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Religious Congregations' HIV and Other Health Collaborations: With Whom Do They Work And What Do They Share?

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Abstract

This study explores how religious congregations interact with other community organizations to address health and, in particular, HIV-related needs within their membership and/or local communities. Case study data from a diverse sample of 14 urban congregations (6 African American, 4 Latino, 2 Anglo and 2 mixed race-ethnicity) indicate they engaged in three types of relationships to conduct HIV and other health-related activities, i.e. those where: 1) resources flowed *to* congregations from external entities; 2) resources flowed *from* congregations to external entities; 3) congregations interacted *with* external entities. These types of relationships were present in roughly equal proportions; thus, congregations were not primarily the recipients of resources from other organizations in these interactions. Financial, material, and human capital resources were shared across these three relationship types, and the most common organization types that congregations were involved with for health efforts were prevention and social service organizations, health care providers, and other congregations. In addition, congregations tended to have more collaborative relationships with other FBOs and to engage with non-FBOs more to either receive or provide resources. Results suggest that congregations contribute to community health by not only sponsoring health activities for their own members but also by providing specific support or resources to enhance the programming of other community organizations and collaborating with external organizations to sponsor congregation-based and community-based health activities.

Keywords

congregations; religion; HIV/AIDS; community partnerships; health collaborations

Introduction

There are an estimated 300,000 religious congregations in the U.S. (Chaves, 2004) and national surveys have found that half of all adults attend religious services at least monthly (Idler, Musick, & Ellison, 2003). The potential role of congregations in promoting health and reducing health disparities has been of persistent interest to public health professionals and policymakers over the last three decades (Anderson et al., 2008; Haugk, 1976; Kim et al., 2006; Lasater, Wells, Carleton, & Elder, 1986; Olson, Reis, Murphy, & Gehm, 1988). This interest is motivated by congregations' ubiquity and the recognition of religion's important role in many individuals' lives. Further, religious institutions often possess

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community legitimacy and the organizational structures and roles that facilitate incorporation of health programs into their settings (Chatters, Levin, & Ellison, 1998).

Much of the literature on congregation-based health programs has focused on interventions initiated or designed by external health professionals and researchers, often in collaboration with congregational leaders (Campbell et al., 2007; DeHaven, Hunter, Wilder, Walton, & Berry, 2004). Less is known about other types of health-related activities in which congregations are involved, for example, those that congregations themselves initiate and/or that are not conducted within the context of a research project. Nationally, only about 10 or 11 percent of congregations report sponsoring some type of health-related programming (Steinman & Bambakidis, 2008; Trinitapoli, Ellison, & Boardman, 2009), and among those who do, almost half work with external organizations to administer their programs (Trinitapoli, et al., 2009). However, little is known about the nature of congregations' involvement with these organizations for health-related programming, including the types of external organizations and the types of resources contributed to the interaction.

Congregations' collaborative relationships are of particular interest in the area of HIV yet are understudied. There have been few systematic attempts to assess the extent of congregational involvement in HIV prevention and support services (Tesoriero et al., 2000) and descriptive studies of congregation-based HIV prevention efforts in the U.S. have largely focused on the African American community and/or have resulted from partnerships between public health entities and individual congregations (Agate et al., 2005; Baldwin et al., 2008; MacMaster et al., 2007; Marcus et al., 2004; Merz, 1997; Tyrell et al., 2008) But, as noted by others, HIV tends to challenge the moral values of religious institutions in ways that other health issues do not (Chatters, et al., 1998; Chin, Mantell, Weiss, Bhagavan, & Luo, 2005), suggesting barriers to collaboration with external organizations. Understanding how congregations collaborate with external entities around HIV and other health activities – including the types of organizations they engage with, the types of interactions that occur, and whether these types of interactions vary for HIV versus other health related collaborations – can help inform future efforts focused on assessing and promoting effective faith-based health partnerships.

The purpose of this paper is to use rich qualitative data to examine the different ways that urban congregations interact with external entities around HIV and other health activities. Since the actual or potential mechanisms by which religious congregations may become involved in HIV activities are poorly understood, we framed our study drawing on the diffusion of innovations literature (Rogers, 2003) and the branch of institutional theory that addresses the diffusion of new organizational forms and practices (Powell & DiMaggio, 1991; Scott, 2001; Strang & Meyer, 1993; Strang & Soule, 1998; Wejnert, 2002). Institutional theory is well-suited to taking into account the cultural and constitutive aspects of religious organizations (e.g., mission, identity, purpose) that may differentiate congregations from commercial or even other types of nonprofit organizations (Chin, et al., 2005). Our resulting framework identifies four sets of factors—norms and attitudes, organizational structure and process, resources, and demographics— that influence both internal and external support for congregational HIV and other health activities (Derose et al., 2010). This paper examines in detail the interactions between congregations and external entities around HIV and other health issues—with a focus on three research questions

1. What types of organizations and individuals do congregations work with to conduct HIV and other health activities?
2. What types of interactions take place between congregations and these entities around HIV and other health activities?

