



Published in final edited form as:

*J Relig Health*. 2013 December ; 52(4): 1093–1107. doi:10.1007/s10943-011-9533-1.

## Promoting Healthy Behavior from the Pulpit: Clergy Share Their Perspectives on Effective Health Communication in the African American Church

**Crystal Y. Lumpkins,**

School of Journalism, University of Kansas, 1435 Jayhawk Blvd., Lawrence, KS 66045, USA

**K. Allen Greiner,**

Department of Family Medicine, School of Medicine, University of Kansas Medical Center, Kansas City, KS, USA

**Christine Daley,**

Department of Preventive Medicine, School of Medicine, University of Kansas Medical Center, Kansas City, KS, USA

**Natabhona M. Mabachi,** and

Department of Family Medicine, School of Medicine, University of Kansas Medical Center, Kansas City, KS, USA

**Kris Neuhaus**

Department of Family Medicine, School of Medicine, University of Kansas Medical Center, Kansas City, KS, USA

Crystal Y. Lumpkins: lumpkins@ku.edu

### Abstract

African Americans continue to suffer disproportionately from health disparities when compared to other ethnicities (ACS 2010; CDC 2007). Research indicates that the church and the pastor in the African American community could be enlisted to increase effectiveness of health programs (Campbell et al. in *Health Edu Behav* 34(6):864–880, 2007; DeHaven et al. in *Am J Public Health* 94(6):1030–1036, 2004). The objective of this study was to investigate African American pastors' perceptions about health promotion in the church and how these perceptions could serve as a guide for improving health communication targeting African Americans. Semi-structured interviews with African American clergy revealed that pastors feel strongly about the intersection of health, religion and spirituality; they also believe that discussing health screening and other health issues more frequently from the pulpit and their own personal experiences will ultimately impact health behavior among congregants. This study suggests that African American clergy see themselves as health promoters in the church and believe this communication (i.e., pastor-endorsed health information materials) will impact health behavior among underserved and minority populations.

### Keywords

African American; Pastors; Health communication; Health promotion; Health programs; Churches

African Americans, the second largest minority group in the United States (Census 2010) suffer disproportionately from several diseases and cancers each year. Currently, morbidity rates for African Americans are higher than Caucasians for stroke (American Heart Association 2011b), colon, breast and prostate cancer (CDC 2007). These along with other health issues such as colon cancer and heart disease are preventable (ACS 2010; AHA 2011a). Community-based activities are in place to address these issues among African Americans; however, the effectiveness and sustainability of those programs are not necessarily patient-focused (Merzel and D'Aflitti 2003). A growing body of research shows the linkage between religion, spirituality and health decision making is consequential in health communication (Egbert et al. 2004) and should be factors considered when targeting specific segments of the population. African Americans in particular subscribe to a religious lifestyle and maintain a strong belief in a higher power. In the African American community, the church is a trusted organization and many African Americans look to church leaders for not only spiritual guidance but for counseling and direction in other areas of life that include social and civic engagement, financial, educational, health or other personal needs (Asante and Asante 1985; Lincoln and Mamiya 2001).

The purpose of this study was to take a grounded theory approach to understand the perceptions of urban pastors' communication of healthy behavior from the pulpit and how this information translated into promoting health screening and disease prevention in the church. The study explored the following: (a) urban pastors' awareness about disease prevention and health promotion in the church; (b) urban pastors' perspectives on disease prevention and health promotion in the church and (c) the extent to which pastors thought about religion and or spirituality and this communication as translatable into: successful screening promotion targeting African American populations via church-sponsored (pastor-endorsed) materials.

The following research question(s) guided the study: (1) How do African American pastors use their communication from the pulpit to improve healthy behavior? And (2) Do Pastors believe their communication will impact the congregation's health behavior?

## **Disease Prevention Programs and the African American Church**

African Americans have the highest death rate from cancer (ACS 2010) and are often at higher risk for heart disease, hypertension and stroke (AHA 2011b). The efforts to develop and design prevention promotion programs that address health disparities among African Americans has evolved from rudimentary to multi-leveled disease prevention programs. Through this evolution and change, the communication of the prevention is critical for the success of public health programs (Berhnhardt 2004); however, the communication component is often ill conceived and does not appeal to the audience that the communication was intended for (Merzel and D'Aflitti 2003). Through an evolving structure that includes a comprehensive communications strategy (Campbell and Quintilani 2006); prevention programs designed with key messages for specific audiences will have the greatest impact on the population at risk.

Prior to the 1990s, the emphasis of disease prevention programs focused on the individual and how to change individual health behaviors. This approach was generally one dimensional and the impact on the population did not yield large results (Ferdinand 1997). In a literature review of prevention programs, researchers assessed community-based interventions and how these programs impacted community change via health promotion efforts. One of the limitations was the insufficiency of tailoring information to sub-groups of the population; some interventions largely followed standardized protocol and did not sufficiently target the community and population (Merzel and D'Aflitti 2003).

