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Abstract. The rural Black church often plays an important role in the lives of many African Americans and frequently functions as an informal helping network in meeting emergency service needs for this group. This article provides a review of the constructs of the Bailey and McNalley-Koney Interorganizational Community-Based Collaborative Framework. Additionally, this paper explores action-oriented measures for integrating constructs into practice to build interorganizational collaboratives with southern rural African American churches.

Keywords: interorganizational collaboration, rural, African American, churches

Today, many African American congregations, in addition to meeting spiritual needs, are extensively involved in practical service provision (Cnaan & Boddie, 2001). Cnaan, Sinha, and McGrew (2004) found that almost nine of every ten congregations, regardless of size and ethnic composition, engage in at least one form of social service provision. Furthermore, Bositis (2006) found that African American churches were heavily involved in directly providing social services such as: food banks (71%), clothing banks (66%), prison ministry (58%), drug abuse counseling (46%), and child care (36%). Yet, many southern rural African American churches face challenges in providing these practical services (Bositis, 2006), in part due to social, economic, and geographic factors (Blank, Mahmood, Fox, & Guterbock, 2002).

Investigation of rural African American life has noted that these communities are among the poorest of the population (Lichter, Parisi, & Taquino, 2012). For example, Lichter et al. (2012), in a 2011 analysis conducted through the National Poverty Center, reported that more than 400 rural counties in the United States had poverty rates exceeding 20%, of which roughly three-fourths were linked directly to the economic circumstances of racial and ethnic minorities. Moreover, about 47% of those rural counties studied were largely African American (Lichter et al., 2012). More specifically, Farrigan, Hertz, and Parker (2014) reported that from 2006 to 2010, the average non-metro African American resided in a county where the poverty rate was 22%. In comparison, the average metro African American person resided in a county where 14-15% of the population was poor. This suggests that non-metro African Americans were significantly more likely to live in areas of high poverty than their metro counterparts, and were therefore likely to suffer many of the problems and limitations associated with poverty (USDA, 2015).

Additionally, it has been reported that rural communities tend not to have access to various specialty care professionals (Gamm, Stone, & Pittman, 2008). This is evidenced in a study by O'Grady, Mueller, and Wilensky (2002), who reported that labor force shortages as well as recruitment and retention of primary care providers were identified as major rural health

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concerns among state rural health offices. Further, Gamm and Hutchinson (2003) reported that access to quality health services was the most frequently recognized rural health priority by state and local rural health leaders across the nation. For these reasons, networks of informal care providers have often become commonplace in rural areas. Extended family, neighbors, and clergy often serve as alternatives to costly or inaccessible services (Chatters et al., 2002; Chatters, Taylor, Jackson, & Lincoln, 2008; Chatters et al., 2011; Taylor, Lincoln, & Chatters, 2005; Woodward et al., 2008; Woodward et al., 2010; Woodward, Taylor, & Chatters, 2011). In rural communities, the church is often a major institution on which community members can rely to support their fundamental core values and beliefs (Torrence, Phillips & Guidry, 2005). These churches are often sponsor assistance programs that address physical and mental health, as well as community concerns (Tangenberg, 2005). Subsequently, this structure requires churches to be responsive to the needs of their members and the external environment (Brown, 2003). An important challenge then is to effectively use the synergy between rural African American churches and the dynamic social services institutions to better meet the needs of struggling rural communities (Lewis & Trulear, 2008).

Increasingly, collaboration between nonprofit and for-profit organizations is being championed as a powerful strategy to achieve a vision that is impossible when such entities work alone (Gajda, 2004). Collaboration is predicated on establishing strategic alliances between local health, mental health and other service organizations, and communities to increase access to resources (Bailey & McNalley-Koney, 1996). The goal of these partnerships is to influence the direction of program creation to enhance service delivery (Bailey & McNalley-Koney, 1996). As such, interorganizational collaborations can encourage participation and representation for many southern rural groups that would otherwise be excluded (Cnaan et al., 2004).

