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The Data Collection/Data Distribution Center: Building a Sustainable African-American Church-Based Research Network

Rev. Moses Goldmon, Ed¹, James T. Roberson, Jr., PhD¹, Tim Carey, MD², Paul Godley, MD³, Daniel L. Howard, PhD⁴, Carlton Boyd, MPH⁴, and Alice Ammerman, PhD⁵

(1) Divinity School, Shaw University; (2) University of North Carolina, Chapel Hill Cecil G Sheps Center; (3) University of North Carolina, Chapel Hill School of Medicine; (4) Shaw University Institute for Health, Social and Community Research; (5) University of North Carolina, Chapel Hill Center for Health Promotion and Disease Prevention

Submitted 2 August 2007; revised 18 January 2008; accepted 12 February 2008.

Supported by NIH National Center on Minority Health and Health Disparities Grants P60 MD000244 and P60 MD000239.

Abstract

Background: This article describes the Carolina–Shaw Partnership for the Elimination of Health Disparities efforts to engage a diverse group of Black churches in a sustainable network.

Objectives: We sought to develop a diverse network of 25 churches to work with the Carolina–Shaw Partnership to develop sustainable health disparities research, education, and intervention initiatives.

Methods: Churches were selected based on location, pastoral buy-in, and capacity to engage. A purposive sampling technique was applied.

Lessons Learned: (1) Collecting information on the location and characteristics of churches helps to identify and recruit

churches that possess the desired qualities and characteristics. (2) The process used to identify, recruit, and select churches is time intensive. (3) The time, energy, and effort required managing an interinstitutional partnership and engage churches in health disparities research and interventions lends itself to sustainability.

Conclusions: The development of a sustainable network of churches could lead to successful health disparities initiatives.

Keywords

Community-based participatory research, community health partnerships health disparities, health promotion, process issues, data collection

Despite many efforts to reduce health disparities, minority and/or underserved populations experience a higher incidence and prevalence of health disparity–related diseases and shoulder a disproportionate burden of preventable morbidity and mortality.¹ Contributing factors include lack of health care, race, culture, social structures and injustices, politics, economics, environment, and lifestyle factors.^{2,3} Finding transferable solutions to combat these problems is exacerbated by the difficulty to reach priority populations with sustainable initiatives.^{4,5}

Proposed approaches to eliminating health disparities

include enhancing physician cultural competency, patient education, empowerment, behavior modification, and socio-political restructuring.^{6–9} These approaches emphasize engaging members of the affected populations in broad partnerships composed of a diverse group of leaders.⁴ In more recent years, such partnerships have included churches,^{10–13} particularly predominantly African-American churches.^{4,5,12,13,16,17} The premise is that engaging the Black Church gives researchers greater access to African-American populations because “the Black Church” plays an important role as health advocates in the Black Community.^{4,17} Churches and academic institu-

tions share a mutual concern for the health and well-being of racial/ethnic minorities. Therefore, efforts that combine their resources increase the likelihood of engaging hard-to-reach populations in sustainable research and intervention initiatives.⁴

Engaging a diverse group of churches is important given the diversity of predominantly Black congregations. In the United States, there are eight historically African-American protestant denominations and a growing number of non-denominational churches. Predominantly Black congregations are also sprinkled throughout most of the more traditional and well-established predominantly White Protestant denominations, the Roman Catholic Church, and Islamic mosques, particularly the Nation of Islam. These churches differ in doctrine, polity, worship style, and organizational structures.⁴

Many of the studies that have involved African-American churches were single efforts with a small number of congregations, often of a single denomination using community-based participatory research (CBPR) methods. CBPR methods enhance the ability to engage African Americans and other hard-to-reach populations as equal partners throughout the research process while addressing topics important to the community.^{5,8,14-16}

Although these initial efforts are promising, there is a need for sustained engagement of more African Americans and other hard-to-reach populations in health disparities research and interventions to enhance both the generalizability of findings and the diffusion of successful interventions among these hard-to-reach populations. Academic–community partnerships should benefit from sustained engagement of African American churches and other communities of faith in research and interventions that enable health professionals to conduct interdisciplinary studies using multiple methods to address an array of diseases. Such efforts should take into account the complex factors that contribute to health disparities.

This article describes the efforts of the Carolina–Shaw Partnership for the Elimination of Health Disparities to recruit, select, and engage a diverse group of African-American churches in a sustainable research, intervention, and dissemination network. The Carolina–Shaw Partnership is a collaborative between the University of North Carolina at Chapel Hill (UNC-CH) and Shaw University that seeks to eliminate differences in minority health care and status. The “partnership” is composed of a

diverse group of researchers, theological educators, and public health professionals from Shaw University Divinity School, the Institute for Health Social and Community Research at Shaw University, and UNC-CH. The project objective is to develop a demographically and geographically diverse network of 25 churches referred to as the Data Collection/Data Distribution Center (DC)², which will work with members of the Carolina–Shaw Partnership to develop sustainable health disparities research, education, and interventions.