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3. In what types of interactions do congregations tend to engage in with different types of organizations?

Methods

This research was conducted within the context of a multi-year study whose primary objective was to better understand the range of HIV activities in which religious congregations engage as well as how and why they become involved in such endeavors, particularly in comparison to the many other health-related issues they might address, such as cancer, diabetes, obesity, drug and alcohol abuse, homelessness, and mental health. Religious congregations vary substantially in their organizational structure, membership, culture and guiding philosophies, and often operate as highly dynamic communities (Chaves, 2004). Given this and the exploratory nature of the research, we opted for an inductive case study design that permitted an in-depth examination of congregational dynamics, triangulation of multiple data sources, and comparison of HIV and health activities across various types of congregations (Eisenhardt, 1989; Yin, 1994). Such an approach provided the time needed to develop rapport critical to eliciting information on a sensitive topic within close-knit communities (Campbell, et al., 2007). We employed several community-based participatory research methods, including on-going involvement of a community advisory board (CAB), formative interviews with community faith-based and public health experts, and reciprocal interaction and feedback with our congregational research participants (Derose, et al., 2010). CAB members included religious and public health leaders identified through the research teams' community contacts and other key informants. CAB members were involved throughout the course of study, including proposal development, study design and implementation, and interpretation and dissemination of results. CAB members played strong roles in helping to identify and recruit congregations, design the research protocol and materials, and develop ways to disseminate the results to non-research audiences.

Congregational Sampling and Case Selection

The study focused on Los Angeles County in southern California, the second largest AIDS epicenter in the United States, and specifically on three geographic areas most highly affected by HIV according to county health department surveillance data. Through community expert interviews, the study's CAB, and other local sources, we created a list of 80 congregations potentially involved in HIV in the three study areas. We then administered a brief telephone screening survey to those congregations, achieving a response rate of 88 percent. The screening survey instrument included questions about current and past HIV and other health activities conducted by the church, the number of regular participants of the church, and the racial-ethnic breakdown of regular participants. Using the screening data and assistance from CAB members, we recruited a purposive sample of 14 congregations that reflected a range of faith traditions, race-ethnicity, congregation size, and level of health and in particular HIV activity (from low activity to high activity). Low HIV activity congregations reported activities that were infrequent or not targeted specifically to HIV, whereas high activity congregations reported frequent and targeted HIV/AIDS activities, and included multiple types of activities that are beyond what congregations traditionally do (e.g., HIV testing).

Table 1 provides key characteristics of the congregations (n=14). Six of the congregations were predominantly African American, 4 were Latino (3 primarily Spanish-speaking and 1 English-speaking), 2 congregations were white, and the remaining 2 were mixed race congregations. We also achieved variation in membership size, denominational types, and HIV activity level.

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Data Collection and Analysis

We employed multiple data collection methods during several visits over a roughly one-year period for each case congregation, primarily during 2007 and 2008. These methods included semi-structured *interviews* with clergy and lay leaders; a *congregational information form* on congregational membership, resources, and programs or ministries; *observations* of religious services, health and/or HIV-related activities, and the facility and neighborhood context; and a review of *archival information* (e.g., congregational web sites, news stories).

The findings described in this paper are based on data from the semi-structured interviews. During the interviews, the following topics were discussed in detail, among others: congregational background; the congregation's mission and priorities; the history of congregational involvement in health and HIV activities, including what they did, how they did it, and challenges encountered; leader, congregation, and community attitudes toward health and HIV; and community dynamics, including congregational relationships with external organizations and individuals to conduct health and HIV activities. The full interview protocol is available upon request from the lead author. A total of 57 individuals were interviewed across the 14 congregations (3 to 6 per congregation), including clergy and lay leaders. Interviewees were selected by virtue of their roles within their respective congregations. We interviewed senior pastors and rabbis and other supporting clergy where available. Lay leaders typically included current or former leaders of HIV or health-related initiatives (e.g., parish nurse, HIV/AIDS committee chairperson). Table 1 summarizes key characteristics about the interview participants (n=57). Across the congregations, slightly more men (30) than women (27) were interviewed, and more lay leaders (35) than clergy (22). Some clergy and lay leaders had health-related backgrounds, but they constituted the minority of interview participants. The interviews, which typically lasted 1.5 hours (range 1 to 4 hours), were conducted in English or Spanish according to the preference of the interviewee, and were audio-recorded, transcribed, and, if appropriate, translated to English for analysis. The transcriptions were complemented with detailed manual notes by a designated note taker.

