

## The Role of Faith-Based Institutions in Addressing Health Disparities: A Case Study of an Initiative in the Southwest Bronx

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**Abstract:** Although many public health initiatives have been implemented through collaborations with faith-based institutions, little is known about best practices for developing such programs. Using a community-based participatory approach, this case study examines the implementation of an initiative in the Bronx, New York, that is designed to educate community members about health promotion and disease management and to mobilize church members to seek equal access to health care services. The study used qualitative methods, including the collaborative development of a logic model for the initiative, focus groups, interviews, analysis of program reports, and participant observation. The paper examines three key aspects of the initiative's implementation: (1) the engagement of the church leadership; (2) the use of church structures as venues for education and intervention; and (3) changes in church policies. Key findings include the importance of pre-existing relationships within the community and the prominent agenda-setting role played by key pastors, and the strength of the Coalition's dual focus on health behaviors and health disparities. Given the churches' demonstrated ability to pull people together, to motivate and to inspire, there is great potential for faith-based interventions, and models developed through such interventions, to address health disparities.

**Key words:** Collaboration, faith-based initiatives, health disparities, community-based participatory research.

**A**s part of a national effort to help reduce racial and ethnic disparities in health, the Centers for Disease Control and Prevention has funded an effort in the southwest Bronx, led by the Institute for Urban Family Health, to reduce morbidity

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and mortality resulting from diabetes and related cardiovascular disease.\* Racial and ethnic disparities in the prevalence, morbidity, and mortality of diabetes have been well documented nationally.<sup>1-2</sup> In this predominantly minority community in the Bronx, the mortality rate for diabetes for women ages 18 to 64 is 20 times higher than in the predominantly White Upper East Side of Manhattan, a ten-minute subway ride away.<sup>3</sup>

The Coalition that formed to carry out this initiative in 2001, Bronx Health REACH, comprises a wide array of 40 community-based organizations. Its initiatives include a nutrition and fitness program, a faith-based outreach program, a training program for community health advocates, a public education and mobilization campaign, and a legal and regulatory agenda.<sup>4</sup> From the early planning stages, the Coalition, like many community-based health education efforts, looked to religious institutions to provide access to at-risk populations and social and emotional support for behavior change.<sup>5-17</sup> In addition, the churches were viewed as potential leaders in the effort to address racial and ethnic disparities in access to care, given the long history of African American and Latino churches in spearheading efforts for social equality and justice.

The 14 churches that participate in the Coalition's efforts have a total of about 4,000 active church members. The churches range in size from 20 members to over 1,500. Several are affiliated with larger umbrella organizations that have other members in the Bronx and elsewhere. Seven of the churches are Evangelical, 4 are Baptist, 1 is Episcopalian, 1 is Seventh Day Adventist, and 1 is Catholic.

Each church is given \$3,000 annually to help defray the costs of participation, and each selects a church member to serve as the *faith-based coordinator* for project. The coordinators provide quarterly reports on their church's activities (listing the number and kinds of events held, number of people attending, materials distributed) and meet monthly to plan events, to receive information, and to share insights. At these meetings, members of the Coalition staff or outside experts present information on diabetes, health insurance coverage, health disparities, and nutrition. In most cases, the coordinator is a volunteer who is paid a small stipend; two are employed by the churches that they represent.

The Coalition's Faith-Based Initiative has two complementary goals: (1) to use the capacity and resources of local faith-based institutions to change the knowledge, attitudes, and behavior of community members concerning health promotion, disease management, and navigation of the health care system; and (2) to mobilize clergy and church members to seek changes in law, regulation, and policy to eliminate discrimination and promote equal access to care. By linking more traditional faith-based health education and behavior change strategies with programming

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\* This community comprises four contiguous ZIP codes (10452, 10453, 10456, and 10457), and includes the neighborhoods of Highbridge, Morrisania, West Tremont, and Morris Heights. The population is approximately 270,000, more than 95% of whom are Black or Hispanic. The Institute for Urban Family Health runs 13 health centers, 4 of which are located in the Bronx, and 9 health care sites for the homeless throughout the Bronx and Manhattan.

to educate those at risk for discriminatory treatment about systemic barriers to care, the Coalition seeks to address multiple causes of health disparities. This case study describes how the Bronx Health REACH churches have been mobilized, and identifies the factors that have facilitated the work of the Faith-Based Initiative, as well as the barriers that have been encountered and lessons learned.