METHODS

(DC)² is a prominent part of the community outreach and engagement component of the Carolina–Shaw Partnership. A description of the partnership, which was established in 2002 by a National Institutes of Health National Center on Minority Health and Health Disparities Project EXPORT grant, has been published elsewhere.¹⁸ The Carolina–Shaw Partnership builds on existing relationships between Shaw University Divinity School (SUDS) and African-American churches. Founded in 1865, SUDS works with Black Churches throughout the Southeastern United States. The Dean of SUDS seeks to build on its tradition of excellence in theological education by increasing its emphasis on research through the establishment of the Action Research in Ministry Institute (ARMI). Action Research is a form of collective self-inquiry that aims to identify practical solutions to the concerns of people that occur within the context of daily living by producing structural change that improves quality of life.^{19,20} The ARMI focus is on leadership development in the “practice of ministry” with an emphasis on African-American church and community leaders. The principles governing the ARMI meshed well with the aims of the Carolina–Shaw Partnership. UNC-CH had significant experience with faith-based initiatives and participatory research through activities such as the “Partnership to Reach African Americans to Increase Smart Eating (PRAISE!)” project. SUDS and the emerging Institute for Health, Social and Community Research were on a quest to substantially improve its research infrastructure.

The development of (DC)², including the sampling methods, recruitment process, plans for sustainability, and utilization follow. This study and all activities of the Carolina–Shaw partnership were reviewed and approved by the University of North Carolina Institutional Review Board (IRB).

Sampling Churches

The first step in establishing (DC)² was to enumerate predominantly African-American churches in North Carolina and to build a reliable database. The database was instrumental in assisting the staff to identify church locations and leaders who are interested in engaging in health disparities research and interventions. Project staff obtained mailing lists from well-established, predominantly Black denominations and the North Carolina General Baptist State Convention. These efforts resulted in broad demographic information about Black Churches in North Carolina. The involvement of the SUDS Dean and a faculty member who are pastors within these denominations was a great asset in obtaining these lists. Generally, church leaders are reluctant to share mailing lists. However, these members of the SUDS staff are actively involved in denominational and association activities where they frequently interact with church leaders. From this foundation a snowball effect occurred wherein pastors, officers, and members provided names and contact information about other churches that may be interested in (DC)². Web-based computer searches also supplemented these efforts.

Information about (DC)² was also disseminated at the SUDS' Annual Health Enhancement Through Medicine and Spirituality Conferences. Recruitment activities were implemented at a variety of regional church meetings.

The second step was to prioritize the regions wherein the churches would be located. Project staff chose to focus on identifying churches in those areas of the state with the greatest health problems for African Americans. A total of four regions were selected. The rationale for selecting these regions and counties are: (1) They represent higher population density of African Americans and thus a higher density of predominantly Black Churches; and (2) They are identified as high economic distress tiers and experience higher incidence and prevalence of health disparities-related diseases. These conclusions were drawn after the project team reviewed NC Geographical Information Services maps, consulted with selected leaders of NC's major African-American denominations, reviewed data from the NC Department of Health and Human Services County Data Book and corroborated findings with staff of the NC Office of Minority Health and Health Disparities and the NC Minority Health Advisory Council.

Recruitment and Selection

After prioritizing the regions, we mailed letters inviting pastors (Central Region = 326; Northeast = 127; East = 78; South Central = 83) to participate in regional "recruitment and information" meetings. We subsequently contacted Pastors who did not respond by phone, e-mail, and/or fax. Because many of the pastors are bivocational and a lot of the contact information was inaccurate, actual contact during follow-up proved challenging.

Each session included (a) an overview of the Carolina-Shaw Partnership, (b) an overview of the Community Outreach Core, the core responsible for implementing the (DC)² network, (c) a description of the SUDS ARMI, (d) (DC)² goals, purpose and methodology, and (e) church selection criteria and process. We stressed the importance of being willing to work with other churches across denominational lines, university researchers, and other public health professionals. Participants were informed that each church would be required to assign a Project Liaison. Church members completed a church demographic survey. Pastors completed "The Pastor as Practitioner Researcher Survey" to assess their interest in engaging in health disparities research and interventions (Appendix A).

After reviewing the surveys and field notes from the meetings and interactions with prospective recruits, the project staff compiled a list of churches that demonstrated an interest, commitment, and capacity to engage in the network. Interest, commitment, and capacity to engage was based on the Pastors' and Liaisons' responses to letters, phone calls, and e-mails during the recruitment process and the submission of completed surveys. Follow-up telephone calls and field visits were made to churches that fit the desired criteria. Field visits consisted of informal interviews with the pastors, the potential (DC)² Liaison, and other key officers. A copy of the interview guide for the field visits is reproduced in Appendix B. These visits provided an opportunity to further explain the project, build key relationships, and assess church capacity and readiness to engage. These visits revealed much variation in the administrative and decision-making procedures of churches. For example, the number and position of people that pastors deemed necessary to involve in the follow-up meetings ranged from two people to the entire congregation. The importance of careful observation and listening to discern who the influ-

ential leaders were within each congregation proved important. In many instances, the pastor proved to be the more influential leader. However, the widely held notion that the pastor represents “the gateway” into the congregation did not always hold true. In some instances, individuals who did not hold “official leadership positions” were the most respected and influential.

