
Pastors' Wives as Partners: An Appropriate Model for Church-Based Health Promotion

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Introduction

Church communities are increasingly recognized as promising venues to reach African Americans regarding health matters. The church has been a pillar of strength and empowerment in the African American community since slavery, acting as the center for education, business, political activism, and religious exhortation.¹ Because church pastors are respected gatekeepers, they are particularly well-suited for organizing and stimulating change among African Americans. Thus, it is essential to engage pastors in health disparities research efforts. Engagement of pastors alone, however, without recognizing the significant influence of pastors' wives, may result in missed opportunities for intervention with African Americans, especially women.

The role of the pastor's wife in the African American church has remained unrecognized despite the severity of health disparities among African American women, and further, the centrality of pastors' wives as change agents. In this paper, we present a church-based educational intervention, Project Sisters in the Spirit (SIS). Following a mixed-methods design, Project SIS was implemented to assess (1) the feasibility of a scripture-based educational intervention aimed at improving breast cancer screening among African American women, including lay church women and both pastors' and deacons' wives, and (2) the receptivity of lay church women to pastors' and deacons' wives as lay health educators. Findings suggest that engagement of and partnership with the pastor's wife may be the appropriate model for church-based health promotion among African American women.

Background

Breast Cancer Screening Efforts in Church Settings

Over the past decade, a growing body of research has documented the relationship between religiosity and health

outcomes among African Americans, with several studies reporting overall positive results for church-based programs aimed at improving self-care health practices, including cancer screening.²⁻¹² Although this topic has not been studied extensively, several investigations have shown that church-based interventions are particularly effective in increasing the number of African American women who screen regularly for breast cancer.^{2,3,13}

Erwin et al¹³ partnered with breast cancer survivors to deliver a community-based educational program to churchgoing African American women, using a quasi-experimental pretest and posttest design. The intervention incorporated spirituality, faith, and witnessing (an African American church tradition) to highlight the importance of early detection and treatment to improve chances of survival. Participants receiving the intervention reported significant increases in the practice of breast self-examination (82.0% vs 69.8%) and mammography (64.4% vs 52.4%) compared with participants in the control group. In another study testing the effect of church-based telephone counseling at promoting annual mammography screening adherence,² findings indicated that the telephone counseling intervention maintained mammography adherence among baseline-adherent participants and reduced the non-adherence rate from 23% to 16%.

Moreover, in studies in which churchgoers were non-adherent with cancer screening before intervention, results have been similar. For example, Mann and colleagues³ promoted cancer screening in church congregations through literature, health fairs, testimonials by cancer survivors, and visits by medical practitioners. At baseline, participants reported up-to-date screening for breast cancer (84%), cervical cancer (78%), colon cancer (62%), and prostate cancer (89%). Nearly 50% of participants who were non-adherent for at least one cancer screening at baseline reported up-to-date screening at 7-month follow-up.

Partnering with Pastors' Wives

Although the level of pastoral involvement in these interventional studies was not documented, other research findings indicate that pastors often play pivotal roles in the success of church-based health promotion programs.^{14,15} Yet, due to the complexities of their multiple community roles and responsibilities, pastors may be constrained in their level of engagement in church-based health programs. Recent findings suggest that pastors face considerable demands that often impede program success and sustainability.¹⁶ Furthermore, Ammerman et al¹⁷ concluded that future church-based health promotion programs should ideally reduce the burden of projects on pastors by working with pastoral delegates or lay church leaders such as pastors' wives.

Pastors' wives are highly influential, esteemed, and recognized figures in their respective communities. As such, the public modeling of the pastor's wife as the "first lady of the church" is expected to help cultivate healthy

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relationships with women congregants and connect for gender bonding as well as spiritual guidance. According to Patricia Watson, wife and co-pastor to Pastor Thomas B. Watson in New Orleans, Louisiana, women dominate African American church attendance and serve in a variety of roles including ordained and appointed leadership positions (oral communication, February 2005, Watson Memorial Teaching Ministries). In some religious denominations, women have their own departments or ministries within the church and have strong alliances among themselves and with the pastor's wife, who traditionally heads the ministry for women.

Generally, the work of the pastor's wife is multifaceted and extends beyond her local church building. In some cases, pastors' wives can reach thousands, perhaps millions of women and their families. Since the televised ministry debuts of Juanita Bynum-Weeks, Joyce Meyers, and Paula White in the early 1990s, the number of conferences, books, and organizations spearheaded by pastors' wives, both nationally and internationally, has significantly increased. For example, Vanessa Long, wife of Bishop Eddie Long, heads the Heart to Heart women's ministry at New Birth Missionary Baptist Church in Atlanta, Georgia, where membership exceeds 20,000 people. Among her many community activities, Long coordinates the Heart to Heart 5K Walk/Run for cancer survivorship, which drew over 6,000 survivors and supporters in 2004. Similarly, in much smaller congregations, pastors' wives have profound influence among their constituents and may contribute significantly to future efforts to reduce health disparities among African Americans.