Prevention programs, in their multidimensional capacity, now include various components that target specific segments such as vulnerable populations. This evolution has caused an expansion in community-based and population-based approaches (Merzel and D'Aflitti 2003) and the reach public health personnel have to address health disparities. These approaches involve addressing risk behavior through multiple interventions and strategies. The premise of these approaches is based on ecological models (McLeroy et al. 1988; Stokols 1996). These models emphasize the impact of the social environment on the individual behavior rather than focusing on the individual behavior alone (McLeroy et al. 1988). The individual's interaction occurs with the social environment on multiple levels that include the interpersonal, organizational, community and policy levels (McLeroy et al. 1988; Stokols 1996); this ultimately drives the design of the intervention. It is through these approaches (community and population approaches) that have given public health personnel the necessary reach to address vulnerable population health issues.

Community organizations such as the church have been resources that public health professionals have turned to assist them in educating about disease prevention (Timmons 2009) and health promotion (DeHaven et al. 2004; Watson et al. 2003) among African Americans. The church is highly regarded as one of the most trusted institutions among many African Americans (Lincoln and Mamiya 2001) and has been instrumental in building effective screening and prevention programs (Campbell et al. 2007a, b; Ferdinand 1997; Peterson et al. 2002). A 2009 Pew Center Report states that 80% of African Americans surveyed attended church at least once a week and consider themselves to be religious (Pew Forum 2007). This religious organization historically galvanized individuals to civic engagement and helped impact social change (Lincoln and Mamiya 2001). The African American church today has evolved into a multi-faceted organization, serving the needs of members but also the surrounding communities through various partnerships that involve educational, social welfare, social justice and also health programs. The church's role in the community makes it a natural partner in addressing health disparities among African Americans.

Church-based health promotion interventions (CBHP) and church-based health promotion programs (CBHPP) have shown to significantly impact several health behaviors among African Americans (Campbell et al. 2007a, b; Peterson et al. 2002). CBHP interventions, from the socio-ecological perspective, position the church as an integral part of the process to influence church members' behavior on multiple levels (Campbell et al. 2007a, b). The WATCH (Wellness for African Americans Through Churches) Project showed computer tailored newsletters and targeted videotapes (TPV) "had significant effect on participants' fruit and vegetable consumption and recreational exercise," (p. 499, Campbell et al. 2004). Researchers hypothesized a multi-component approach (tailored and targeted materials combined with a lay health advisor (LHA) would be more effective than TPV or LHA alone. CBHP and CBHPP (Church-based Health Promotion Programs) are effective ways to reach African Americans about several types of diseases and cancers and could have a significant impact on health behavior. From a socio-ecological approach, the church targets African Americans about health issues on multiple levels including an intrapersonal, interpersonal, organizational, and environment/policy level. On the intra-personal level, the beliefs that an individual has in God impacts how health information is processed. The church and what it represents has a direct impact on this information processing, as those with a belief in God will ultimately accept or reject health outcome based on that information (Lumpkins 2010). The African American church also facilitates health communication activities on an interpersonal level. Many small group activities such as support groups help members to cope with life threatening diseases or with prevention. On the organizational level, the pastor's leadership is vital as he/she is in a position to help promote health issues within the church (and the community). Finally, on the environment and policy level, African

American churches have historically taken a role that has shaped its immediate surroundings. Here, the focus is on the organizational level where the pastor's communication can impact the other levels (intrapersonal, interpersonal, community, policy) and becomes a part of the prevention program aimed to address health disparities within the African American community (Watson et al. 2006).

The effectiveness of the pastor's communication is exemplified in national prevention program initiatives such as the National Cancer Institute and American Cancer Society's "Body and Soul: A Celebration of National Eating and Living" (Campbell et al. 2007) and the American Heart Association's "Power Sunday" (American Heart Association 2011b). The Body and Soul program focuses on increasing consumption of fruits and vegetables among African Americans to combat chronic illnesses and disease. The program grew out of efficacy intervention studies (between 2004 and 2006) within the African American community aimed to increase promotion of fruit and vegetable consumption among African American church members (Campbell et al. 2007). At 6 month follow-up, the intervention participants showed a significant increase in fruit and vegetable intake, a decrease in fat intake and a greater motivation to eat fruits and vegetables. When participants were asked about the exposure to the intervention, 89% self-reported that they heard messages from the pulpit supporting the project (p. 873, Campbell and Quintilani 2006) compared to 75% who attended the church kick off and 90% from educational materials (i.e., video and church cookbook). The intervention involved a multiple component that included self-help materials; VA's or volunteer assistants and also pastoral support.

The American Heart Association encourages churches each May to participate in a national effort to increase awareness about the risk African Americans face with having a stroke. The AHA partners with African American churches to distribute educational materials about the "Power to End Stroke" campaign (ASA 2009). One part of the day includes a healthy sermon or message about the dangers of stroke. The goal is to raise awareness about the dangers of stroke among African Americans and to encourage congregants to fill out a pledge card. These pastorled sermons are the linkage between health messages and spiritual messages to create an influential communication that will ultimately impact behavior.