## Methods

This study of the Faith-Based Initiative is a part of a larger evaluation of the Coalition's work.<sup>18–20</sup> As with the other components of the evaluation, this case study used a community-based participatory approach.<sup>18,21–24</sup> The Coalition leadership and the faith-based leaders and coordinators participated in framing the questions, collecting the data, reviewing the findings and drafts of this paper, and identifying the next steps for understanding and strengthening the initiative's effectiveness. Institutional review board approval for the evaluation was obtained from both New York University and the Institute for Urban Family Health.

The evaluation team, working with the Coalition's leadership and the faith-based coordinators, began with, and then periodically returned to, the use of a detailed logic model to understand the theory that guided the design and development of the Faith-Based Initiative.<sup>23–25</sup> To understand the implementation and evolution of the Faith-Based Initiative, the evaluators held a 2-hour focus group with all 14 of the faith-based coordinators, and conducted a total of 15 in-depth interviews with 11 key participants, including several interviews with the leadership and senior staff of the Coalition, and on-site, one-on-one interviews with 3 of the pastors and 3 of the faith-based coordinators. The evaluation team used semi-structured interview protocols to collect data on topics relating to the purpose, structure, role, accomplishments, challenges, and sustainability of the effort.

The evaluation team also reviewed program data collected on a routine, but somewhat irregular, reporting basis from the participating churches, as well as materials distributed by the churches, including flyers and articles in the church bulletins. In addition, the evaluators administered a brief resource survey to participating pastors in order to understand the membership and structure of the churches.

Throughout the five years of the initiative, the evaluation team observed and participated in the quarterly Coalition and subcommittee meetings, the monthly meetings of the faith-based coordinators, pastors' breakfasts, and faith-based events. A draft of this paper was presented for review and comment to the Coalition leadership and to members of the Faith-Based Initiative at a monthly coordinators' meeting. We also shared a draft with and received comments from all of the lay leaders and pastors who were interviewed. Insights gathered from all of these processes were incorporated into the final paper.

## Results

Our findings relate to three key aspects of the program's implementation: (1) the recruitment and engagement of the church leadership; (2) the use of existing church

structures as venues for education and intervention; and (3) changes in church policies and practices. Each of these is discussed below.

**Recruiting and engaging the church leadership.** In the planning stages of the REACH Coalition, the Institute for Urban Family Health, the lead agency in the Coalition, recruited one of their long-time community partners, Joyce Davis, to conduct focus groups, help shape the intervention, and then direct the Faith-Based Initiative. Ms. Davis, a well-known and respected lay leader of one of the Coalition churches and a charismatic presence in the community, served as a knowledgeable guide and liaison to the community. It was Ms. Davis who recognized the need for strong clergy leadership.<sup>14,28-29</sup> As she stated, “It must be the pastors who take the lead. The pulpit is raised up literally and figuratively—that word comes from a higher place.” It was she who identified the pastor to head the Faith-Based Initiative, Reverend Robert Lewis Foley of the Cosmopolitan Church of the Lord Jesus Christ, who has a long history of civil rights activism. She also recruited into active leadership her own pastor, the Reverend Dr. Joe Albert Bush of the Walker Memorial Baptist Church. Pastors Foley and Bush, in turn, used their connections to identify and recruit other pastors who they thought would be responsive.

These pastors have maintained and strengthened their leadership of the Faith-Based Initiative in part because the Coalition leaders and staff have recognized and deferred to their political savvy and to their experience in community organizing. From the beginning, the pastors and the faith-based coordinators were asked to create and direct the intervention, not simply to participate in a prescribed set of activities. For example, in setting the agenda for a community-wide, faith-based event, the Project Director (C.R.) initially envisioned a corporate-style program, with tightly structured presentations. She realized, however, that the pastors had a different vision of the event. With her support, the lead pastors designed the *Call to Action*: a religious service about health and health disparities attended by more than 600 people from 15 congregations, with music, singing, testimonies, and preaching. The pastors’ ability to convene large groups of people, which was demonstrated early on, gave them a powerful position as Coalition leaders.

