Key Attributes of Health Ministries in African American Churches:
An Exploratory Survey

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Abstract

Background: *Church leaders are considered instrumental in the successful implementation of church-based health programs. However, it is unknown which program attributes they perceive as important and which program attributes exist in their congregations.*

Objective: *To explore the perceived importance and existence of health ministry-related attributes in predominately African American churches.*

Methods: *Cross-sectional survey, with a convenience sample of 98 registered church leaders attending a conference on health and spirituality in Raleigh, NC. Attendees were asked to complete a brief survey assessing perceived importance (very important vs. somewhat or not important) and existence (yes vs. no) of 20, health ministry-related attributes in their churches. Percent perceived as very important, percent existence, and their differences were assessed for each attribute.*

Results: *Seventy-two (73.5%) of the attendees completed the survey. Attributes perceived as very important were: displaying health information in churches (73.6%); hosting health fairs for church members (72.2%); pastoral, church-based Internet access (70.8%); willingness to receive foundation funding for activities (66.7%); and incorporating health messages in Sunday bulletins (65.3%). For each of these program attributes, there was a gap between the proportion rating them "very important" and existence of the attribute in their own congregations (range diff in %: -8.3 to -22.2).*

Limitations: *Lack of generalizability due to sample selection and homogeneity.*

Conclusions: *Among leaders surveyed, despite perceived importance, attributes did not exist for all. Future studies should evaluate whether attributes considered important by church leadership parallel an increase in the development and maintenance of health program activities, and are associated with congregation health behaviors and health outcomes.*

Key Words: *health ministry; African Americans; perceptions; churches*

Introduction

There has been an increased interest in African American churches as conduits for health information and program outreach to help prevent or reduce the burden of chronic diseases.[1,2] However, little is known about church attributes or infrastructures used to carry out health outreach and services to church congregations and their surrounding communities. Outreach services are typically conducted through health ministries, defined as special missions that integrate faith and health for their members and the communities they serve.[3] Health ministries are integral to the overall ministry of the church, and are organized to address health needs through activities and information dissemination related to spiritual, emotional, social, and physical health and wellness. They may be of particular importance to community-based health programs since millions frequently go to churches to find help for coping with life.[4]

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Despite the existence of church-based health ministries, little is published about them, including their characteristics, structures, or effectiveness. Even less is known about them in African American churches. Most literature on health ministries and their functions has been in the area of parish nurse programs. The recorded history of a health ministry model through the work of parish nurses dates back to 1836 in Kaiserwerth, Germany.[4] Rev. and Mrs. Fliedner established the "Deaconness" movement where, by 1900, over 25,000 trained nurses representing religious organizations served the ill in communities in Europe, the US, Egypt, Russia, and Hong Kong.[4]

Today, parish nurse programs continue to provide services to churches and local communities. Their success is largely dependent on church leadership. Pastors play key roles in the development and maintenance of parish nurse programs. If pastors are not interested, there is little hope for implementation.[4] However, for pastors who endorse such a program, they provide support by: assisting in the selection of congregation members to serve on a task force; helping the group bring the message to the congregation; helping to select and contact other pastors in the community who might be interested in such a program or collaboration; and providing the project with a strong biblical foundation for whole-person healthcare.[4] Once pastors select the parish nurse program leader, a health cabinet, typically comprised of the pastor, parish nurse, and other lay members, is formed to assist individuals and families in improving and maintaining their own health and that of their community, through worship, education, support networks, recreation, and fundraising.[4,5] Roles, needs, and challenges may differ across churches based on size,[6] location,[7] and program mission.[4]

As with these parish nurse programs, lay leaders and staff are key to the successful implementation of health programs in African American churches.[8] Such programs will exist only if pastors and their church leaders perceive them to be essential, efficacious in reducing disease risk, and consistent with the church mission.[9] However, it is not known whether attributes similar to those identified as essential in traditional parish nurse programs exist in health ministries in African American churches.[10] Furthermore, it is unknown what church leaders perceive to be important attributes for a health ministry, or whether these characteristics exist in their own congregations. This exploratory study describes the perceived importance of church-based health ministry attributes in a sample of leaders of predominantly African American churches, and the extent to which perceptions of importance diverged from reported existence of these attributes in their respective churches.