## Health Communication from the Pulpit

The role of preaching in the African American church is central to the oral tradition in black culture in America (Lincoln and Mamiya 2001). The communication of the pastor is influential to members of the church because of his or her leadership role and what it represents. This leadership role of the pastor often extends beyond spiritual and religious communication and includes health advice (Aholou et al. 2009; Watson et al. 2006).

A 2010 study by Moore and colleagues that examined HIV/AIDS communication strategies among African American church leaders showed African American pastors value their role as health advocate (Moore et al. 2010). They also felt that it was their role to help "de-stigmatize HIV/AIDS and related testing," (p. 9, Moore et al. 2010). Anshel (2010) proposed the pastor's role as an intervention to impact health behavior among people of faith and theorized that both the pastor coupled with the influence of religious institutions help individuals of faith make positive health decisions. The pastor's intervention by way of communication in the church becomes not only a message from a trusted individual and one that is considered a spiritual guide but also a conduit of information from a higher authority—God. Members see the pastor as an individual who interprets sacred text and as an advocate for adhering to God's word. A person of deep faith will experience a disconnection when he or she does not adhere to values that reflect sacred text (Anshel 2010).

Levin conceptualized the role of the Black pastor in health behavior change as integral and multidimensional. The pastor takes on a health-related social change role, adapting his duties as the prevention calls for. This involvement places the pastor in an active role in preventive medicine on multiple levels including the tertiary, secondary and primary levels of prevention (p. 96, Levin 1986). These health-related roles have made pastors “ideal people to take part in planning, promoting and delivering preventive health care in the Black community,” (p. 94, Levin 1986). Pastors, on all levels of preventive care, are in a position to address the needs of the community. Levin states that on a tertiary level, pastors are agents who “serve as liaisons between hospitalized patients and their families.” Ministers take on the role as counselor assisting those with mental illness to helping individuals get through rehabilitation (p. 94, Levin 1986). On the secondary level, pastors serve the role as “diagnostician” and allied health professionals in primary care settings—churches serve as primary care centers. At the primary level, they are involved in health education interventions and health promotion. The pastor, being part of multiple levels of prevention, are leaders of the Black church and are thus, incorporating their role as health behavior change agent into the duties of the church.

The pastor’s role in health behavior change and communicating that change is a critical component of prevention. The pastor’s communication (and framing of health issues in health information) about health issues in the church setting is considered to bolster appeal and credibility in health promotion materials targeting African Americans because of the trust in the organization (the church), the proclivity of religious practice among African Americans and also the belief in a higher power. The inclusion of critical communication components such as the pastor’s communication will impact the effectiveness of prevention programs targeting African Americans.

## Method

The researchers used grounded theory as an approach to analyze the perceptions of church pastors’ communication as health promotion of health issues and disease prevention to congregants. Grounded theory is a method where data collection and analysis occur concurrently (Strauss and Corbin 1990). It is used to “explain a given social situation by identifying the core and subsidiary processes operating in it. The core process in grounded theory is the guiding principle underlying what is occurring in the situation and dominates the analysis because it links most of the other processes involved in an explanatory network,” (p. 1357, Baker et al. 1992). Grounded theory is rooted in symbolic interactionism (the symbolic interactionist school of sociology) where “human action is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another’s actions. This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behavior,” (p. 180, Blumer 1969). In terms of analyzing data, the nature of the theory drives restructuring and reanalysis and follows the constant comparative method (Patton 2002) where data are coded and then revised as additional information is collected. “Emerging concepts determine what information will be sought next and interview questions may change to focus the study,” (p. 1358, Baker et al. 1992). Categories eventually develop and link to form a conceptual framework.

The data collection and analysis served as a conceptual framework for how pastors emphasized and de-emphasized health issues based on how they constructed and interpreted positive health behavior. The qualitative approach allowed for a (deeper) contextual understanding of the phenomenon of how pastors perceive themselves as health communicators. This type of communication describes the culture and reality that they (pastors) communicate health in and how it could impact future health behavior.

## Sample Selection

Six clergy from the Kansas City, Missouri and Kansas City, Kansas urban core participated in semi-structured interviews in 2010. Participants in the study were included based on the following criteria: (a) African American and (b) Pastor of a predominately African American church in the urban core of the Kansas City, Missouri or Kansas City, Kansas area. Participants were informed that their participation was voluntary and no incentive was offered. A purposive convenience sampling technique was used for the study.

The sample included men ranging in age from 43 to 70. All participants had some level of post-secondary education except for one who had seminary and military education courses post high school. The years in ministry ranged from 10 to 30. The church membership of the sample varied from 50 to 1,000 members (see Table 1). Although there was some diversity in denominations, most (four) were Baptist; one was pastor of a Church of God in Christ congregation, and another was pastor of a non-denominational church. None of the pastors had formal health training in any specific topic. However, three had (expired) CPR training and all participants had attended a health fair or health workshop.

## Data Collection, Coding and Data Analysis

Data collection consisted of an open-ended, semi-structured interview format and data were analyzed inductively using the constant comparison method (Patton 2002).