Invitations were extended on a regional basis by the Community Outreach Core Staff, which consists of representatives from both UNC-CH and SUDS. Considerations included (1) observations and reflections on interactions with prospective recruits and (2) the diversity of churches that were in the candidate pool (denominational affiliation; urban–rural balance; size of congregations; interest of the pastor and/or Liaison; and perceived capacity of the church for sustained engagement in project activities). A purposive sampling technique was applied whereby the project staff used their discretion based on prior knowledge and experience to make selections that best meet the purposes of the study from a population that “is considered to be most representative of the population as a whole.”^{21–24}

We mailed letters of invitation and covenant agreements to Pastors of selected churches. The covenant agreement described: (1) the expectations of the churches—to respond to surveys, participate in research projects and interventions, talk about the project with other churches in their areas, and host meetings; and (2) what the churches could expect to receive as a member of the partnership. These expectations included support from SUDS and the other research cores of the Partnership, networked computers, and ongoing relationships with other pastors and church leaders engaged in health disparities initiatives. The term “covenant agreement” rather than contract was used because of the familiarity of “covenants” in the Black church culture. Additionally, the word “covenant” represents a relationship rather than a legal obligation. The elements of the agreement outlining the expectations were designed to facilitate sustainability by establishing realistic expectations. Previous studies have shown that African-American church leaders have high expectations regarding university obligations in research partnerships and that studies using CBPR methods are better able to meet these expectations.⁴

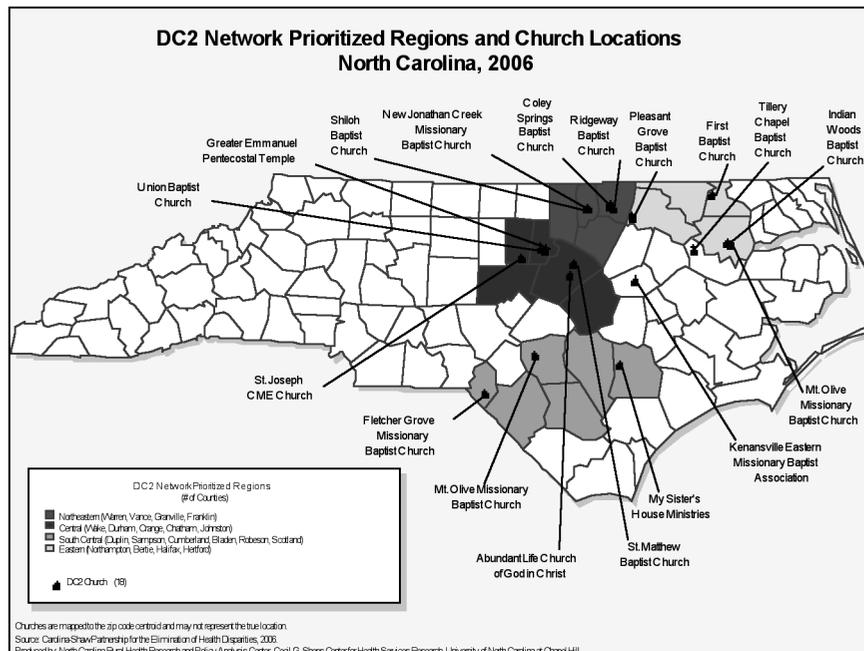


Figure 1: Data Collection/Data Distribution Center Network Prioritized Regions and Church Locations, North Carolina 2006

Characteristic	Number	Number and Percent of Total
Region*		
Central	5	5/18 (28%)
Eastern	5	5/18 (28%)
North Eastern	4	4/18 (22%)
South Central	4	4/18 (22%)
Denomination		
Baptist	14	14/18 (77%)
Church of God in Christ	1	1/18 (5%)
Methodist	2	2/18 (11%)
Pentecostal	1	1/18 (5%)
Location		
Rural	11	11/18 (61%)
Urban	6	6/18 (33%)
Other	1	1/18 (5%)
Characteristic	Range	Average
Age of church (years)	3–139	74
Pastor's tenure (years)	1–27 years	9
No. of active members	45–2,000	460

*See Figure 1 map for list and visual of regions.

Eighteen churches have signed covenant agreements (Figure 1). Salient characteristics of the churches are contained in Table 1. The prioritized regions and the associated Counties are shown in Figure 2. Each church was given a computer with Internet access. To sustain church engagement, covenant churches will also receive information about education and research activities of other network members and assistance from SUDS with the development and/or expansion of a health ministry in their church. Computers are used to assist Liaisons in communicating more effectively with research staff and other network churches and to collect and distribute information to church and community members.