Methods

Study Sample

The study population was a convenience sample of 98 pastors, other ordained clergy, or lay leaders in predominantly African American churches in NC who were registered attendees of the 2004 Third Annual Health Enhancement through Medicine and Spirituality (HEMS) Conference, held in Raleigh, NC. This assembly was a collaborative effort between the Shaw University Divinity School, the oldest historically black university in the South, and the Old North State Medical Society, based in Durham, NC. The conference theme, "Building an Effective Ministry of Health and Healing," emphasized church accountability for the community's welfare and the need for collaboration between churches, academia, and other institutions to address African American health problems through effective outreach programs. The analysis sample included the 72 attendees (73.5%) who filled out an informed consent and health ministry assessment survey. The study's protocol and informed consent form were approved in 2004 by the Institutional Review Board at The University of North Carolina at Chapel Hill School of Public Health.

Health Ministry Assessment Survey

A health ministry assessment survey was administered to conference attendees and included questions on: respondent demographics (age, gender, marital status, and annual household income); church characteristics (respondent roles, denomination, church size and location); and the perceived *importance* and *existence* of 20 health ministry attributes in the church or congregation represented by the respondent. Since no scale to date has been published that captures parish nurse program or health ministry attributes, the HEMS conference organizers compiled an exploratory list of health ministry attributes based on literature on parish nurse programs,[4-6] church-based studies,[2,9-14] and attributes deemed important based on the conference theme of leadership, outreach, and collaboration (e.g., technological attributes for collaboration and outreach). Attributes were grouped into four areas: *leadership and staffing* (leadership decisions, appointments, personnel roles, responsibilities, and expertise, and working relationships with other church groups that may impact behaviors related to chronic disease [e.g., the kitchen committee's food choices and preparation practices]);[4-6,10-14] *function* (activities that may be conducted by a health ministry, whether part of the church health infrastructure or through outreach);[4-6,9] *technology and funding* (characteristics associated with Internet access for quick acquisition of health ministry-related information as well as information on capital development and fundraising);[4-6,15] and *collaboration* (research partnerships with academic institutions and local community organizations, such as health agencies, outreach programs, and foundations).[1,5]

For each attribute, respondents rated the *level of importance* (very; somewhat; not at all) and current *existence* in their church (yes; no; don't know). It was anticipated that the number of potential respondents would have been no greater than 100, which represented the approximate number of persons who pre-registered for the conference. Thus, for importance, a three-level, rather than a standard five-level, response category was created to minimize potentially small cell sizes in the analysis. Existence measured an individual respondent's perceived existence of the attribute in the church of which he/she was a member. To maximize anonymity of respondents, data were not collected on the name of church; so more than one respondent may represent some churches.

Variable Measurement and Analysis

Sample demographics and levels of importance and existence of health ministry attributes were evaluated. The proportion of attendees for which each attribute was very important (versus somewhat important and not at all important) and corresponding level of existence (percent existence among the entire analysis sample) are reported. McNemar's test of differences in proportions was used to compare differences in percentages of importance and existence of the 20 attributes. Where attributes were rated as very important, Fisher's exact test was used to evaluate individual effects of clergy status (pastor and other clergy vs. non-clergy or laity),[4,5] geographic location (urban vs. rural),[7] and church size (300 members (large) vs. <300 members (medium and small)).[6,17] It was hypothesized that the percent difference in attribute importance and existence would differ for: clergy and non-clergy members of urban compared to rural churches; and for larger versus smaller or medium-sized churches.

Results

Of the 72 respondents, 43 (59.7%) were women (Table 1). Approximately 39% of the sample were clergy (senior pastors or associate ministers). Most were members of large Baptist churches located in urban communities.

Among the 20 attributes (Table 2), the display of health information at the church was the attribute most frequently rated as very important (73.6%). Other attributes ranking high in importance were: hosting health fairs for members (72.2%); pastoral access to the Internet (70.8%); willingness to receive foundation funding for activities (66.7%); and incorporating health messages in Sunday bulletins (65.3%). The pastor leading the health ministry and making all of the decisions was perceived as being the least important (25.0%). A higher proportion reported an attribute as being important than existent in their churches for 18 of the 20 attributes. For the five most frequently rated as very important, the difference in percentage between existence and importance ranged from –8.3% to –22.2%. For all 18 attributes, differences in percentages between existence and importance ranged from –5.5%, where the health ministry is headed by a healthcare professional (p=0.359) to –27.8%, where the health ministry has a system for keeping track of the church members' health status or specific health indicators (p<0.001).