After all field work was completed, we extensively coded interview transcripts to capture prominent themes. We used both inductive and *a priori* approaches to identifying themes: The interview data themselves suggested important concepts to examine, while our initial conceptual review, questions from the interview protocol, and the research team's experience guided the selection of additional themes (Ryan & Wagner, 2003). We organized these themes into a codebook, along with their definitions and examples of their application.

Six members of the study team, including three of the authors of this article, participated in coding the interviews using specialized computer software for qualitative data analysis (Muhr, 2006). Study team members worked together in pairs to assign specific codes to relevant portions of the interview transcripts, closely interacting throughout the process to ensure they developed and retained a shared understanding of the codes for which they were responsible. The coding teams drafted an initial set of major thematic categories, including types of congregational health activities, how activities are organized, the involvement of external entities, and facilitators of and barriers to these activities. In subsequent coding iterations, coders further refined the major thematic codes. For example, in an early stage of coding, all collaborations with external entities were tagged with a single, high-level code. After all 57 interviews were coded for the presence of collaborations, the passages tagged with the collaborations-related coded were reviewed and coded again to break the collaborations down into specific interaction types.

In this paper we examine themes related to congregations' relationships with external entities, including the nature of the interaction and the types of entities (both organizations

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and individuals) with which congregations interacted in some way. Since the goal of the overall study was to understand what factors influence congregation-based HIV activities and whether these differ or are similar to factors that affect other health-related activities, we focused on interactions related to HIV as well as other health concerns. Moreover, our definition of other health concerns was a broad one; not only did it encompass issues such as diabetes and cancer, but also substance abuse and public health issues such as homelessness. Yet, we did not include in our analysis interactions pertaining to non-health related issues that were mentioned during interviews (e.g., collaboration related to building a school, renting meeting space to groups not involved with health or HIV issues). Finally, in order to avoid double-counting a specific entity, we only included interactions in which an organization or individual was expressly identified by name; in other words, non-specific references such as bringing in “a speaker” or working with “other churches” were excluded from this analysis.

Ultimately, we identified 177 distinct interactions or relationships between our 14 case study congregations and external entities. Our preliminary coding and analysis suggested that one way to distinguish among these relationships was to examine the direction in which resources flowed; thus, we subdivided these relationships further into three broad categories: resources primarily flowing *to* congregations from external entities, resources primarily flowing *from* congregations to external entities, and congregation interactions *with* external entities. Interactions assigned to this third category were those in which resources flowed in both directions between congregations and external organizations, or, alternatively, were directed to other beneficiaries (e.g., a congregation and an external organization jointly planning a health fair to benefit both congregants and local community members). We also examined whether the frequency of each type of relationship varied depending on whether it focused on HIV or other health concerns. External entities fell into five general types: faith-based organizations, health care providers, public health and other government, prevention and social services, and other. In total, there were 151 unique external entities involved with our 14 case study congregations in some health effort.

Results

What Types of Organizations and Individuals Do Congregations Work with to Conduct HIV and Other Health Activities?

As noted above, we identified 177 distinct relationships between our 14 study congregations and external entities with whom they interacted to conduct health and HIV activities. Given the geographic proximity of some of our congregations and the large service areas of some of the external organizations, some organizations were mentioned by multiple congregations. Therefore, to quantify the different types of organizations interacting with congregations in our study area, we focused on the 151 unique external entities identified.

As seen in Table 2, 39 percent of the external entities were other faith-based organizations, most commonly other congregations (15%), a faith-based alliance or coalition of congregations (11%), or another type of faith-based organization or FBO (e.g., faith-based social service agency). The other 61 percent were mostly secular health-related organizations such as prevention and social service agencies (24%) and health care providers (16%), and other non-FBO and non-health organizations (15%), such as private businesses, universities, and non-profit organizations. Only 3 percent of the external organizations were faith-based health care providers (e.g., a Catholic hospital) and only 6 percent were public health departments and other government agencies. [We also examined the frequency of organization type among all interactions (not just unique organizations) and the results were similar].

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What Types of Interactions Take Place Between Congregations and These Entities Around HIV and Other Health Activities?

We classified congregation interactions or relationships with other community organizations and individuals into three distinct types based on the flow of resources, and further explored whether different types of relationships were more prevalent if they focused on HIV-related support as distinct from general health concerns. We did not observe such variation, and in this section, our discussion encompasses both interactions related to HIV as well as other health areas.