LESSONS LEARNED

1. Collecting accurate demographic information on the location and characteristics of African-American churches helps to identify and recruit churches that possess the qualities and characteristics that researcher's desire. To date, a database of over 3,400 African-American churches has been developed. The database was developed using a variety of methods and resources. Having members of the SUDS faculty and administration who are familiar with and have good working relationships with church

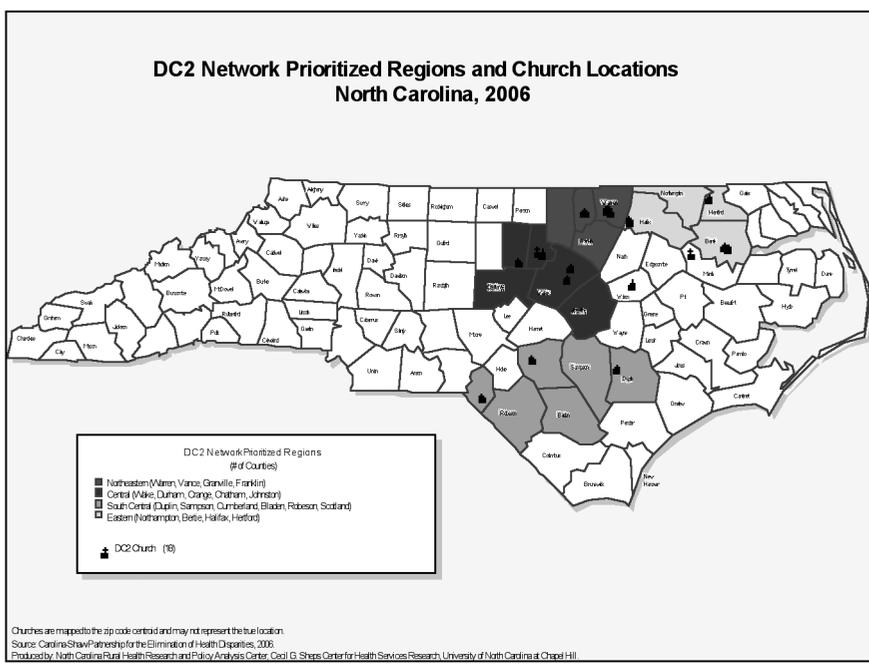


Figure 2: Data Collection/Data Distribution Center Network Prioritized Regions and Church Locations, North Carolina 2006

leaders enhanced our ability to obtain church mailing lists and other demographic information about potential participants.

2. The process used to identify, recruit and select churches is very time intensive and took much longer than originally anticipated. Researchers who seek to establish broad-based partnerships that engage churches must recognize that a great deal of time and resources are required to establish a foundation for building good working relationships.

Considerable time and effort was needed to generate letters and other recruitment materials, obtain IRB approval, make follow-up phone calls, and make logistical arrangements for information sessions and follow-up meetings. It took over 6 months to identify the prioritized regions. Arranging for and conducting initial information and recruitment sessions took another 9 to 12 months. Although the strategy to stagger the planning and implementation of the recruitment and information sessions proved helpful, this process made conducting follow-up contacts and visits even more challenging due to the need to complete multiple tasks simultaneously. For a period of 12 to 18 months, project staff was planning and implementing recruitment and information meetings in some regions while conducting follow-up visits, extending invitations, and processing covenant agreements in others. The time-intensive process of identifying, recruiting, and selecting churches required an interdisciplinary team of theological educators, administrators and pastors, public health professionals, and data analysts. Theological educators and administrators who also serve as pastors helped to identify and make initial contact with church leaders. Public Health professionals assisted with the development of research methods, tailoring IRB protocols and instruments to CBPR methods, and developing a database that assisted with the collection and storage of key data on churches and leaders. Data analysts assisted with the development of sampling strategies and techniques. Church leaders and pastors responded to questionnaires, provided data about the health needs, concerns, and activities of their churches, and provided input on what they thought would make an effective partnership.

Overall, each recruited church required three to five separate contacts, usually, beginning with the pastor. Many of the pastors assigned other staff or church leaders to work with research team members. Scheduling follow-up meetings when pastors (many of whom are bivocational) could participate further complicated matters; therefore,

meetings had to be scheduled during evenings and weekends. Geographically, churches located in the more rural eastern region represented farther traveling distances. To work more efficiently, follow-up visits to these regions were clustered.

3. The time, energy, and effort required to initiate an inter-institutional partnership and subsequently identify and engage church and community members in health disparities research and intervention produce residual rewards and outcomes that will contribute to sustainability. For example, the multiple informal contacts made during the recruitment process produced an informal network of churches that extends beyond (DC)². Some of the churches that possessed many of the desired characteristics to participate in the network were not selected to participate in the (DC)² network. These churches were not included because the targeted number of churches in their region was already met or they did not demonstrate the capacity and/or willingness to sustain engagement. However, some of these churches are involved in other research and intervention efforts. These activities include the annual SUDS Health Enhancement Through Medicine and Spirituality Conference, the NC African-American churches "Eat Smart Move More" initiative, and serving as pilot churches to help test the instrumentation and methods for the (DC)² congregational health assessment.
4. Denominational structure impacted the type of recruitment and communication strategies necessary for success. Although denominational differences did not prove to be an insurmountable challenge in our study, project staff did find that governing structures and practices varied by denomination and by local church.