With social workers playing a key role in providing human services to a diverse population, it is important to develop practice models that correspond to theoretical understandings of culturally proficient practice (Davis, 2009). The Bailey and McNalley-Koney model (1995) is one such conceptual framework that groups can use to develop interorganizational community-based collaboratives that are responsive to the human service needs of rural African American communities. The Bailey and McNalley-Koney model emphasizes the creation of a relationship, or partnership, among parties through the integration of eight core constructs that ideally lead to the achievement of a common goal (Bailey & McNalley-Koney, 1996).

Few studies address the establishment of interorganizational community-based collaboratives between rural social services agencies and southern rural African American churches. In a time of inter-professional collaboration, strategic alliances between churches and social service agencies are imperative. Therefore, the purpose of this paper is to explore the eight constructs of the Bailey and McNalley-Koney (2000) interorganizational framework for integration into community-based alliances between southern rural African American churches and human service agencies. These constructs are leadership, membership, environmental linkages, strategy, purpose, tasks, structure, and systems.

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Brief History of Rural African American Churches' Engagement in Collaboratives

Lincoln and Mamiya (1990) argue that the African American church has been traditionally comprised of seven African American Christian denominations, which include the African Methodist Episcopal Church; the African Methodist Episcopal Zion Church; the Christian Methodist Episcopal Church; the National Baptist Convention, U.S.A.; the National Baptist Convention of America, Unincorporated; the Progressive National Baptist Convention; and the Church of God in Christ. The Church has served a prominent role as an informal social service provider throughout its history, and the churches' involvement in collaborative arrangements with social welfare services has been documented by several historians and researchers (Allen, Davey & Davey, 2010; Barnes, 2004; Hankerson, & Weisman, 2012). Although collaboratives have been examined throughout the history of African American churches, a limited number of studies have focused specifically on southern rural African American churches and their engagement in collaborative efforts.

The Free African Society, established by Richard Allen and Absalom Jones in 1787, was one of the earliest examples of the interconnection of the church and social services within the African American community. The Free African Society, which led to the founding of the Mother Bethel A.M.E. Church in 1794, was formed to address the economic, social and spiritual needs of African Americans (DuBois, 1899; Lincoln & Mamiya, 1990; Sernett, 1999). The National Negro Movement of 1915 provides another historical example of early collaborations between social service organizations and the African American church. From 1915 to 1950, in a national strategy to bring public health practices to Blacks, African American churches coordinated efforts with public health agencies in a movement known as "Health Improvement Week" (Bediako & Griffith, 2007). The movement's objectives were for church leaders to consult with state health officers on public health problems within the African American community, and use churches and their personnel as vehicles for disseminating information about preventable illnesses among African American people. Through collaborative arrangements, the churches and agencies would use expressions such as music, song, and sermons with a focus on health and healthy living to encourage parishioners to participate in the endeavor. Additionally, mass meetings were organized and speakers were invited to discuss issues regarding health and healthy living (Bediako & Griffith, 2007; Quinn & Thomas, 1996).

Subsequent studies examined African American churches' alliances with social service-type agencies. For instance, Mays and Nicholson (1933) published a notable study that was at the time one of the most extensive surveys of African American churches of a range of denominations located in both rural and urban areas. Mays and Nicholson (1933) examined outreach efforts by both urban and rural African American churches, particularly regarding cooperation with non-church programs. Mays and Nicholson (1933) found that while both urban and rural African American churches collaborated with a variety of social agencies and programs to enhance health and mental health service delivery within the African American community, African American urban churches were far more active than those in rural communities in cooperating with external agencies. They further suggest this lack of cooperation by rural African American churches was partly due to the paucity of social service agencies in rural areas (Mays & Nicholson, 1933). Lincoln and Mamiya (1990) contend that the Mays and Nicholson study established a basis for future research on African American churches, and identified the need for further studies addressing church-agency alliances.