Resources TO Congregations from External Entities

Approximately one-third (35%) of the relationships we documented were instances in which a congregation interacts with an external entity to receive some type of resource, including financial support, materials or supplies of some kind, or person-based support (i.e., human capital) for congregation-based health activities. Financial resources provided to congregations from external entities included different types of donations and grants. For example, one lay leader described how her employer provided seed money to start an HIV-related ministry:

> …[W]e liked the project, we thought it was doable for us and it became something that was my pro-bono work. And so we actually got our seed money from [my employer]. They gave us the first thousand dollars to start buying supplies and getting started; and periodically [they] would give us some of the money that we used in our early years before we did other fundraising to fund our work. (White, Reform Judaism Synagogue A)

Another congregation reported receiving financial assistance from a local non-profit so that it could continue hosting its HIV/AIDS support group on a regular basis. A third congregation not only received financial support in the form of a grant from a private foundation, but also was furnished with a list of service providers and other resources to which it could apply the grant funds if it chose to do so.

The next category of resources congregations often received from external entities included materials and supplies. As the following comments illustrate, material resources typically included toiletries, food, and health-related supplies for congregational health activities:

> The big Holiday Inn used to have the hotel here, and when they closed, they gave the church a whole bunch of the soaps and shampoos and stuff [for the congregation's homeless ministry]. (Mixed race Mainline Protestant church)

> But we used to have the most awesome food giveaway. We were able to tap into Trader Joe's, Whole Foods and other grocery stores. And we used to give lots of food-fruit, vegetable and fish-away; sometimes other meats, but lots of just really healthy things [for distribution to the local community]. (African American Mainline Protestant church A)

> A very effective program for one of the congregation's community Passover seder [the festive meal for this holiday] was to use a cartoon character and health materials provided by the LA County Dept of Health for its anti-syphilis campaign targeted to gay men. During the reciting of the 10 plagues, the cartoon character and education materials were passed out when they got to the plague of boils. Along with the kitsch factor, it made for a very effective health education message by folding it into a religious context with deeper meaning. (White Reform Judaism synagogue B)

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In each of these examples, the congregations used the material resources received to provide services or support for members of the congregation and the community: the homeless, those in need of food, and those attending Passover seder, respectively.

Congregations not only received health promotional materials and medical supplies from external entities, but also enjoyed support in the form of human capital-based resources, such as volunteers to staff an event or individuals with health-related expertise. A number of congregations engaged speakers to come in and address their membership about various health issues. For example, during an interview at a Jewish synagogue, we were told, "A woman spoke from a new domestic violence shelter called [local shelter]. [She was] a volunteer who moved everybody to tears, a very effective speaker," (White Reform Judaism synagogue A). Doctors, nurses, and other healthcare professionals from outside the congregations also provided support, as the comment that follows demonstrates:

> We set up a center, per say, and the church became the center so they [men from the church and the community] could come get their exam totally free. Three, four expert doctors that specialize in prostate cancer from the [local university] came; they specialize and they did all the exams. They were here all day, from nine in the morning to seven at night. (Latino Pentecostal church)

In some cases, a congregation's interaction with an outside person or organization led to its receiving a combination of resources. For example, flu shots involve both the provision of the actual vaccination as well as the involvement of a healthcare professional to administer the dose, and a rehabilitation home includes not only residential facilities but also counseling and other support from healthcare professionals. Additional examples of multiple types of resources provided to case study congregations follow:

> We started out doing it [HIV testing] with [local health provider]. They would bring the vans. He would bring the van out and test for us. (African American Roman Catholic church)

> She [lay leader] had the County really helping and assisting in a lot of our health fairs where we had the health fair van, and then anybody in the neighborhood, anybody in the congregation could get HIV testing, different type of immunizations… free immunization shots and what not. (African American Baptist church)

Resources FROM Congregations to External Entities

Almost the same proportion of interactions, 32 percent, was characterized as those in which the congregation provided resources to another organization or professional. As in the case of resources given *to* congregations, resources flowing *from* congregations took one of three distinct resource types, financial, material, or human capital-related, or were a combination of those three. Financial resources typically took the form of a monetary donation to another organization for health-related causes, as the following comments indicate:

> We have a very active chapter of the Jewish World Watch, which is focused now on Darfur rescue, and we've raised a lot of money and sent people to Chad to deliver solar cookers for the women. (White Reform Judaism synagogue A)

> We usually raise, for congregations…the most money in the AIDS Walk here in Long Beach. (Latino Roman Catholic church A)