CONCLUSIONS

Below are principles learned that could prove helpful to other researchers who seek to engage churches in health disparities research by building sustainable networks. First, researchers must be clear about the type of network that is desired. The (DC)² network is analogous to practice-based research networks established across primary care and specialty medical practices to conduct a variety of studies in practice settings. Just as research is not a primary function of a family practitioner's office, it is not a primary function of African-American churches. However, the interest of many African-American church leaders in the holistic health of their congregants makes participation in health disparities research,

interventions, and information dissemination a natural extension of their primary activities. Just as with physician research networks, establishing church networks is time consuming and necessitates a great deal of two-way communication. Additionally, a variety of ongoing tasks must be completed to maintain an established network. Some of these tasks include consistent two-way communication, managing changes in church leadership (particularly pastors), and negotiating with health professionals about engaging participants in additional projects and securing ongoing funding.

As a result, we recommend that those seeking to build a sustainable church and/or community-based health disparities research, intervention, and dissemination networks consider the following.

- Allocate sufficient time and resources (financial and human) to systematically recruit and select churches. The amount of time and effort expended in church recruitment will almost certainly be greater than anticipated. Repeated reassurance regarding the churches' ability to engage as participants rather than mere subjects upon whom research is conducted is necessary.
- Enumeration of all black churches in a geographic area is extremely valuable and has benefits that exceed the primary project goals. However, a trusted and preferably known person should serve as a liaison between the academic and church communities. The involvement of the SUDS Dean and a faculty member who also serve as pastors of predominantly African-American churches greatly enhanced access to information about churches during the recruitment and selection process.
- Early attention to database and data management is a worthwhile investment. Database managers will likely not be the same staff making site visits to churches. Valuing the contributions of project members with different skills and experiences is an important part of the organizational process. Therefore, sufficient resources should be allocated to ensure a professionally diverse project staff that possesses the requisite technical and relational skills and experiences.

Simply having a network is insufficient. It is important to quickly initiate project-specific work to maintain enthusiasm and demonstrate value to the churches and prospective funders. (DC)² churches are currently involved in multiple projects. Additionally, a number of appearances and presentations at participating church health fairs and health education

and promotion conferences have occurred. Recently, each of the 18 churches completed a Congregational Health Assessment (Appendix C). The purpose of the assessment was to collect information about the health needs, concerns, and priorities of each congregation. Each church was mailed an aggregate report along with a summary of the results from their church. These reports will serve as a catalyst to further engage in ongoing participatory dialog between members of the Carolina–Shaw partnership and church leaders using CBPR principles. Along with the relationships that were established during church recruitment, and the dialog that is occurring as the Partnership engages the various churches in specific research projects, these discussions should enable the development of sustainable project-specific work that addresses the concerns of all stakeholders in a mutually beneficial manner.

A major challenge in all CBPR efforts is the amount of time, coordination, and relationship building required for success. The time-intensive nature of CBPR makes it difficult to attain short-term success as defined by traditional research projects such as subsequent grant proposals, publications, and professional presentations. These challenges proved true in our formative research. Areas that challenged traditional successes were (1) time requirements for identifying, recruiting, and selecting churches, (2) balancing the many time demands associated with being part of an interinstitutional–interdisciplinary partnership, and (3) distinguishing (DC)² activities from other church-focused efforts being conducted within the prioritized regions.

Summarily, the systematic, networked approach to collaborative research, education, and interventions with communities served by Black Churches described in this article has great potential for the development of mutually beneficial health disparities initiatives. Although the amount of effort and resources required to develop such networks is substantial, so are the potential rewards. As the project continues, research results will be disseminated through conferences, workshops, the computer network, newsletters, and fact sheets to participating churches and their communities, ensuring that the loop of communication from participant to researcher and vice versa is completed in a manner that increases the likelihood of sustaining our efforts to effectively address health disparities.

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Appendix A. Pastors as Practitioner-Researcher Survey

As shepherds, porters, and advocates, pastors are essential to the health and well-being of those they serve and are important catalysts in the war against health disparities. Health Educators possess knowledge and skills on how to access funding, develop, and evaluate sustainable programs/ministries and access resources that can be of benefit to church and community members. To form more effective partnerships by bringing together the expertise of both groups, the Community Outreach Core of the Carolina–Shaw Partnership will develop the Pastor as Practitioner-Researcher Initiative. This section of the questionnaire is designed to assess your interest and willingness to participate in this effort. Please answer the following questions about the role you would like to play in this initiative. These data will be kept separate from those in the rest of the survey.