The interview guide explored areas regarding health screening promotion, beliefs about cancer and general health prevention and the pastor and the church as health promoters. Interview questions changed to sharpen the focus of the study and concepts revised.

The interviews were conducted in settings determined by the participants and lasted between 60 and 100 min in length. The participants were assured that their identities and church names would be kept confidential. The interviews took place between February and April of 2010. With the consent of the interviewees, the conversations were digitally recorded and later transcribed verbatim for analysis. The interview guide for the study consisted of 28 questions. There were eight additional questions that captured demographic and background information. Several questions focused on the pastor and church as a communication channel to communicate screening and healthy living to the church. The questions overall were divided into five major areas that included: (1) Professional and biographical information; (2) Church demographics; (3) Health screening knowledge; (4) Beliefs about Cancer Screening; and (5) The pastor and the church as health promoters. Some of the questions included: (a) Have you attended health workshops or seminars on cancer prevention or other health topics? (b) What is your perspective of health promotion of cancer screening? (c) Do you feel the church could be used more to transmit health messages to church members? (d) Do any of your sermons focus on health in any way such as healing the sick?

For the purposes of multiple perspectives and validity, reliability and trustworthiness, the coding and analysis were done by three coders. The team included one African American Christian, one African Christian post doctorate/Master of Public Health student and one Caucasian medical doctor/Master of Public Health student (spiritualist). All coders met prior to coding to familiarize themselves with the coding process for the study and grounded theory principles.

The diversity of the team added to the interpretive perspectives. The team met twice a month over the course of 5 months for 60–90 min in each meeting. During this process, prior to each meeting, each team member read the transcripts multiple times, using an open-coding

process and assigned categories to the data. The bi-weekly meetings allowed researchers to compare and contrast categories identified during the individual open-coding. Once categories and their properties were agreed upon, the team utilized the constant comparison method across transcripts to determine the similarities and differences between the participants' responses (Strauss and Corbin 1990). This open-coding "enables examining, comparing, conceptualizing and categorizing data," (p. 61, Strauss and Corbin 1990). Grounded theory allowed the researchers to discover how the pastors' interpretation of health disease and prevention among African Americans lead to the construction of health messages communicated to their congregants. Pastor social construction of how they interpreted the importance of healthy behavior from the pulpit is shaped by their awareness of and personal encounters with health issues and interactions within the culture. Based on this and how pastors internalize information and interpret meanings they have assigned to health behavior will influence how they deliver healthy communication and promotion of prevention from the pulpit, the church and the community. This interpretation of their communication resulted in six salient themes.

## Results

After reviewing the transcripts from the interviews, the researchers identified six major themes that emerged from the data concerning how information is communicated by the pastor about health in the church setting. The themes can be categorized by the following topics: (1) Pastor Personalization of Health; (2) Pastor Assessment of Congregation's Health; (3) Pastor Usage of Authority; (4) Linkage of Spirituality, Religion and Health; (5) Participation in Health Ministries; (6) The church as an agent for Healthcare equity and access.

### Theme 1: Pastor's Personalization of Health

The most salient theme from the interviews was the pastor's personalization of health. This theme emerged as a dominant category for how pastors communicate various aspects of health behavior. The concept among these pastors referred to the assessment of his personal experiences with health issues and or health issues that a family member experienced. These experiences were then used as a way to communicate the urgency of why individuals in the church should get screened or do something to either react or become proactive in health screening and disease prevention. One property of this category was the pastor's internalization of his own health and health status. This internalization or interpretation of his health then became a part of his intrapersonal communication and why he should adopt healthy behavior such as involvement in cancer screening and choosing a nutritious diet. This decision-making process served as part of a communication strategy to encourage and promote health among congregants (thus a part of communicating health issues that the pastor had internalized as important and also, those health behaviors that the pastor had self-efficacy in performing successfully).

Well the thing is there are things wrong but I felt good. And that's what the doctor told me, he said you feel good. He said I know you feel good, you think you're in good health, but the thing is we see stuff in your labs. We see things and we want to take care of them before you start feeling bad, because when you start feeling bad it may be too late. So, we try to take care of it before you start feeling bad. Well when you feel good you don't want to be bothered with a doctor. But that's the thing. And that's a lot of black men's problems, we don't care to go to a doctor until it's too late.

Another property/dimension of personalization of health focused on (referent other) someone that had a close relationship with the clergy such as a family member. The

experience of witnessing the family member's coping with a health issue(s) revealed how the pastor interpreted the family member's health crisis/crises and how this translated into a basis for communication with others about health decision making.

Well the first was breast cancer (his mother's battle with cancer). Matter of fact, she just had another mass removed yesterday. They have to test that, but they don't believe that it was anything, but they wanted to remove that. She had a mastectomy, a couple months ago. But, God has, you know, he's blessed her through that. I had an aunt die a few years back with congestive heart failure. And along with that, I think you begin to take a look at your life and you want to see people healthy.