> Well, they did this thing where they have this jar, and people put change in it, basically, loose change. And I think from that, in about a month or two, just from the change, they've raised probably about $400. What will probably happen, we'll probably match it and send the money to our greater church and they'll make sure

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> that it gets to the right people in South Africa. (African American Mainline Protestant church B)

Although material resources also frequently took the form of donations, particularly to help another organization's members or clients, they varied greatly. Congregants collected clothing, purchased toys and medical supplies, provided meeting space, and distributed toiletries, for instance. The remarks that follow help to convey this diversity in material resources provided by congregations to external organizations:

> Every month we go to [local medical center]. We have an ongoing outreach program where we provide clothing and any household items-TVs, stoves, different things. We also… there are so many things. We have annual toiletries drive where we collect toiletries and distribute them to like [local social service agency] as well as toys for the children. (African American Roman Catholic church)

> When we participated in going to Africa, we sent medical supplies. We sent underwear. We sent everything imaginable to people as well as medicine. We bought Ibuprofens. We bought needles. … We sent mostly, you know, cotton Q-tip swabs and just all kinds of medical things. (African American Mainline Protestant church A)

> The only thing we've done is [for] [local HIV/AIDS support agency], we have sometimes helped host their weekend [workshop]. We've, like, opened the doors, so they could have it here. … We opened the doors and didn't charge them for use of the space and, you know, allowed them to get a foothold to be able to do the seminars. (White Reform Judaism synagogue B)

Congregations also provided support to other community organizations by tapping into their leadership and membership. Our interviews included examples of congregations providing support in the form of volunteer labor for other congregations' health fairs or decorating a hospice facility for the holidays, for instance. In another case, a lay leader told us, "[Local drug treatment facility] also holds forums, and we assist them when they're putting on these forums" (African American Roman Catholic church). Further, as these comments illustrate, our case study congregations also shared their leaders' expertise with other organizations:

> [Local social service agency] …. is a women's halfway house, and they have some women there that are HIV positive, and then some women that are not. We've this year made a commitment with them. One Friday night a month, we're going to go over there and do a self-esteem building type of class that I'm going to do with them. (Mixed race non-denominational church)

> I [clergy leader] was on their community advisory board for a billion years at [local AIDS support agency], and I co-chaired it for many years. We were, like, the kitchen cabinet for the executive director. We'd come in and do stuff for staff, you know, for volunteers, you know, and like parties for the staff. I used to do staff trainings, those kinds of things. (White Reform Judaism synagogue B)

Finally, some of the cases in which congregations provided resources to an external entity included a combination of the aforementioned resource types. Typically, these interactions involved human capital-related and material resources, such as when a congregation both purchases food and participates in delivering it to local health clinic patients:

> The third Friday of the month we meet up in a kitchen that we have and we prepare sandwiches and then we take it down to the clinic and feed the people that are there sometimes all day long, waiting to see a doctor or whatever…and they get hungry. And so we feed the folks and we are one of a number of churches in the local area that feed at [local AIDS clinic]. (Mixed race Mainline Protestant church)

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Congregations' Interactions WITH External Entities

This third category of relationships accounted for 33 percent of all the interactions between our case study congregations and external entities. While the first two types of interactions involved the movement of resources from one member of the dyad to the other, in this case, resources move in both directions within the dyad, as shown below:

> [W]hen the Health Department is doing a fair or something like that, what I do is I get them [congregants] in … the backside door. I'll say [to] the Health Department, you know, "How can we help?" And they said "Oh well, you guys can serve the food." You can do this. You can do that. And so I got them [congregants] in the service end of it, where they were serving and making themselves feel good about doing it. But at the same time, here were all these speakers on STDs and all kinds of HIV stuff. … They had to listen to it, because they were there, waiting to serve the lunches. …[I]t has a dual purpose. It has the purpose where we are giving and we are getting. And I'm getting them educated. (Mixed race Non-denominational church)

> [W]e've had enough volunteers [for the HIV/AIDS clinic lunches]. A couple of months ago, a bunch of kids came from the [local seminary]. They had to do a community outreach project [a requirement that the congregation helped to fill]. And they were here that day and helped with the preparation and the serving. (Mixed race Mainline Protestant church)

We also found instances in which congregations worked with another entity – or entities – in such as way that resources flowed not within the dyad but rather to a distinct beneficiary. In the examples that follow, that beneficiary was the local community. In the first example, members of the congregation collaborated with a local community organizing network to reach out to community members potentially interested in job training for health careers, and in the second example, two churches worked together to increase the number of local men who would take advantage of a free colon cancer screening