1. Do you feel that the African-American church should be involved in activities designed to address health issues that impact your community?
Y N
 2. Have you ever been involved in an education or research activity designed to address health issues?
Y N
 3. Would you like to serve as a resource to people who want to learn more about health issues that impact your community? (Circle one)
Y Possibly, if I had a chance to learn more about this.
N
 4. Would you like to serve as a resource to people who are seeking assistance in making decisions about whether or not to become involved in a particular health initiative? (Circle one)
Y Possibly, if I had a chance to learn more about this.
N (skip to 6)
 5. If yes or possibly, what information would help you become better prepared to fulfill this role? (check all that apply)
 Basic information about the risks and benefits of various types of health education and related research initiatives.
 Names of trusted health educators who I could contact for additional information.
 Basic information about the major health issues that impact your community (e.g., diabetes, heart disease, cancers).
 Other: _____
 6. Would you like to serve as a resource to health educators who want to learn more about how to establish true partnerships with churches and other community organizations? (Circle one)
Y N
 7. During the presentation, we discussed Action Research in Ministry (ARM) where researchers and churches form partnerships to identify and address health issues of mutual concern. Would you be willing to offer some of your expertise in an ARM class, seminar, or conference? (Circle one)
Y N (skip to bottom of page)
 8. What information and/or skills are you willing to share to help researchers establish true partnerships with churches and other community organizations? (check all that apply)
 How to approach pastors for help
 Church etiquette
 Gaining community support
 Other: _____
- Please provide your name and contact information (optional):
Name: _____
Address: _____
Phone No(s): _____
E-mail: _____
- Check here if you would like for us to include you on our listserv or mailing list to receive information on upcoming participatory research seminars, classes, conferences, etc.

Thank you!

Appendix B. Data Collection/Data Distribution Center (DC)² Demographic Survey: Please complete the following survey.

All information is confidential and will only be used in group summaries. Thank you!

Church Name _____ Date _____

1. What is your gender?
 - a. Male
 - b. Female
2. What is your date of birth? _____
3. What is the highest level of education that you attained? (Please circle your answer.)
 - a. Less than high school
 - b. Some high school
 - c. Graduated from high school/GED
 - d. Some college (technical school; bible school, community college)
 - e. Associate's degree (AA/AS)

Please specify degree for any of the following:

 - f. Bachelor's degree (BA/BS) _____
 - g. Masters degree (MA/MS/MDiv) _____
 - h. Doctorate degree (PhD/ThD/EdD/DMin) _____
 - i. Honorary doctorate _____
4. Please indicate which of the following describes you best:
 - a. Pastor only
 - b. Pastor and employed elsewhere (or self-employed).
If yes, what is the average number of hours worked per week on other job? _____
5. To what, if any, denomination* does your church belong?
 - a. African Methodist Episcopal (AME)
 - b. African Methodist Episcopal Zion (AMEZ)
 - c. Christian Methodist Episcopal (CME)
 - d. Church of God in Christ (COGIC)
 - e. National Baptist Convention of America, Inc.
 - f. National Baptist Convention, USA, Inc. (NBCUSA)
 - g. National Missionary Baptist Convention of America
 - h. Progressive National Baptist Convention, Inc. (PNBC)
 - i. Non-Denominational
 - j. Other (Please specify) _____
6. In what year was your church founded or started? _____
7. How many years have you been pastoring at your current location? _____
8. How many years have you been pastoring churches? _____
9. Approximately how many active members were in your congregation in 2003? _____
10. About how many people attend services held at your church? (If your church has more than one service, please indicate the number attending each service by indicating only one choice for each service).

a. Less than 100	d. 300-399
b. 100-199	e. 400-499
c. 200-299	f. 500 or more

Sunday 8 am _____

Sunday 11 am _____

Sunday evening _____

Midweek Bible Study _____

Other: _____
11. What is the approximate age distribution of your congregation? (Please indicate the *percentage* in each category below. Total of all lines should equal 100%; for example 10% of congregation may be 17 or younger, 5% 18-35, etc.).

_____ % 17 years of age or younger	_____ % 46-65
_____ % 18-35	_____ % 36-45
_____ % 36-45	_____ % Over 65
12. What is the approximate gender distribution of your congregation? (Please indicate the *percentage* in each category below; total of all lines should equal 100%)

_____ % Male	_____ % Female
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13. What is the approximate race distribution of your congregation? (Please indicate the *percentage* in each category below; total of all lines should equal 100%)

_____ % African American	_____ % Native American
_____ % Asian American	_____ % White
_____ % Latino/Hispanic	_____ % Other
14. How many Ministers are on staff at your church?
 - a. Paid _____
 - b. Unpaid _____
15. Would you describe your church location as? (Circle one.)
 - a. Rural
 - b. Urban
 - c. Suburban, or
 - d. Something else _____

Thank you!

* Please note that the denominations listed in question #5 represent the major historically Black denominations as identified by the Congress of National Black Churches.

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Congregational Health Assessment

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This survey will collect information about the health needs, concerns, and priorities of your church. Specifically, we are interested in the perceptions and health-related attitudes of church members. This information will help the Data Collection/Data Distribution Center (DC²) staff and the health ministry at your church:

- 1) identify and mobilize the resources to improve health;
- 2) develop ministry activities that address the needs of church members; and
- 3) to engage in health-related research and service projects.

Your opinions are important to this project. Your responses will remain anonymous and confidential. The results from this survey will only be reported as group data and neither you nor your church will be singularly identified in any public report or manuscript.

Health Conditions Within Your Church

Today's date:

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2	0	0
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month
day
year

Please indicate the extent to which you believe the following health conditions are a problem for members of your church or their families.