### **Theme 2: Pastor's Assessment of the Congregation's Health**

Another salient theme that emerged from the interviews was the pastor's personal assessment of his congregation's overall health status. Clergy used this assessment to pinpoint major health issues to communicate one-on-one and also at the congregation level. The aspect of this category that was prevalent included personal observation of health behavior. The clergy described the physical conditions of the congregation. These physical conditions were assessed through either observation in the church setting or outside of the church setting during visitation at the hospital. In addition to observation, the pastor also assessed the individuals via interpersonal and group communication. Pastors often had personal conversations with individuals of the church per one-on-one meetings or through group meetings. Pastors also extracted this information through formal settings via surveys given in the church to query the congregants about their health status. These strategies all lead to a conceptualization for *how* pastors gathered information to formulate a strategy to communicate to the congregation about areas of health to focus on. This also explained their perceptions about *what* health topics were most important and needed to be shared and communicated.

Well, there are some chronic illnesses in the church. There are a lot of people with diabetes and hypertension. And you'll find that mostly in the elderly congregation. I'm a diabetic myself. And so when we've got... we've done surveys and tried to get a feel for the health of the church.

### **Theme 3: Pastor's Usage of Authority**

From clergy responses, there were two central properties of usage of authority to promote health information in the congregation. Pastors first saw themselves as an authority figure in promoting positive health behavior information among congregants. The leadership role as a spiritual leader also meant they had a duty as a leader in other aspects of their congregants' lives. In other cases, the pastors utilized the training and skills of medical professionals (e.g., doctors and nurses) who were members of their church or who were well known in the local and neighboring community. The authority of the pastor and or those affiliated with the pastor that possessed medical acumen to discuss health issues symbolized discipline, boundaries and structure to create parameters that congregants needed to make healthy decisions.

Someone can get up and make an announcement that there will be a health screening here Saturday (at) 1:00, but unless that pastor comes up behind them and say don't forget this health clinic, this health screening, people listen to him and they listen to the preacher and it resonates more, they take in more when it's coming from the preacher. A lot of times people don't even hear the announcement, their minds are somewhere else. But when the pastor speaks up, even if there's a program in the church that needs to go over, the pastor needs to announce it. He



needs to put some emphasis on (it), because that's where the attention is, on the pastor and that's just how it is.

Clergy essentially use their authoritative positions and the credibility of medical personnel to leverage (communicate) what congregants should do to lead healthy lives. While the type of authority used varied from authoritarian, shared authority or authority by affiliation, the pastors employed some type of authority to emphasize positive health decision making and behavior.

#### **Theme 4: Linkage of Spirituality, Religion and Health**

Clergy saw a necessity to intertwine the tenets of Christianity with spiritual beliefs to advocate health behavior change. The properties of this linkage included a Christian faith-based perspective that placed Jesus of the Judeo-Christian tradition/religion as the focal part of health and belief in holistic health. The Jesus of the bible was not only a *spiritual* figure but also a healer and performer of miracles. These miracles were not magical or mythical but were linked with the physical act of obedience. Many of the pastors in this sample cited several passages from the bible that detailed healings that were performed and emphasized the part of the story that Jesus told the individual who was sick to act on his/her faith. The spiritual faith for these pastors symbolized a belief in a higher power that can heal; however, it is the responsibility of the individual to physically do something that will move that individual to better health. In many instances, the pastor emphasized the importance of doctors and medical personnel; they believed God had gifted these individuals with the knowledge and skills to treat and keep patients healthy. The religious dimension of this linkage between spirituality and health represented the physical act of the individual not only doing what he/she must do to become healthy or stay healthy but was woven into what is necessary to obey God and keep his commandments (body as a temple of God).

As it relates to our spirituality, it's important for us to realize that our body's a gift from God and that as a gift from God you need to take care of it—that we have a responsibility to be a good steward over this body. And I think that preaches in almost any pulpit, being a good steward over this gift of our physical body.”

#### **Theme 5: Participation in Health Ministries**

A fifth category that emerged from the interviews included the clergy's participation and encouragement of health events at the church and in the community. The genesis of these events was essentially initiated by members of the congregation, community members affiliated with the church or a combination of these. The properties of this category were multi-leveled where the health activities were church based, church to church or church and the community. Whether the health activity or event took place in the church or the community, the church and the pastor were affiliated with that event. At the church level, members and the pastor collaborate to address health issues on a primarily interpersonal or group level. At the church to church level, many of the churches either were in the same district or collaborated to co-sponsor or participate in an event such as a health fair. Events co-sponsored by the church and community participants (such as the Black Healthcare Coalition) were also health activities that the pastor articulated as a way to motivate members to better health through their communication.

I think with the nurses bringing that (health issue) to our attention, we had an aerobics class that was going on here at the church for a while; just trying to get people's mind focused in on staying healthy. And I think that's something that we will try to start up again and continue. We had several women that really enjoyed doing that. But I think once they brought that to my attention and I knew what I was doing personally, I thought it was a good idea. I think now it's, we're at a point

now that it has to be voiced even more so, for us as African American people to get healthy.