Methods

Project SIS, funded by the Association of Teachers of Preventive Medicine and the Centers for Disease Control and Prevention, was a 6-month pilot study. Using a mixed-methods design, the study quantitatively examined breast cancer screening behaviors among lay church women and qualitatively assessed their attitudes about health education delivered by pastors' and deacons' wives.

Study Design and Measures

To conduct this mixed-methods study, a pretest and posttest survey design was used to measure breast cancer screening behaviors. The survey instrument combined selected close-ended items from the Behavioral Risk Factor Surveillance Survey,¹⁸ a modified version of an instrument used by Champion and Scott,¹⁹ as well as newly developed items.

Thirty-eight newly developed items elicited data related to the respondents' relationship with God, their pastor, their pastor's wife, and other women in the church. The remaining items consisted of questions that elicited Likert-scale responses regarding breast cancer screening. Sever-

al steps were taken to establish validity and to address the potential weaknesses of using this combined survey measure. Preliminary versions of the survey instrument were pretested and followed by in-depth interviews with seven pastors' and deacons' wives in a similar church setting. The results of the interviews led to further revisions to the survey. The reliability and validity of the revised survey was evaluated using test-retest correlation, Cronbach's alpha, and factor analysis, respectively.

Additionally, qualitative data were collected using an open-ended interview guide that was designed to capture information about specific issues related to program feasibility. By looking in-depth at the opinions of women regarding health education led by pastors' and deacons' wives, we identified several strategies that could be useful to researchers interested in partnering with pastors' wives for church-based health promotion.

Participant Recruitment

To facilitate participant recruitment, the church liaison for the Jefferson County Department of Public Health identified two African American churches fitting the study inclusion criteria and arranged telephone and face-to-face meetings with designated church leaders to generate their interest and support. The church leaders were then responsible for garnering the support of their respective pastors. Both churches expressed interest in participating; only one participated in the program. The second church did not complete study-related paperwork within the time required for participation. The participating church leader, who was also a deacon and the coordinator for the health ministry, then recruited 39 women to take part in the pilot program using targeted messages delivered via pastoral announcements, solicitations by the investigator, and printed materials. Thirty-two women consented to participate in the program.

Procedures

The investigator, in collaboration with the church leader and the public health department liaison, developed a scripture-based breast cancer education curriculum to be piloted as a part of Project SIS. This six-unit curriculum was designed to use scripture as a framework for understanding the importance of breast cancer screening. The curriculum was designed for delivery in conjunction with ongoing health ministry and women's fellowship activities.

Data Collection

The program was delivered by the investigator at Sardis Baptist Church in Birmingham, Alabama. The participants completed the informed consent process, which involved an orientation session where consent forms were signed and the pretest surveys were completed. The participants then attended six 2-hour educational sessions that mim-

icked women's bible study. The sessions were offered on Tuesday evenings for 6 consecutive weeks, with catered meals provided at no cost to participants. The weekly sessions included testimonials by Christian breast cancer survivors, breast self-examination lessons, and weekly prayer and scripture meditation. After completing the educational program, participants were honored in a culminating banquet and celebratory worship service at the church. Spouses of the participants, including the pastor and associate ministers and deacons, attended this service and offered reflections per stories shared by their wives.

Posttest surveys were administered at the end of the program, and certificates of completion and monetary incentives were provided to participants. As part of a process evaluation, qualitative interview data were collected to evaluate the feasibility of engaging pastors' wives in church-based health promotion. After the program, participants requested that the program continue and received the support of the pastor and his wife. The pastor's wife and six other women volunteered to act as lay health educators.

Data Analysis

All quantitative analyses were performed using the SPSS statistical program (SPSS Inc, Chicago, Ill) and a cross-checked double data entry system. Analysis of the quantitative items consisted of frequencies and central tendencies. A frequency distribution showed how similar the responses were in regards to their screening behaviors. Comparisons of the demographic characteristics and screening behaviors were analyzed using chi-square and *t* tests. Changes from baseline to follow-up were examined within each group using the McNemar's Test for Paired Data.