Health Conditions	<i>not a problem</i>	<i>small problem</i>	<i>moderate problem</i>	<i>big problem</i>	<i>very big problem</i>
1. High blood pressure (hypertension)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Cancer (any type)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Diabetes (Sugar)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Heart attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. HIV/AIDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Other sexually transmitted diseases (STDs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Glaucoma (elevated pressure in the eye)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Sickle Cell disease/anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Kidney dialysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Health Conditions	<i>not a problem</i>	<i>small problem</i>	<i>moderate problem</i>	<i>big problem</i>	<i>very big problem</i>
13. Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Respiratory problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Dental problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Personal Information

18. How often do you attend church (including regular church services, Bible study, and meetings)?

- 3 or more times a week
- twice a month
- twice a week
- twice a year
- once a week
- once a year
- once a month
- special occasions only

19. About how far do you travel one way to attend church services?

- 0-5 miles
- 6-10 miles
- 11-15 miles
- 16-20 miles
- more than 20 miles

20. What is your gender? male female

21. Which age range best describes you?

- 18-24
- 45-49
- 25-29
- 50-55
- 30-34
- 56-65
- 35-39
- 66-70
- 40-44
- over 70

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22. What is the highest grade of school you completed? *[Mark only one.]*

- less than high school
- some high school
- graduated from high school/GED
- some college
- graduated from college

23. What degrees have you earned, if any? *[Mark all that apply.]*

- Technical degree
- Trade School certificate
- Bachelor's Degree
- Master of Divinity
- Other Master's Degree
- Jurist Doctorate
- Doctorate
- MD
- Honorary Degree
- Other → _____

24. Current employment status: *[Mark only one.]*

- part-time
- full-time
- retired
- disabled
- unemployed

25. Current/past type of employment: *[Mark all that apply.]*

- hourly worker
- salaried worker
- management level worker
- professional worker

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Health of your family and loved ones

26. Do you have a **family member or a loved one** who has been told by his or her doctor that (s)he has any of the following health conditions? *[Mark all that apply.]*

- Arthritis
- Asthma/COPD/Bronchitis/Emphysema
- Cancer (any type)
- Diabetes (sugar)
- Glaucoma (elevated pressure in the eyes)
- Heart Disease (heart attack, angina or congestive heart failure)
- High Blood Pressure (Hypertension)
- HIV/AIDS
- Lupus
- Obesity
- Other Sexually Transmitted Disease (STDs)
- Sickle Cell Disease/Anemia
- Other → _____

Your health

27. How often do you get a medical check up?

- once every three months
- once every six months
- once a year
- once every two years or less

28. Are you concerned about your ability to pay for needed health care services?

- yes
- no

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29. Have you ever been told by a doctor that you have any of the following health conditions?
[Mark all that apply.]

- Arthritis
- Asthma/COPD/Bronchitis/Emphysema
- Cancer (any type)
- Diabetes (sugar)
- Glaucoma (elevated pressure in the eyes)
- Heart Disease (heart attack, angina or congestive heart failure)
- High Blood Pressure (Hypertension)
- HIV/AIDS
- Lupus
- Obesity
- Other Sexually Transmitted Disease (STDs)
- Sickle Cell Disease/Anemia
- Other → _____

30. In the past 12 months, how often have you done the following things **on a weekly basis** to improve your health or to stay healthy?

	<i>very often</i>	<i>often</i>	<i>unsure</i>	<i>seldom</i>	<i>never</i>
a. be physically active for a total of 30 or more minutes on most days of the week	<input type="radio"/>				
b. try to lose weight	<input type="radio"/>				
c. eat healthy foods	<input type="radio"/>				
d. get 8 or more hours of sleep	<input type="radio"/>				

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Concerns about your health & the health of the people close to you

31. Please indicate your level of agreement for each of the following statements:

	<i>strongly agree</i>	<i>agree</i>	<i>neutral</i>	<i>disagree</i>	<i>strongly disagree</i>
a. I am concerned about my health.	<input type="radio"/>				
b. I am concerned about the health of my family, friends, and church members.	<input type="radio"/>				
c. I would like to learn more about how to live a healthy life.	<input type="radio"/>				
d. I would like to learn how to communicate better with my doctor.	<input type="radio"/>				
e. I would like to learn more about resources that are available to help me live a more healthy life.	<input type="radio"/>				
f. I would like to learn more of what the Bible says about how to live healthy.	<input type="radio"/>				
g. I would like to learn more about diabetes.	<input type="radio"/>				
h. I would like to learn more about hypertension.	<input type="radio"/>				
i. I would like to learn more about cancer.	<input type="radio"/>				
j. I would like to learn more about HIV/AIDS.	<input type="radio"/>				
k. I would like to learn more about heart disease.	<input type="radio"/>				
l. I would like to learn more about stroke.	<input type="radio"/>				



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Role of the church concerning health