### **Theme 6: The Church as an Agent for Healthcare Equity and Access**

The pastors discussed health behavior also in terms of social barriers. The aspects of the theme varied however the over arching theme of lack of health resources, healthcare equity and access linked these issues together. Two pastors discussed the need for neighborhood hospitals and how these are resources that churches can partner with to help reduce healthcare disparities in the area. One other pastor talked about economic barriers as an impediment to eating healthy. He mentioned that quality food prices in the neighborhood are either too high or there is a lack of fruits and vegetables in the neighborhood where his church members live. Other issues were also access to and equal access to insurance and healthcare among congregation members. Pastors felt that if these barriers were removed and articulated to congregation members, their attitude and outlook on health outcomes would be more believable, realistic and achievable. Pastors discussed these barriers in terms of advocacy issues that should be communicated for positive change—essentially that self-efficacy of an individual would be increased to actually perform the change. In the pastors' perspectives, the social issues were factors that have to be addressed and solved or the cycle of unequal and/or no access to health care and thus health disparities would continue. Pastors noted that this must be communicated at the church, community, regional and even national level. This signified not only advocacy in terms of access to quality health and healthcare on multiple levels but also points to elements of media advocacy.

### **Discussion**

The present findings suggest pastors see themselves as health promoters and could discuss health issues more frequently from the pulpit; they also believe spirituality linked with religion is translatable into successful health promotion program planning and could be part of church- and faith-based information materials. The clergy see their leadership in the church as part of this communication and influential in positively impacting health behavior among not only congregants but the surrounding community.

The study examined African American clergy's perspectives on how to effectively communicate health behavior change to congregants. Through the pastor's self-reflection of their own communication and the researcher's analyses of these reflections, there were some reoccurring themes that surfaced in the semi-structured interviews. Clergy believed that their communication could be used to bolster health promotion in the church setting by emphasizing certain health information strategically. The communication strategies illuminated in the semi-structured interviews included: (a) pastor's personalization of health (b) pastor's assessment of the congregation's health (c) pastor's usage of authority (d) linkage of spirituality, religion and health (e) participation in health ministries and (f) the church as an agent for healthcare equity and access. These themes could be used then as a basis for future health communication and promotion strategies when targeting African American or faith-based communities about health issues such as health screening and disease prevention.

The ongoing effort to increase effectiveness of health promotion with culturally specific information is making a difference but much more needs to be done. Many of these efforts are culturally sensitive and come from the perspective of the researcher and not necessarily the views of the target audience or individual. Dutta (2007) proposes a cultural-centered approach where communication efforts include the culture for who the information is created. In public health, this translates into community-based participatory research or CBPR where the culture is a part of the process (Israel 2006). Here, this study shows that

pastors of predominately African American churches know their congregations and the community in which they worship. Drawing from these perspectives would be beneficial to create a communication model of health behavior change that is appealing to African Americans who are either spiritual or religious.

The study provided contextual information about pastor's perspectives of communicating health behavior and how this could guide public health personnel in program planning; however, there were some limitations. Not all churches in the sample were the same size. In fact, there were two churches that greatly outnumbered the other church congregations. These churches had more resources and time to commit to health issues when compared to the smaller churches. The smaller churches partnered with other churches within their district to participate in health fairs and other health events or relied on community partners such as the Black Healthcare Coalition. In addition, all pastors interviewed were male and four were pastors of Baptist churches. Information gathered and then analyzed in the study was not exhaustive; the analysis yielded other themes between two or three pastors, however, these were not dominant across all interviews. In addition, there were some categories that emerged in one interview but not in the others. Data gathered also did not yield specific information on how the clergy communication would impact any one cancer or health screening but provided general information as to how this could impact preventive behavior for various health issues. The researchers, however, were able to gain rich information about pastors' perspectives of communicating health behavior within the church setting and how this could translate into actionable steps to improve health promotion programs within the African American church. The results can guide researchers and public health personnel in future health program planning by helping to: (1) clarify the health communication component for the program and (2) add to the sustainability of the program.

Evaluation of health programs have indicated that effectiveness of programs targeting minority populations could be enhanced by adding a carefully designed and constructed communication component into the health program. In many cases, the communication aspect of the program is missing, not clearly defined nor is it a critical component (Berhnhardt 2004). This study shows African American pastors see themselves as valued and trusted voices in relaying health behavior information to congregants and thus a critical part of the communication process in relaying pertinent health information.

Utilizing this type of communication (from the African American pastor) helps serve as a guide for not only public health personnel but researchers when testing specific health communication messages that will resonate with African American and faith-based populations concerning health issues. The pastor's role is integral to not only the church but also the community as he/she is a liaison between the medical, research and faith-based communities (Levin 1986; Timmons 2009).