Limited associations of clergy status, church geographic location, and church size on existence of the 20, health ministry attributes were found; therefore full results are not shown. More clergy than non-clergy perceived access to the Internet as very important (p=0.02). More leaders from larger than smaller churches identified hosting community health fairs as very important (p=0.01). Urban compared to rural leaders perceived having a health professional head the health ministry as very important (p<0.001).

Table 1.
Sample Demographics (N=72)

Characteristics	N (%)
Gender	
% Male	21 (29.2)
% Female	43 (59.7)
Missing	8 (11.1)
Church Role	
Senior Pastor	10 (13.9)
Associate Minister/Ordained Clergy	18 (25.0)
Auxiliary/Board Member	10 (13.9)
Other	29 (40.3)
Missing	5 (6.9)
Denomination	
Baptist[a]	28 (38.9)
Other Denomination[b]	25 (34.7)
Non-Denominational	9 (12.5)
Missing	10 (13.9)
Church Membership Size	
Small (<100)	9 (12.5)
Medium (100-299)	17 (23.6)
Large (300+)	33 (45.8)
Missing	13 (18.1)
Church Geographic Location	
Urban	33 (45.8)
Rural	18 (25.0)
Suburban	11 (15.3)
Missing	10 (13.9)

a Baptist includes: National Baptist Convention of America, National Baptist Convention USA, Inc., National Missionary Baptist Convention of America, and Progressive National Baptist Convention, Inc.

b Other Denomination includes: African Methodist Episcopal, African Methodist Episcopal Zion, Christian Methodist Episcopal, Church of God in Christ, and other denominations.

Discussion

In this exploratory study, display of health information was deemed most important, emphasizing, as in other studies, a continued interest in health information dissemination and education in African American churches.[9,11] The other attributes considered most important by at least 65% of the sample were in the areas of function/technology and funding. Reasons these particular attributes may be considered most important is that they can reach a large number of people at one time and/or open up financial and collaborative opportunities for gathering and using information to help sustain church-based or church-sponsored health programs.[16,17] For attributes considered least important, findings reveal that research may be less of a priority for health ministries than practice (as indicated through functional attributes). In addition, despite the recognized importance of pastoral approval before implementing a health ministry leadership structure,[1,4,5,18] this sample may be comfortable with church members, rather than the pastor, making daily decisions and fulfilling the responsibilities of a health ministry. This may be a necessity for pastors since their multiple commitments to their own families, congregations, and colleagues can make additional time commitments to such activities challenging.[19]

Table 2.
Differences in Existence and Perceived Importance of Health Ministry Attributes (N=72)

Attribute	Attribute Area	% (N) Exist[b]	% (N) Very Important[a]	Difference in %[c]	p-value[d]
1. Church displays health information (pamphlets)	Function	65.3 (47)	73.6 (53)	-8.3	0.359
2. Church hosts health fairs for members	Function	58.3 (42)	72.2 (52)	-13.9	0.064
3. Pastor has access to Internet at church	Technology and Funding	63.9 (46)	70.8 (51)	-6.9	0.109
4. Church is willing to receive foundation funds for its health ministry	Technology and Funding	52.8 (38)	66.7 (48)	-13.9	0.013
5. Health messages/announcements are in Sunday bulletins at least once per month	Function	43.1 (31)	65.3 (47)	-22.2	0.006
6. Church hosts health fairs for the community	Function	38.9 (28)	63.9 (46)	-25.0	<.001
7. Health ministry uses biblical scripture with members	Function	52.8 (38)	62.5 (45)	-9.7	0.442
8. Pastor appoints member to be head of the health ministry	Leadership and Staffing	65.3 (47)	58.3 (42)	7.0	0.664
9. Pastor incorporates health messages in sermons monthly	Function	44.4 (32)	58.3 (42)	-13.9	0.286
10. Church has earmarked funds specifically for health ministry	Technology and Funding	30.6 (22)	58.3 (42)	-27.7	0.002
11. Church is willing to receive government funds for its health ministry[e]	Technology and Funding	45.8 (33)	58.3 (42)	-12.5	—
12. Health ministry works with the kitchen committee	Leadership and Staffing	34.7 (25)	56.9 (41)	-22.2	0.007
13. Health ministry is headed by a healthcare professional	Leadership and Staffing	51.4 (37)	56.9 (41)	-5.5	0.359
14. Church has separate 501c3 for outreach ministries	Technology and Funding	31.9 (23)	56.9 (41)	-25.0	<.001
15. Members have access to Internet at church	Technology and Funding	27.8 (20)	48.6 (35)	-20.8	<.001
16. Health ministry has system for keeping track of members health	Function	19.4 (14)	47.2 (34)	-27.8	<.001
17. Church participates in research with local community organizations	Collaboration	31.9 (23)	47.2 (34)	-15.3	0.011
18. Church participates in research studies with universities	Collaboration	23.6 (17)	41.7 (30)	-18.1	0.013
19. Health ministry occasionally provides members transportation to physicians office or health centers[e]	Function	23.6 (17)	37.5 (27)	-13.9	—
20. Pastor leads ministry and makes all of the decisions	Leadership and Staffing	36.1 (26)	25.0 (18)	11.1	0.122

