covered currently or within past 2 years Current health activities or held within past 2 years 	<i>Health Promotion Experience</i>
	<ul style="list-style-type: none"> Current partnerships or within past 2 years Research projects 	<i>External Collaboration</i>
Church boards, ministries, and committees	<ul style="list-style-type: none"> Boards, ministries, or committees (i.e., purpose of group, number of members, meeting frequency, and Pastor role) 	<i>Health Promotion Experience</i>
Collaboration	<ul style="list-style-type: none"> Collaboration with other organizations 	<i>External Collaboration</i>

Note: Not all items used in FBO-CI scoring; some items used for descriptive purposes only

Table 2

FBO-CI data from pilot testing in 34 African American churches

Survey Item	<i>M (SD) or n (%)</i>
FBO-CI Total Score	150.2 (16.2)
<u>Staffing and Space</u>	50.1 (6.4)
Number of adult members	
100	8 (23.5)
101–499	16 (47.1)
500	10 (29.4)
Number of members attending weekly	
100	14 (41.2)
101–249	8 (23.5)
250	12 (35.3)
Pastor employed outside of church	
Yes	6 (17.6)
No	28 (82.4)
Pastor education level (<i>n</i> = 31)	
Bachelors degree or less	7 (22.6)
Masters degree	13 (41.9)
Doctorate	11 (35.5)
Church owns building (<i>n</i> = 33)	
Yes	24 (72.7)
No	9 (27.3)
Number of full-time staff (<i>n</i> = 32)	2.6 (3.1)
Number of part-time staff	6.6 (10.2)
Number of volunteers	60.2 (45.1)
<u>Health Promotion Experience</u>	50.0 (8.1)
Church currently has a health ministry or health activities	
Health ministry	23 (67.6)
Conducts health activities	7 (20.6)
Neither	4 (11.8)
Mean number of years of current health ministry	2.1 (0.8)
Mean number of health topics covered in past 2 years (<i>n</i> = 33)	6.6 (4.5)
Mean number of health activities covered in past 2 years	2.9 (1.8)
<u>External Collaboration</u>	50.1 (8.1)
Mean number of areas receiving technical assistance (<i>n</i> = 33)	4.8 (4.1)
Mean number of collaborations with outside organizations	9.1 (21.1)
Research with other organizations (<i>n</i> = 28)	
Yes	12 (42.9)
No	16 (57.1)

Note. Variation in sample size due to missing data

Table 3

Reliability analysis of the FBO-CI items

FBO-CI Subscale	Cronbach's alpha	Item	Item-total correlation
Staffing and Space	.79	Number of adult members	.67
		Number of members attending weekly	.61
		Pastor employment	.35
		Pastor education level	.30
		Building ownership	.56
		Number of full-time staff	.57
		Number of part-time staff	.45
		Number of volunteers	.55
Health Promotion Experience	.83	Current health ministry or health activities	.78
		Number of health topics covered within past 2 years	.67
		Number of health activities completed within past 2 years	.61
		Years since health ministry established	.60
External Collaboration	.67	Number of areas receiving technical assistance	.41
		Research project completed in church	.44
		Number of collaborations with outside organizations	.59