Qualitative responses were analyzed using content analysis processes to identify common themes. First, inductive analysis was used, with patterns, themes, and categories emerging from the data. To maintain the truth value of the data, two investigators developed systematic open-coding schemes independently; then, both schemes were compared for similarities and differences. After convergence and divergence were analyzed, a level of reliability was determined by measuring the coded data for inter-coder agreement for the extent to which the two coders assigned the same code to each theme, thus allowing salient themes to be identified for this paper.

Results

Participant Characteristics

Demographically, the convenience sample ($n = 32$) included 3 pastors' wives (9%), 6 deacons' wives (18%), and 23 lay church women (73%) from metropolitan Birmingham, Alabama, who self-reported their practice of breast self-examination and mammography. All participants in the sam-

ple were premenopausal or postmenopausal with no prior or suspected invasive breast cancer of any type, and they ranged in age from 28 years to 72 years. Most were married (75%) and employed for wages (81%). Of the 28 participants who reported some formal college education, 19 had completed at least 4 years of college. Sixteen participants reported annual incomes of \$75,000 or more, and 13 (40%) reported between \$30,000 and \$60,000. All participants reported having health insurance.

Breast Cancer Screening

Participants reported a significant increase from baseline to follow-up in the proportion of women claiming to practice breast self-examination within the past month (68% vs 100%, $P < .0005$). Most women over 40 years of age (53%) indicated that they had performed breast self-examination within the last month; 100% indicated having had a mammogram within the past 2 years.

Feasibility of Engaging Pastors' Wives

Survey items and interview questions were specifically designed to explore respondents' relationships with God, their pastors, their pastors' wives, and other women congregants. All respondents indicated that they have a meaningful relationship with God and consider their church an extension of themselves and their families. Most women reported that the church influences them in many areas of their lives (88%); however, fewer than 70% indicated that the church influences attitudes and behaviors related to health. All respondents reported belief in the Bible proverb that "the body is the temple of God," while 40% indicated that they do not treat their bodies as if they belong to God.

All respondents indicated that they would see a physician for mammography if instructed by their pastors. Likewise, 100% indicated that they would follow the instructions of a pastor's or deacon's wife regarding this same matter. Regarding sources for health education in the church, nearly 95% of study participants reported that they get ideas regarding health from other women in the church. Similarly, over 80% indicated that they take advice about health care and screening from the pastor's wife. Furthermore, qualitative data revealed that lay church women rely on the pastor's wife for direction and insight regarding a variety of issues including beauty and image, job-related matters, and family dynamics.

Study Limitations

This pilot study included a small convenience sample composed of African American women attending a traditional Baptist church in the Bible Belt; thus, generalizability of the findings is limited. Nevertheless, the findings offer at least suggestive evidence indicating that engagement of and partnership with the pastor's wife may be the appropriate model for church-based health promotion,

Strategies for Partnering With Pastors' Wives

- Consider that not all pastors' wives are extensively involved in church; some are simply support to their husbands and assume no obligation to the church.
- Be aware of the specific role and associated responsibilities the pastor's wife may assume in church ministry. Health promotion activities may be beyond her scope and/or interests.
- Ascertain details about how well the pastor's wife relates with other women in the church, recognizing that she can be one of the most respected women in the African American church and community.
- Show consideration for the pastor's ultimate decision-making responsibility by deferring to him on issues beyond the wife's capacity.
- Augment the program plan with appropriate strategies to address the aforementioned issues.

especially among African American women. Another limitation associated with the small sample size, religious denomination, and geographic location is that the findings may not reflect perspectives of other women from other religious backgrounds living in diverse regions of the United States. Moreover, close-ended surveys that elicit limited response options may affect the interpretation of data. To address this limitation, data retrieved from in-depth interviews were composed of detailed discussion and probing of the phenomenon under investigation.

Discussion and Implications

Current models of church-based health promotion have relied on the pastor as the conduit for generating interest and involvement in projects as well as coordinating routine program activities. Although recent literature suggests that pastors are overcome by their many responsibilities as church leaders and community activists, no published studies have considered the pastor's wife as an essential partner in the promotion of health behavior change. This research, in concert with previous investigations, supports the notion that the church is a trusted social institution within the African American community and highlights the inherent strength of the relationship between pastors' wives and lay church women. As such, research institutions and healthcare providers can collaborate with pastors' wives to better understand ways to align their unique assets to positively influence health behaviors and reduce morbidity and mortality rates.