The Faith-Based Initiative’s dual focus, on health education and behavior on the one hand, and disparities and discrimination on the other, proved to be a powerful combination in attracting and maintaining the commitment of the pastors. For a number of the pastors, exposure to the issue of racial and ethnic disparities in health has been, as Reverend Foley put it, “an illumination,” providing information and a perspective that resonated with their personal concerns and served to validate their own experiences of injustice.<sup>8</sup> Several see the issue of health equality in political terms, as “the next phase in the civil rights movement” or related to “Catholic social gospel that fostered political action in the 1960s.” As a result, the pastors became the driving force behind the Coalition’s Action Committee, which sponsored and organized the Call to Action and subsequently led a 500-person trip to Albany to propose a comprehensive legislative agenda.<sup>4</sup>

In explaining their commitment to the Faith-Based Initiative, some pastors and coordinators emphasize these political activities; others focus on the Coalition’s health messages. Indeed, many of the church leaders see a strong link between

religion and healing<sup>10</sup> and view health promotion as a core tenet of their church's mission. As one pastor stated, "We can't separate our Christian lives from how we treat our bodies." Initially, the health education materials provided by the Coalition were devoid of religious content. The pastors and coordinators identified this as a missing element. The theme of the "body as the temple of the Lord" has emerged in sermons, written materials, prayers that begin meetings, and conversations with the participants.

Another element in maintaining the involvement of church leaders has been the personal commitment of the Coalition staff and leaders to the initiative and their efforts to foster and nurture relationships with individual pastors and lay leaders. Although the Institute for Urban Family Health had previously worked with only one of the participating churches, the Institute and its senior staff came to the initiative with credibility and a track record from long-standing and productive relationships with many community-based organizations in the neighborhood. One of the pastors explained that he initially became interested in the Coalition's work because, he recognized the Institute's leader as "a man on a mission." Similarly, the Coalition Project Director has invested a tremendous amount of time in building and sustaining her relationships with individual pastors, by speaking at church and religious society events (often in the evening and on weekends), and attending ceremonial occasions. Other researchers have suggested that demonstrating respect for church priorities and donating time to a church cause is helpful in fostering trust between the health professionals and the church leaders.<sup>10</sup> These elements have been critical in keeping the pastors active and engaged in the Coalition's Faith-Based Initiative.

**Using existing church structures and approaches.** Researchers have noted that many churches have organizational structures and communications systems that can be used to implement health programs or transmit health messages.<sup>14</sup> Of the 11 churches responding to the resource survey, all have ministries or auxiliaries.

Many of the coordinators have been able to use these structures for their outreach and educational programs. For example, one coordinator has implemented the Coalition's after-school nutrition curriculum in the weekly girls club meeting. Another has integrated diabetes education and information about racial disparities into the Christian Brothers Fellowship. Another coordinator has added a nutrition component to the church's gospel aerobics class.

Existing church structures have also proved to be useful for individual outreach. All of the participating churches have *class* or *contact leaders*. These are lay leaders who keep an eye out for problems among an assigned group of congregants, periodically contacting them and following up if someone has been absent from church. Through these lay leaders, coordinators have identified diabetic shut-ins, people who rarely leave their homes because of illness. Some coordinators have made house calls to provide nutrition counseling; others have sought to refer people to the Coalition's community health advocates or to other services.

Church events of all kinds, as well as newsletters and bulletin boards, have provided an opportunity to distribute materials about diabetes.<sup>10</sup> In addition, two of the pastors have religiously-oriented radio programs, which the Coalition

has used to disseminate information and foster discussion about the causes and consequences of racial and ethnic disparities in health access and outcomes, and to publicize Bronx Health REACH events.

The churches also have a strong ethos and structure that supports community service and volunteerism.<sup>10</sup> As one coordinator said in describing her efforts to improve the health of her fellow parishioners, “Next to saving souls, it’s right up there with it.” Another man stated, “This is my ministry.”