32. The next questions ask for your opinion about the role of the church concerning health. Some churches have a health ministry which focuses on the promotion of health and healing as part of the mission and ministry of that faith group (church) to its members and the wider community. Each program is unique, due to the beliefs and spiritual practices as well as the assets and needs of the congregation and community it serves. Please indicate your level of agreement for each of the following statements:

	<i>strongly agree</i>	<i>agree</i>	<i>neutral</i>	<i>disagree</i>	<i>strongly disagree</i>	<i>no health ministry at my church</i>
a. The church has a responsibility to promote healthy living.	<input type="radio"/>	<input type="radio"/>				
b. The Health Ministry at my church is very active.	<input type="radio"/>	<input type="radio"/>				
c. I would like to attend the programs and services offered by the Health Ministry.	<input type="radio"/>	<input type="radio"/>				
d. I would like to help with the Health Ministry at my church.	<input type="radio"/>	<input type="radio"/>				
e. During programs at my church, healthy foods are generally available.	<input type="radio"/>	<input type="radio"/>				
f. During programs at my church, most members make healthy food choices.	<input type="radio"/>	<input type="radio"/>				
g. During programs at church, I generally make healthy food choices.	<input type="radio"/>	<input type="radio"/>				

Lifestyle and environmental issues that affect the health of your church family

33. Please indicate the extent to which you believe the following health-related concerns are a problem for members of your church and their families:

Lifestyle & Environmental Issues	<i>not a problem</i>	<i>small problem</i>	<i>moderate problem</i>	<i>big problem</i>	<i>very big problem</i>
a. Inadequate housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Lack of financial resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Smoking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Lifestyle & Environmental Issues	<i>not a problem</i>	<i>small problem</i>	<i>moderate problem</i>	<i>big problem</i>	<i>very big problem</i>
e. Alcohol addiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Drug addiction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Violence (including suicide and homicide)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Physical inactivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Unhealthy eating habits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Mental health problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Divorce	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Domestic violence or abuse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Communication problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

34. I would be willing to participate through my church in a research project that promotes health. yes no

35. I feel confident that I could successfully participate, through my church, in a research project that promotes health. yes no

36. In the past two years, I have participated through my church in a research project that promotes health. yes no

37. I am ready to participate through my church in a research project that promotes health. yes no

38. I would use a computer to find health-related information if a computer was made readily available to me at this church. yes no



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39. I would **most** prefer to receive health-related information through the following means: *[You may mark as many as three choices.]*

- | | |
|---|---|
| <input type="radio"/> sermons | <input type="radio"/> television/radio broadcasts |
| <input type="radio"/> CD/DVDs | <input type="radio"/> workshops |
| <input type="radio"/> web-based computers | <input type="radio"/> other → _____ |

40. Please use the box below to elaborate on any response that you have made in this survey. In addition to adding detail to any of your responses, you can also offer any recommendation that you believe will address these issues.

Thank you for participating in this survey!

Appendix D. SHAWU 04-005, Data Collection/Data Distribution Center (DC)² (Phase II) Carolina–Shaw Partnership for the Elimination of Health Disparities

Interview schedule for follow-up field visit*

Note: These interviews are semi structured conversations. Although the following questions will guide the discussion, additional questions may be asked. The purpose of this interview is to further assess the interest, capability, and commitment of your church to carry out the work of the partnership. Project staff will use data collected during this interview to help make informed decisions about which churches to invite to become a covenant partner of the (DC)² network.

1. How long have you been involved with this church?
(This will help you to assess minister's knowledge about and visibility in the community and among church membership.)
2. Do you live in the community now, or have you lived in this community before? (Church leaders with personal ties to the community may have a stronger commitment to seek change.)
3. What social outreach programs has the church been involved in previously? (Learn if the church is community focused, open to different activities, and most important, if your project may conflict with or complement their efforts.)
4. Has the church worked with community health professionals before? (This may show if the church is comfortable working with "outsiders" and sharing recognition. Find out the results of any previous partnerships and what changes, if any, would be made in hindsight.)
5. Do you have members who can help? In which areas are your members experienced (i.e., nursing, education, counseling, transportation, custodial, administration)?
6. Does your church work with other community-based or community-focused organizations, particularly churches that are not a part of your denomination? (Determine if the church is connected to the community outside its congregation and if it wants to work with others, particularly other churches across denominational lines.)
7. What are some prominent community health problems in the neighborhood? (Church leaders often know more about community problems than researchers and social workers, particularly those problems that people do not report or underreport.)
8. Has the church addressed health issues previously? (Learn how the church has dealt with issues, the response of the community, the obstacles, and the success. There is no need to reinvent the wheel.)
9. How can we be of assistance to you, your church, and your neighborhood? (In order not to be perceived as a threat or as just coming to take from the community, work toward being a true partner. Do not make false promises.)
10. How can you be of assistance to us? (Acknowledge the value of the church, its leader, and its congregation to take advantage of these untapped resources.)
11. What other organizations or individuals do you suggest I speak with about my project? (The local minister knows where the resources are within the community and will help you to get a leg up on gathering information and people power.)

*Tuggle M. It is well with my soul: Churches and institutions collaborating for public health. Washington, DC: American Public Health Association; 2000.