> So we're members of [a local community organizing network]. And so we work with them and … we're going to do work in the area of health-work. We're going to meet … to talk about this, there seems to be a training opportunity for people who are able to work in health. So we're going to look for people from this community wishing to get trained and who meet the requirements for the training. … I think it will be the hospital; we're working with the hospital, with hospitals like such. We're making connections with hospitals. Here at [NAME OF CHURCH] we decided to work on health, but there is another church that decided to work on public safety, they're going to have…a training on what is public safety, maybe for people wishing to be policemen, wishing to join the police force in a certain area. So, they're also providing training … it's like helping to better the community. (Latino Roman Catholic church B)

> Regarding the health area, we have joined forces with the African-American church, [local church]. Approximately once a year, they have a program…what's it called? The test to check men for colon cancer. … a colonoscopy. So, we invite all men forty, fifty years old and above, free of charge. All of the efforts made to help them have been free. (Latino Pentecostal church)

Lastly, while many of the "resources *to*" and "resources *from*" type of interactions were simpler in nature in terms of being a one-time occurrence or closely resembling a transaction, the "interaction with" type of interaction was more often characterized by a give-and-take relationship that lasted for months or even years. For instance, in the case of the colon cancer screening cited above, two churches worked together to reach out to the

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local community – an effort we classified as an "interaction *with*" type of collaboration – but the relationship between the church and the health organization that was brought in to actually conduct the colon cancer screening was regarded as "resources *to*" type of collaboration. While not always a "partnership" in terms of shared resources, joint programming, and tight goal alignment, this third category of interactions that we documented includes exchanges, such as the ones described in the remarks that follow, that more closely resembled a truly collaborative venture between entities:

> Well, we need to be advocates when there are public policy issues. We need to be advocates for people with AIDS so that they feel part of the community. Like our friends up the street, [local congregation], are you familiar with them? We have kind of a brother/sister relationship in our congregations and we're doing-in fact, we're taking a joint trip to Israel. One of their priests and I are going to be speaking together on the panel. I was there on All Saint's Day and I preached and he comes here on Yom Kippur. I mean, there's a lot going back and forth. (White Reform Judaism synagogue B)

> [W]e are going to partner with [local church], because they contacted me. They're doing a quilt, a memorial quilt of African-Americans who have died [of AIDS]. And they're contacting ministries to see if they would want to contribute a panel or panels to their quilt. So, I'm working with them now. (African American Roman Catholic church)

We regarded this second example as an "interaction *with*" type of collaboration because there was a give-and-take type of relationship between the two congregations, one in which a lay leader from the focal church helped the second church with its efforts to add panels to its AIDS quilt. In other words, the relationship consisted of more than donating a quilt panel to the cause.

In What Types of Interactions do Congregations Engage in with Different Types of Organizations?

Table 3 provides a breakdown of how the three types of relationships described above varied by external entity. Specifically, the two rows in bold-faced font summarize the proportion of FBOs and non-FBOs for each collaboration type, and the additional rows provide comparable figures for each specific type of FBO and non-FBO. Just over half (53%) of all relationships characterized as congregations' "interactions *with*" external entities involved other FBOs, compared to 23 percent of "resources *to*" and 41 percent of "resources *from*" relationship types. Over three quarters (77%) of all relationships characterized by "resources *to*" congregations from external entities involved non-FBOs, and over half (59%) of all relationships characterized by "resources *from*" congregations to external entities involved non-FBOs, most commonly prevention and social service organizations.

In addition, each column of figures in Table 3 shows the proportion of each relationship type that was attributed to a particular type of organization. For example, 8 percent of all the interactions characterized as "resources *to*" a congregation (from an external entity) involved another congregation, while 13 percent of interactions classified as "resources *from*" a congregation to an external entity involved health care providers. Faith-based alliances accounted for the largest proportion of "interactions *with*" type of relationships (24%), other organizations (e.g., private businesses or corporations) constituted 27 percent of "resources *to*" type relationships, and prevention and social service organizations represented 41 percent of relationships involving "resources *from*" a congregation.

In sum, when looking at all the types of relationships that our case study congregations engaged in with external entities to conduct their HIV and other health activities, they

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tended to have the "richest" types of interactions with other FBOs, and engaged more with non-FBOs such as health care providers and prevention organizations to either *receive* resources from them for their congregation-based health activities or *provide* specific resources to the prevention and social service organizations' health efforts.