**Changing church policies and practices.** Several of the churches have made fairly significant changes to their policies and practices as a result of their participation in the Faith-Based Initiative. For example, two of the pastors routinely incorporate health messages into their weekly sermons, and all of the churches include clippings and other health-related materials (some provided by the Coalition and some from other sources) in the weekly church bulletins.<sup>†</sup>

One of the most pervasive changes has been in the food served at church events. Early on, one coordinator described the typical menu at a breakfast held to discuss diabetes: “grits and sausage, and bacon.” At first, even the leading pastors were skeptical about ability of the coordinators to prepare healthy and tasty food, and reluctant to take on this issue. Recognizing that they needed to win over the pastors, the coordinators held a taste-test in which traditional recipes were prepared in a healthy manner. The pastors’ initial reluctance, followed by their dramatic conversion, had a slightly scripted quality to it, which seemed deliberately designed to model the behavior change they sought to encourage within their congregations.

Now, nine culinary committees meet monthly to learn how to cook with less salt and fat, how to modify recipes, and how to prepare healthy and tasty vegetables. Several of the churches are tackling the problem of how to ensure that the culinary committees are part of the menu planning process for events sponsored by other ministries. As one key coordinator explained, “We need to provide them with enough information and authority so that they can defend their position about healthy food preparation.”

Through the Coalition’s nutrition education, several of the coordinators realized that the food provided by their food pantry was inappropriate for the chronically ill. One coordinator noted that she and the church’s pastor are “trying very hard to get the right kind of foods from the food bank because the elderly come, and we talk to them about nutrition, and then we give them the wrong things.” Another coordinator has worked with United Way to learn how to run a food pantry that meets the needs of people with different medical conditions.

## Conclusions

This case study of the Bronx Health REACH Faith-Based Initiative has several limitations. First, although our observations are supported by studies of other faith-based programs, our focus on one initiative in one neighborhood may, to

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<sup>†</sup> For example, in 2003 and 2004, during National Nutrition Month (March) and National Diabetes Month (November), 4,000 church bulletins inserts were distributed each week.

some extent, limit the generalizability of our insights. In addition, research suggests that certain characteristics of churches, such as congregation size and the education levels of ministers, are associated with involvement in health outreach programs.<sup>5,8</sup> Here, we looked at the initiative as a whole, without trying to understand how the different characteristics of the churches might have affected their participation. Third, we have not yet collected data on program impact. Although we have heard from the pastors and coordinators numerous stories of church members who have become much more knowledgeable about nutrition and who are taking a more active role in addressing their health care needs, we have not collected individual level data that would support these observations or call them into question. We are now undertaking a survey of parishioners to assess such changes, which we will continue to measure as the program expands.

Despite these limitations, we believe that we have learned important lessons through the Faith-Based Initiative that may be of use to others.

First, the recruitment of a trusted and well-connected community leader to spearhead the effort and to serve as part of the Coalition leadership was vitally important and was only possible because the lead agency had a successful track record in the community. Because the Coalition's leadership included people who already were well known and well regarded in the community, there was a platform of mutual trust upon which to build.

Second, the pastors and the coordinators were intimately involved in designing the initiative, and have continued to help shape its direction. This has been important for several reasons. First, it has meant that participants feel responsible for the program's success. Throughout the implementation of the initiative, both the pastors and the coordinators have made suggestions about how to improve its effectiveness. The coordinators, as the Coalition's eyes and ears in the community, share their insights at their monthly meetings. Their findings serve as an informal needs assessment and feedback loop. In addition, the collaborative approach allowed the churches to shape the initiative in a way that reinforced their institutional goals and was in keeping with their operational style. This was evident, for example, in the decision to infuse the initiative's health messages with more religious content.<sup>30</sup> Finally, their role in the initiative meant that the faith-based leaders were committed to a set of *goals*, rather than to the implementation of a defined program. This allowed program implementation to spill over into institutional change, blurring the line between the two. For example, neither the Coalition staff nor the faith-based leadership is quite sure whether the work of the nine culinary committees is part of a funded Coalition activity or a change in policy and practice that grew organically out of it.