a Percentage is computed as ([number very important/total n of 72 respondents] x 100).
b Percentage is computed as ([number exist in the church/total n of 72 respondents] x 100).
c Difference in % is an absolute difference computed as (%exist - %very important).
d Two–sided exact p-value obtained from McNemar's test of difference in proportions of perceived very important and exists within the church.
e No statistics computed due to missing or zero values in cross tabulation table.

For most of the attributes, the proportion of the sample perceiving them as very important was greater than the proportion reporting the attributes existed in their churches. These findings, coupled with their attendance at the HEMS conference, whose theme focused on health ministries, reflect a potential interest to increase these attributes. Additionally, significant differences between perceived importance and existence across all four attribute categories imply that characteristics for effective health

ministry service and outreach may be multi-dimensional.[20] Formal assessment of functional activities, technological access, and collaborative partnerships may lead to an increase and improvement in the churches' attributes and help shape and implement effective church-based interventions in the future.

Limitations

There are limitations to this study. The convenience sample of predominantly Baptist conference attendees limits the generalizability of the findings. Another limitation is lack of information on both the church attended and whether an established health ministry existed in their churches. It is possible that more than one respondent attended the same church, hence a clustering (or inter-correlation) in responses. Non-response is another limitation. Some attendees (24%) did not complete the survey, raising the concern that respondents may have different perceptions or prevalence of existence of these health ministry attributes than non-respondents. Additionally, some who filled out the survey did not complete all of the demographic questions, making it difficult to determine whether the results would have been different by clergy status, urbanity, or church size. Despite these limitations, the study's findings are useful for generating hypotheses about key attributes and their implementation in predominantly African American churches.

Conclusions

Churches represent the oldest institution among African Americans.[21,22] Compared to other organizations, they are typically better able to disseminate information within the wider African American community,[1,20,22] and are also associated with an increased likelihood of positive healthcare practices.[23] This exploratory study represents new evidence on health ministry attributes in this sample of church leaders. Further understanding of these and other attributes, including how well they operate and are implemented, and whether they parallel an increase in the development and maintenance of health ministry program activities, will provide valuable information for designing subsequent church-based observational studies and interventions and assessing improvement in congregation behaviors and health outcomes. **NCMedJ**

Acknowledgements: The authors would like to thank Thea Monet, Health Enhancement through Medicine and Spirituality (HEMS) Conference collaborator and Executive Director of the Old North State Medical Society, and the attendees of the Third Annual HEMS Conference. The authors also thank M. Ahinee Amamoo, Director of the Center for Biostatistics and Data Management in the Institute for Health, Social, and Community Research for her assistance with data management and analysis. The HEMS Conference and this study were partially funded by the National Institutes of Health, National Center on Minority Health and Health Disparities (P60 MD000239), Carolina-Shaw Partnership for the Elimination of Health Disparities. Dr. Carter-Edwards and Ms. Jallah were also supported, in part, by the National Center on Minority Health and Health Disparities, grant R24 MD000167, and the DHHS, Agency for Healthcare Research and Quality, grant R24 HSO13353. Dr. Carter-Edwards was also supported in part by a grant from the National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK, Grant No. R01 DK64986).

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