Discussion

Literature on the role of congregations in promoting community health has tended to focus on congregations as organization-based conduits for reaching underserved populations with health programming and to what degree these efforts have been "faith-based" (coming from within the congregation, involving the congregation in design and delivery of the intervention, and incorporating spiritual elements into the health intervention), "faith-placed" (developed and implemented solely by external entities such as researchers or health professionals) or collaborative (developed in partnerships between churches and external groups) (Campbell, et al., 2007; DeHaven, et al., 2004). What is common to all these conceptualizations of "faith-health collaboration" is the idea that congregations, as organizations, contribute to community health primarily by sponsoring, either actively or passively, congregation-based health-related activities. Along these lines, we did find many examples among our case study congregations of how their collaborative relationships with external organizations – in particular those that involved resources *to* congregations and congregations' interactions *with* external organizations – resulted in health programming for their congregants. While these examples support the common perception that congregations-based health programs often rely on goods or services from others, a novel finding regarding the role of private organizations and other non-health organizations emerged: 27% of resources *to* congregations came from a combination of businesses, universities, and nonprofits with missions less directly related to health. This finding suggests that inter-sectoral collaborations are indeed happening, and helps to define a role that for-profit companies and organizations outside the health field can play as the government increasingly relies on such interactions to support health and social services-related programs.

Further, when studying the variety of ways that congregations interact with external entities around health, we found that approximately a third of the time these relationships were characterized by resources flowing *from* congregations *to* external entities for the latter organizations' own health-related activities. Two examples of this included congregational leaders serving on community health organizations' boards and congregational volunteers providing support (financial, material, and/or human capital) to community prevention and social service agencies. Further, another third of the time these relationships were characterized by resources flowing in both directions (between congregations and external entities) in a more collaborative fashion. In other words, most of the time, our case study congregations were not passive beneficiaries of collaborations, but instead were involved actively in collaborating with external entities both to serve their own congregations and their broader communities. Accordingly, these types of relationships appear to be important ways that congregations are promoting HIV and other health issues in their communities and may be something more sustainable over time than congregation-sponsored health programming that relies heavily on externally-provided resources. As Jackson and Reddick (1999) noted, many congregations are limited in their capacity to implement and manage long-term health projects that require heavy commitments of time and resources. But many more congregations are probably able to provide specific support or resources to enhance the programming of others or collaborate with external organizations to sponsor congregation-based and community-based events. In this way, congregations not only serve as conduits for information and services directed toward their members, but are engaged actively in

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augmenting the information and services of external providers that are directed towards other community members.

When we looked at type of interaction (resources *to* congregations, resources *from* congregations, and congregations' interactions *with* external entities), we thought that their relative frequency might vary based on whether the focus of the interaction was HIV or another health issue. However, as noted earlier, we did not find differences in the frequency of interaction type when dealing with HIV compared to other health issues.

Yet, we did find that the type of external entity did vary across different types of interactions, with the "richest" types of interactions (interactions where resources flowed in both directions and/or that were more collaborative) between congregations and other FBOs. It may be that congregations are more comfortable interacting with other FBOs around health issues as compared to secular organizations, particularly if sensitivities are involved (e.g., reproductive or sexual health issues). Congregations may find it easier to partner with other FBOs who share a similar set of values. Congregations may also be exposed to and aware of fellow FBOs because they are already connected through a non-health related interaction.

It is important to note that even though 61 percent of the interactions or relationships between congregations and external entities were with non-FBOs, very few of these (6% overall or 10% of non-FBOs) were with public health departments and other government agencies. This suggests that there may be greater barriers to overcome between congregations and such entities as compared to non-governmental health care providers and prevention and social service organizations. In a national study, 83 percent of local health departments reported partnership activities with FBOs, but the most common interaction was "exchanging information," (Barnes & Curtis, 2009). While important, this is perhaps less valuable than an exchange of material or human capital-based resources like what our case study congregations reported. In a related vein, a study of local health department partnerships in one state (Wisconsin) suggested that although FBOs are examples of organizational partners that health departments are encouraged to include in public health improvement efforts, FBOs may be underutilized in such partnerships, particularly those focusing on health promotion and chronic disease prevention (Zahner & Corrado, 2004).

The results of this study shed light on a phenomenon relatively unstudied to date, namely, the detailed nature of congregations' involvement with other community entities for health-related programming that serves both congregants and the broader community. The congregations included in our case study sample proved to be a rich source of information about this topic, but as this was a non-random sample, their experiences may not be typical. Our purposive sample was designed to include congregations of various faith traditions, ethnicities, sizes, and level of HIV activity in communities highly affected by HIV (these were also lower income areas), though we did select only congregations that had some level of health activity. Additional research is required to determine whether our findings extend to other congregations based in different parts of the United States, particularly those located in non-urban areas or more conservative ones, such as the South.