Third, from the start, faith-based leaders were valued as powerful and respected resources. Others have written about the "dual system of identity in black communities,"<sup>12</sup> with one set of identities ascribed by society and an alternative set conferred by the church, which offers leadership opportunities and positions of authority. It was this latter status that defined the roles of the faith-based leaders within the Coalition. Indeed, to some extent, their participation in the Faith-Based Initiative allowed several of the faith-based leaders to translate this status into the

wider world. Many of the pastors already were active in the political arena, but this initiative allowed several of the pastors and coordinators to assume broader leadership roles by setting the agenda of the larger Coalition and by working at the city, state, and national levels to promote health equality. Several of the pastors and coordinators have been invited to participate in other health-related initiatives or events (for example, those sponsored by the American Diabetes Association and the American Heart Association). Several have become spokespersons on the issue of health disparities, bringing this perspective to other activities, including leadership of local and national associations of religious leaders, and, in one case, the community board of a hospital.

Fourth, the Coalition's dual agenda—promoting healthy behaviors and advocating equal access to care—galvanized support and interest among a wide array of partners. It is often assumed that coalitions work best when the partners are 'on the same page' and motivated by the same objectives. Yet our work with the Bronx Health REACH Coalition in general, and with the Faith-Based Initiative in particular, suggests that there are advantages to a coalition's having more than one page in its book.<sup>20</sup> Different partners have different organizational cultures and may internalize different aspects of a coalition's mission. In this case, some pastors and coordinators were motivated by the problem of racial and ethnic disparities in access to care, and others by the community's dire need for disease prevention, early detection, and management.

Some of the initiative's strengths have also created challenges.

The engagement of a core group of pastors has been critical to the program's success. Now the Coalition faces the challenge of how to keep this group engaged, without crowding out other institutions. On the one hand, the Faith-Based Initiative has clergy members of sufficient prominence that others may wish to join. At the same time, it is challenging to bring in other faith-based leaders when the current leadership is so strong and visible. Of particular concern is the growing identification of the initiative with predominantly African American churches. In its next phase, the research team will be exploring the role and structure of predominantly Latino churches in the community, as the Faith-Based Initiative seeks to expand to those churches.

As the religious content of the initiative has been strengthened, the ability of the Faith-Based Initiative to attract members of other faiths may become more limited. Although the Faith-Based Initiative has reached out to neighborhood mosques, and recently engaged one Islamic leader who attended a pastors' breakfast, it is not yet clear whether and how the Christian message will be adapted to accommodate those groups. Given that part of the strength of the initiative derives from the connection between its health messages and religious tenets, it may be more appropriate to develop separate efforts for groups of other faiths.

Building and operating as a true community partnership is a time-consuming endeavor. The implementation of a pre-existing screening program or health curriculum would have required fewer meetings, less negotiation, and less need for the education of all participants. Moreover, because the Faith-Based Initiative is so dependent on personal engagement and commitment, a great deal of staff time



is spent nurturing the relationships, in ways that can sometimes feel tangential to the project itself.

Finally, the open-ended, participatory nature of the intervention creates challenges in terms of measurement and accountability. A highly prescriptive program with specified deliverables and required timeframes certainly would have been easier to monitor and measure. The fluid nature of this initiative has made it difficult systematically to collect data to monitor activities and performance.

The Faith-Based Initiative is currently a visible and vibrant component of the Coalition's work. A strong infrastructure has evolved that supports both health education and political advocacy. Given that over half of Americans consider themselves members of a religious organization,<sup>31</sup> and given the churches' demonstrated ability to pull people together, to motivate and to inspire, there is great potential for faith-based interventions to address health disparities.

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## Notes

1. Black SA. Diabetes, diversity, and disparity: what do we do with the evidence? *Am J Public Health*. 2002 Apr;92(4):543–8.
2. Moritz DJ, Ostfeld AM, Blazer D 2nd, et al. The health burden of diabetes for the elderly in four communities. *Public Health Rep*. 1994 Nov-Dec;109(6):782–90.
3. New York University Center for Health and Public Service Research. Analysis of New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS) database. 1998. New York University Center for Health and Public Service Research, 1998 (unpublished).
4. Calman N. Making health equality a reality: the Bronx takes action. *Health Aff (Millwood)*. 2005 March-April;24(2):491–8.
5. Thomas SB, Quinn SC, Billingsley A, et al. The characteristics of northern black churches with community health outreach programs. *Am J Public Health*. 1994 Apr;84(4):575–9.
6. Cnaan R. Our hidden safety net: social a community work by urban American religious congregations. *Brookings Rev*. 1999 Spring;17(2):50–3.
7. DeHaven MJ, Hunter IB, Wilder L, et al. Health programs in faith-based organizations: are they effective? *Am J Public Health*. 2004 Jun;94(6):1030–6.
8. McRae MB, Carey PM, Anderson-Scott R. Black churches as therapeutic systems: a group process perspective. *Health Educ Behav*. 1998 Dec;25(6):778–89.