The sustainability of programs can also be attained by reviewing and modeling the communication strategies of the pastor. The pastor as a leader of African American churches is intimately involved with the infrastructure of the church; the communication that the pastor imparts is carefully constructed through his experiences and interaction with congregants. This knowledge and communication will serve well when applied to the implementation and sustainability of health programs because it is familiar, trusted and part of an already existing communication exchange in this setting. Through these strategies, health program designers/managers have a communication guide to incorporate specific messages and language to build programs that become a lasting part of the community in which medical and faith-based organizations have a shared and vested interest for sustainable programs.

## Future Directions

Pastor communication about healthy behavior to their congregants is one part of many factors public health personnel should consider when developing health promotion programs targeting African Americans. The communication component is critical for the success of the program (Berhnhardt 2004) and must appeal to the targeted population to be successful. Future research should include a larger sample of pastors throughout the urban core to allow a better representation of the urban core that exemplifies the breadth of African American clergy. While the qualitative approach allowed the researchers to gain rich detail about the pastor's communication, a focus group of pastors and subsequently a quantitative survey among African American congregants will help researchers to generalize information and further test message effectiveness of pastor health communication. In addition, the subsequent inquiry should focus on one health issue instead of a broad scope of health issues. The qualitative findings can serve as a springboard for formulating testable health communication messages and strategies that address specific health disparities among African American congregants. Further, health promotion research that examines the pastor's role as health promoter/communicator can provide clues as to how public health personnel formulate strategies to reach minority populations. Pastors are not only individuals who are able to serve as a person who can identify health issues in the community but also individuals who can impact behavior (Anshel 2010; Watson et al. 2006) and could be instrumental in communicating health issues such as HIV/AIDS through diverse communications tactics (Moore et al. 2010). The present study shows how pastors' interpretation of their communication with congregants can serve as a beginning to build effective health communication models for health behavior change. The pastor's communication in many settings is one that is important and when linked with an individual's beliefs could impact behavior. Future research should look at specific types of health (i.e., cancer screening) and whether the pastor's communication will impact attitudes and behavior intention among congregation members. Public health professionals working with a key individual in the African American community such as the African American pastor, have a resource that is trusted, credible and also a part of African American life. The church also, a large part of the community, is a partner to impact not only congregation members but community members as well.

## Acknowledgments

The project was supported by Grant Number 3R01CA123245-03S1 from the National Cancer Institute. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Cancer Institute or the National Institutes of Health.

## References

- Aholou TMC, Gale JE, Slater LM. African American clergy share perspectives on addressing sexual health and HIV prevention in premarital counseling: A pilot Study. *Journal of Religion and Health*. 2009; 50(2):330–347. [PubMed: 19495984]
- American Cancer Society. Cancer facts and figures for African Americans 2007–2008. 2010. Retrieved from <http://www.cancer.org/downloads/STT/CAFF2007AAacspdf2007.pdf>
- American Heart Association. 2011a. Retrieved Sept 12, 2011, from [http://www.heart.org/HEARTORG/GettingHealthy/GettingHealthy\\_UCM\\_001078\\_SubHomePage.jsp](http://www.heart.org/HEARTORG/GettingHealthy/GettingHealthy_UCM_001078_SubHomePage.jsp)
- American Heart Association. 2011b. Retrieved from [http://www.heart.org/HEARTORG/Affiliate/Power-To-End-Stroke-Kansas-City\\_UCM\\_304038\\_SubHomePage.jsp](http://www.heart.org/HEARTORG/Affiliate/Power-To-End-Stroke-Kansas-City_UCM_304038_SubHomePage.jsp)
- American Stroke Association. 2009. <http://www.powertoendstroke.org/>
- Anshel MH. The disconnected values (intervention) model for promoting healthy habits in religious institutions. *Journal of Religion and Health*. 2010; 49:32–39. [PubMed: 19127434]
- Asante, MK.; Asante, KW. African culture: The rhythms of unity. Westport, CT: Greenwood; 1985.