Along with the many benefits, there are potential challenges associated with partnering with pastors' wives, specifically, interpersonal and theological. Interpersonal challenges are associated with negative relationships that may exist between pastors' wives and lay church women. Interestingly, pastors' wives themselves expressed the need to address personal issues with women within their churches before they could lead any church-based activity, especially if they had not previously led a ministry or organized meeting with women congregants. According to qualitative data from this study, theological challenges include the perceptions by many that (1) the pastor's wife

should be someone who is less vocal and active, (2) the position of pastor's wife should be separate from that of pastor or teacher, and, (3) formal coursework or training in religion is required for leadership in the church setting.

Based on conclusions drawn from the qualitative data analysis, we suggest strategies that could be useful to researchers interested in partnering with pastors' wives for church-based health promotion (Table). Although pastors' wives in this study were amenable to an educational intervention that required their presence and involvement, not all pastors' wives will be as inviting or interested in health-promoting activities. Researchers in church-based health promotion must be able to (1) assess the general level of involvement by the pastor's wife in the local church, (2) have a good understanding of her defined role and responsibility in ministry, (3) determine personality and other leadership factors that may constrain relationships between the pastor's wife and lay church women, and (4) develop an appropriate approach for addressing these important issues so that public health objectives can be efficiently and effectively met.

In addition, researchers should respect the role of the chief administrator — the pastor. While many pastors' wives function in leadership roles, they do not have the ultimate decision-making power for the church. Therefore, the importance of the pastors' support and approval cannot be overstated. This model could have significant implications for research and more optimal targeting of health promotion activities to African Americans.

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References

1. Lincoln CE, Mamiya LH. *Black Church in the African American Experience*. Durham, NC: Duke University Press; 1990.
2. Duan N, Fox S, Derose KP, et al. Maintaining mammography adherence through telephone counseling in a church-based trial. *Am J Public Health*. 2000;90:1468-1471.
3. Mann BD, Sherman L, Clayton C, et al. Screening to the converted: an educational intervention in African American churches. *J Cancer Educ*. 2000;15:46-50.

4. McNabb W, Quinn M, Kerver J, et al. The PATHWAYS church-based weight loss program for urban African-American women at risk for diabetes. *Diabetes Care*. 1997;20:1518-1523.
5. Oexmann MJ, Ascanio R, Egan BM. Efficacy of a church-based intervention on cardiovascular risk reduction. *Ethn Dis*. 2001;11:817-822.
6. Peterson JA, Yates BC, Atwood JR, et al. Effects of a physical activity intervention for women. *West J Nurs Res*. 2005;27:93-110.
7. Schorling JB, Roach J, Siegel M, et al. A trial of church-based smoking cessation interventions for rural African Americans. *Prev Med*. 1997;26:92-101.
8. Smith ED, Merritt SL, Patel MK. Church-based education: an outreach program for African Americans with hypertension. *Ethn Health*. 1997;2:243-253.
9. Turner LW, Sutherland M, Harris GJ, et al. Cardiovascular health promotion in north Florida African-American churches. *Health Values*. 1995;19:3-9.
10. Voorhees CC, Stillman FA, Swank RT, et al. Heart, body, and soul: impact of church-based smoking cessation interventions on readiness to quit. *Prev Med*. 1996;25:277-285.
11. Weinrich S, Holdford D, Boyd M, et al. Prostate cancer education in African American churches. *Public Health Nurs*. 1998;15:188-195.
12. Yanek LR, Becker DM, Moy TF, et al. Project Joy: faith based cardiovascular health promotion for African American women. *Public Health Rep*. 2001;116(suppl 1):68-81.
13. Erwin DO, Spatz TS, Stotts RC, et al. Increasing mammography practice by African American women. *Cancer Pract*. 1999;7:78-85.
14. Taylor RJ, Ellison CG, Chatters LM, et al. Mental health services in faith communities: the role of clergy in black churches. *Soc Work*. 2000;45:73-87.
15. Levin J. Roles for the black pastor in preventive medicine. *Pastoral Psychol*. 1986;35:94-103.
16. Markens S, Fox SA, Taub B, et al. Role of black churches in health promotion programs: lessons from the Los Angeles Mammography Promotion in Churches Program. *Am J Public Health*. 2002;92:805-810.
17. Ammerman A, Corbie-Smith G, St George DM, et al. Research expectations among African American church leaders in the PRAISE! Project: a randomized trial guided by community-based participatory research. *Am J Public Health*. 2003;93:1720-1727.
18. Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Questionnaire*. Atlanta, Ga: US Dept of Health and Human Services, Centers for Disease Control and Prevention; 2002. Available at: <http://www.cdc.gov/brfss/index.htm>. Accessed on July 5, 2005.
19. Champion VL, Scott CR. Reliability and validity of breast cancer screening beliefs scales in African American women. *Nurs Res*. 1997;46:331-337.