9. Wiist WH, Flack JM. A church-based cholesterol education program. *Public Health Rep.* 1990 Jul-Aug;105(4):381–8.
10. Hale C, Sutherland MS, Harris GJ. Community health promotion: the church as partner. *J Prim Prev.* 1995;16(2):201–16.
11. Campbell MK, Demark-Wahnefried W, Symons M, et al. Fruit and vegetable consumption and prevention of cancer: The Black Churches United for Better Health project. *Am J Public Health.* 1999 Sep;89(9):1390–6.
12. Eng E, Hatch J, Callan A. Institutionalizing social support through the church and into the community. *Health Educ Q.* 1985 Spring;12(1):81–92.
13. Sanders EC 2nd. New insights and interventions: churches uniting to reach the African American community with health information. *J Health Care Poor Underserved.* 1997 Aug;8(3):373–5.
14. Chatters LM, Levin JS, Ellison CG. Public health and health education in faith communities. *Health Educ Behav.* 1998 Dec;25(6):689–99.
15. Zahner SJ, Corrado SM. Local health department partnerships with faith-based organizations. *J Public Health Manag Pract.* 2004 May-Jun;10(3):258–65.
16. White House Office of Faith-Based and Community Initiatives. Regulatory changes: final rules. Washington, DC: White House Office of Faith-Based and Community Initiatives, 2005. Available at <http://www.whitehouse.gov/government/fbci/reg-changes.html>.
17. Levin J, Chatters LM, Taylor RJ. Religion, health and medicine in African Americans: implications for physicians. *J Natl Med Assoc.* 2005 Feb;97(2):237–49.
18. Kaplan SA, Dillman KN, Calman NS, et al. Opening doors and building capacity: employing a community-based approach to surveying. *J Urban Health.* 2004 June; 81(2):291–300.
19. Kaplan SA, Calman NS, Golub M, Davis JH, Billings J. Racial and ethnic disparities in health: a view from the south Bronx. *J Health Care Poor Underserved.* 2006 Feb; 17(1):116–27.
20. Kaplan SA, Calman NS, Golub M, Ruddock C, Billings J. Fostering organizational change through a community-based initiative. *Health Promot Pract.* 2006 (in press).
21. Minkler M, Wallerstein N, eds. *Community based participatory research for health.* San Francisco: Jossey-Bass, 2003.
22. Minkler M. Using participatory action research to build healthy communities. *Public Health Rep.* 2000 Mar-Jun;115(2–3):191–7.
23. Flynn BC, Ray DW, Rider MS. Empowering communities: action research through healthy cities. *Health Educ Q.* 1994 Fall;21(3):395–405.
24. Israel BA, Schulz AJ, Parker EA, et al. Review of community-based research: assessing partnership approaches to improve public health. *Annu Rev Public Health.* 1998; 19:173–202.
25. McLaughlin JA, Jordan GB. Logic models: a tool for telling your program's performance story. *Eval Program Plann.* 1999 Spring;22(1):65–72.
26. Renger R, Titcomb A. A three-step approach to teaching logic models. *Am J Eval.* 2002;23(4):493–503.
27. Kaplan SA, Garrett KE. The use of logic models by community-based initiatives. *Eval Program Plann.* 2005 May;28(2):167–72.
28. 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 May;92(5):805–10.
29. Reid LV, Hatch J, Parrish T. The role of a historically black university and the black church in community-based health initiatives: the project DIRECT experience. *J Public Health Manag Pract*. 2003 Nov;Suppl:S70–3.
  30. Musgrave CF, Allen CE, Allen GJ. Spirituality and health for women of color. *Am J Public Health*. 2002 Apr;92(4):557–60.
  31. Kosmin B, Mayer E, Keysar A. *American Religious Identification Survey*. New York: The Graduate Center of the City University of New York, 2001.