- Baker C, Wuest J, Stern PN. Method slurring: The grounded theory/phenomenology example. *Journal of Advanced Nursing*. 1992; 17:1355–1360. [PubMed: 1430643]
- Berhnhardt JM. Communication at the core of effective public health. *American Journal of Public Health*. 2004; 94(12):2051–2053. [PubMed: 15569948]
- Blumer, H. *Symbolic interactionism. Perspectives and method*. Engelwood Cliffs: Prentice-Hall, Inc; 1969.
- Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-based health promotion interventions: Evidence and lessons learned. *Annual Review of Public Health*. 2007a; 28:213–234.
- Campbell MK, James A, Hudson MA, Carr C, Jackson E, Oates V, et al. Improving multiple behaviors for colorectal cancer prevention among African American church members. *Health Psychology*. 2004; 23(5):492–502. [PubMed: 15367069]
- Campbell MK, Quintilani LM. Tailored interventions in public health: Where does tailoring fit in interventions to reduce health disparities? *American Behavioral Scientist*. 2006; 49(6):775–793.
- Campbell MK, Resnicow K, Carr C, Wang T, Williams A. Process evaluation of an effective church-based diet intervention: Body and Soul. *Health Education Behavior*. 2007b; 34(6):864–880. [PubMed: 17200096]
- CDC. State profiles on chronic disease. 2007. Retrieved from [www.cdc.gov/nccdphp/states/](http://www.cdc.gov/nccdphp/states/)
- Census. 2010. Retrieved from <http://2010.census.gov/2010census/data/>
- DeHaven MJ, Hunter IB, Wilder L, Walton JW, Berry J. Health programs in faith-based organizations: Are they effective? *American Journal of Public Health*. 2004; 94(6):1030–1036. [PubMed: 15249311]
- Dutta MJ. Communicating about culture and health: Theorizing culture-centered and cultural sensitivity approaches. *Communication Theory*. 2007; 17(3):304–328.
- Egbert N, Mickley J, Coeling H. A review and application of social scientific measures of religiosity and spirituality: Assessing a missing component in health communication research. *Health Communication*. 2004; 16(1):7–27. [PubMed: 14979849]
- Ferdinand KC. Lessons learned from the healthy heart community prevention project in reaching the African American population discussion. *Journal of Health Care for the Poor and Underserved*. 1997; 8(3):366–371. [PubMed: 9253228]
- Israel BA, Krieger J, Vlahov D, Ciske S, Foley M, Fortin P, et al. Challenges and facilitating factors in sustaining community-based participatory research partnerships: Lessons learned from the Detroit, New York City and Seattle urban research centers. *Journal of Urban Health*. 2006; 83(6):1022–1040. [PubMed: 17139552]
- Levin JS. Roles for the black pastor in preventative medicine. *Pastoral Psychology*. 1986; 35(2):94–103.
- Lincoln, CE.; Mamiya, LH. *The black church in the African American experience*. Durham: Duke University Press; 2001.
- Lumpkins C. Sacred symbols as a peripheral cue in health advertisements: An assessment of using religion to appeal to African American women about breast cancer. *Journal of Media and Religion*. 2010; 9(4):181–201.
- McLeroy K, Bilbeau D, Steckler A, Ganz K. An ecological perspective on health promotion programs. *Health Education Behavior*. 1988; 15:351–377.
- Merzel C, D’Aflitti J. Reconsidering community-based health promotion: Promise, performance and potential. *American Journal of Public Health*. 2003; 93(4):557–574. [PubMed: 12660197]
- Moore D, Onsomu EO, Timmons SM, Abuya BA, Moore C. Communicating HIV/AIDS through African American churches in North Carolina: implications and recommendations for HIV/AIDS faith based programs. [Original]. *Journal of Religion and Health*. 2010.1007/210943-010-9396-x.
- Patton, MQ. *Qualitative research and evaluation methods*. 3. Thousand Oaks: Sage Publications, Inc; 2002.
- Peterson J, Atwood JR, Yates B. Key elements for church-based health promotion programs: Outcome-based literature review. *Public Health Nursing*. 2002; 19(6):401–411. [PubMed: 12406175]

- Stokols D. Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*. 1996; 10:282–298. [PubMed: 10159709]
- Strauss, A.; Corbin, J. *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park: Sage Publications, Inc; 1990.
- Pew Forum US Religious Landscape Survey. 2007. Retrieved from <http://www.pewforum.org/docs/?DocID=389>
- Timmons SM. Pastor's influence on research-based health programs in church settings. *Journal of Health Disparities Research and Practice*. 2009; 3(2):92–102.
- Watson DW, Bisesi L, Tanamaly S, Branch C, Novgrod J, Sim T, et al. African American clergy's perceptions of leading health problems in their communities and their role in supporting parishioners' health. *The Journal of Pastoral Care & Counseling*. 2006; 60(1–2):13–16. [PubMed: 16733946]
- Watson DW, Bisesi L, Tanamaly S, Sim T, Branch CA III, Williams E. The role of small and medium-sized African-American churches in promoting healthy life styles. *Journal of Religion and Health*. 2003; 42(3):191–200.

Table 1

Description of African American pastors and their congregations

	Position in church	Age	Education	Denomination	Years in the ministry	Congregation size	Demographics	Attended health workshop Or Health training	Perspective of spirituality in health communication materials/dialog
Eric	Associate pastor	63	High School Diploma	Baptist	16	500/250 active = 500	Predominately Female; adults 45-75	Yes	Yes
Jimmie	Sr. Pastor	62	Bachelor's Degree	Baptist	28	120/50 active >500	Predominately Female; children and teens	Yes—CPR training	Yes
Ian	Sr. Pastor/elder	62	Bachelor's Degree	COGIC	44	800/400 active <500	Predominately Female; adults between 25 and 45	Did not provide	Yes
Greg	Sr. Pastor	43	Master's Degree	Baptist	20	120/50 active >500	Predominately Female	Yes	Yes
Terry	Bishop	43	Master's Degree	Non-denominational	10	200/150 active >500	Predominately Female, children and teens	Yes	No
Robert	Associate pastor	70	Master's Degree	Baptist	10	1,000 <500	Predominately Female, children	Yes	Yes

Names have been altered to protect clergy identities