We should also acknowledge that congregations provide health-related programming *without* interacting with external organizations or professionals, and these activities are not captured in the present analyses. Survey research has identified that approximately half of the congregations that do implement health programs nationally do so without collaborating with external organizations (Trinitapoli, et al., 2009). We found that approximately 40 percent of our case study congregations conducted HIV activities without external involvement, though there was a wide range in this percentage when broken down by type

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of activity (citation removed for blinding). Thus, to fully capture congregations' contribution to community health, future studies should examine congregations' health-related programming that is not done in collaboration.

Our analysis techniques had their limitations as well: given our desire to avoid double-counting specific entities, we only included named organizations and professionals in our tally of entities that with whom the case study congregations interacted. Moreover, we were unable to quantify how frequently a congregation interacted with a particular organization or to characterize the interaction in terms of its depth or quality. As noted earlier, the line of inquiry pertaining to relationships with external entities was part of a large effort with multiple research objectives, and our interview protocol did not include a detailed line of questioning that would have readily yielded such information. Our results suggest that efforts to characterize congregations' relationships with external entities for the provision of HIV and other health services and programming for congregation and community members along such dimensions would be a valuable pursuit, particularly given the somewhat surprising observation that many congregational interactions involve either their providing support to another entity, rather than receiving it, or some sort of give-and-take between entities. Such studies would help delineate further to what degree congregations can be seen as part of the constellation of non-profits or community-based organizations in a given community. In many minority communities, congregations are often not merely voluntary associations but rather pivotal social institutions, and are therefore integral to the well-being of the communities they serve.

Current trends involving the devolution of government programs towards the private and nonprofit sectors have increased reliance on inter-sectoral collaborations—networks, alliances, or partnerships among public, secular, faith-based nonprofits and for-profit organizations (Graddy & Chen, 2006). At the same time, there is increased interest in the role that congregations play and can play in community-based health promotion, particularly in collaboration with public health and health care providers (Center for Disease Control and Prevention, 2008; Koenig, 2003). Understanding the full range of ways that congregations currently interact with other community organizations for health-related activities can suggest avenues for scaling up these efforts and will likely provide a better accounting than in the past of the resources needed to sustain such initiatives.

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Table 1

Congregation and Interview Participant Characteristics

Congregations (*n*=14)	**Number**
Predominant race/ethnicity[a]	
African American	6
Latino	4
White	2
Mixed	2
Congregation size[b]	
Large (501 members)	6
Medium (151–500 members)	5
Small (150 members)	3
Denomination	
Evangelical/Pentecostal/Non-denominational	4
Mainline Protestant	4
Catholic	3
Jewish (Reform)	2
Baptist	1
HIV activity level[c]	
High	6
Medium	4
Low	4
Interview Participants (*n*=57)	**Number**
Race/ethnicity	
African American	22
White	18
Latino	15
Asian	1
Other	1
Gender	
Male	30
Female	27
Role	
Lay	35
Clergy	22

[a]The predominant race/ethnicity comprises 70% of regular participants (except for "mixed").

[b]Measured in terms of regularly attending congregational participants.

[c] *Low* activity congregations reported activities that were infrequent or not targeted specifically to HIV (e.g., food bank); *Medium* activity congregations reported activities that were more frequent and targeted to HIV but still an extension of what congregations already do (e.g., pastoral care); *High* activity congregations reported frequent and targeted HIV/AIDS activities, and included multiple types of activities that are beyond what congregations traditionally do (e.g., HIV testing).

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Table 2

Types of External Entities that Congregations Collaborated with for HIV and Other Health Activities (n=147)

Type of External Entities	Percentage of All External Entities
Non-faith-based Organization	**61%**
Prevention & social service organizations	24%
Health care providers [a]	16%
Other	15%
Public health departments & other govt. agencies	6%
Faith-based Organization (FBO)	**39%**
Congregations	15%
Faith-based alliances	11%
Other types of FBO	10%
Faith-based health care providers	3%
TOTAL	100%

[a]This category also includes a charitable foundation that primarily funds community health services.

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Table 3

Types of Relationships for HIV and Other Health Activities by Types of External Entities

	Resources TO Congregations from External Entities (N=62)	Resources FROM Congregations to External Entities (N=56)	Congregations' Interactions WITH External Entities (N=59)
Non-faith-based Organization	**77%**	**59%**	**48%**
Health care providers	18%	13%	17%
Prevention & social service organizations	19%	41%	17%
Public health departments & other govt. agencies	13%	0%	7%
Other	27%	5%	7%
Faith-based Organization (FBO)	**23%**	**41%**	**53%**
Congregations	8%	11%	19%
Faith-based alliances	6%	5%	24%
Faith-based health care providers	2%	9%	5%
Other type of FBOs	6%	16%	5%
TOTAL	**100%**	**100%**	**100%**