The next major survey of African American church collaborative alliances was by Lincoln and Mamiya (1990). In their five-year national survey, Lincoln and Mamiya inquired whether African American churches engaged in securing and utilizing government funding and/or participating in government-funded programs for the purpose of creating a hub whereby non-church community groups could use the church facilities for other programs or meetings. The vast majority of urban African American churches participated in government-funded programs, while 95.2% of rural churches did not participate in any government-funded program, and only 2.7% claimed involvement in such programs (Lincoln & Mamiya, 1990). Of those rural churches that had participated in government-funded programs, only 1.4% received government funds. Lincoln and Mamiya (1990) reported that the lower rates of participation by rural African American churches could be attributed to the lack of knowledge and experience for applying to such programs and the absentee pastorate. Moreover, their study found no participation by rural African American churches in funded programs such as food services (breakfast or Meals on Wheels), the Comprehensive Employment and Training Act (CETA) programs, housing for the elderly and the indigent, daycare, job search, substance abuse prevention, food and clothing distribution, and other tutorial and remedial education programs (Lincoln & Mamiya, 1990). Further, their research noted that rural African American churches were less likely than African American churches in urban areas to allow their churches to be used by other groups such as civic entities like block associations, neighborhood improvement groups, citizens' patrols, and community organizations. On the other hand, rural churches were more inclined to allow civil rights groups to use their facilities (Lincoln & Mamiya, 1990).

Billingsley and Caldwell (1991) studied collaborative efforts by African American churches and reported that many of the churches in their study had established elaborate and extensive networks of collaboration with other churches and community agencies. For example, they found that 73% of churches with outreach programs collaborated with secular agencies in the community as part of their outreach efforts (Billingsley & Caldwell, 1991). Specifically, of the agencies studied, welfare departments ranked third among agencies that had working relationships with African American churches. Billingsley and Caldwell (1991) also reported on the tendency of African American churches to serve as centers for community activities. It was reported that more than 43% of the churches with outreach programs allowed their facilities to be used by non-religious groups, which suggests that the African American church could be considered a community institution (Billingsley & Caldwell, 1991).

Other studies further illustrate similar patterns of activities involving the wider community collaboration of services including employment counseling, senior citizens' services, hospice care, food pantries (Barnes, 2004; Brown, 2008), and youth programs (Cook, 2000). With regard to the establishment of faith-health collaborations, few rural African American churches engaged in this endeavor. For example, Steinman and Bambakidis (2008) examined the prevalence of religious congregations' collaborations with health agencies and found that rural African American churches were less likely than any other type of congregation to participate in faith-health collaborations. Further, in a study of rural African American churches' ability to develop health prevention campaigns, Torrence, Phillips, and Guidry (2005) note that creating collaborative partnerships with health professionals and African American churches aids in the success of church-based programs. What is more, Blank et al. (2002) noted that African American churches can be essential partners with formal care systems, particularly in the areas

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of primary care delivery, community mental health, health promotion, disease prevention and health policy.

Consequently, forging a cooperative understanding between the groups may prove to be the best outcome for all parties in addressing social welfare service needs identified by members of African American communities (Lewis & Trulear, 2008). In light of these expectations, the central focus of this paper is on helping African American individuals, families, and communities in southern rural areas to access vitally needed specialty care services.

Bailey and McNalley-Koney Framework for Interorganizational Community-Based Collaboration

A number of models have been developed to enhance collaboration within social service-oriented alliances (Gajda, 2004; Chandler Center for Community Leadership, 1993; Peterson, 1991); however, the Bailey and McNalley-Koney (2000) framework of inter-organizational collaboration focuses on partnership building among organizations and individuals who unite to work collectively through common strategies toward a shared goal. This is accomplished through integrating eight core components: leadership, membership, environmental linkages, structure, strategy, purpose, tasks, and systems. Using these components, the framework emphasizes an understanding of key processes inherent to the development of collaboration (Bailey, 1992).

Leadership

Within this framework, leadership includes the individuals and/or organizations that formally or informally guide and direct the activities of the collaborative. Bailey and McNalley-Koney (2000) report that leadership may consist of one or both of the following: (a) the organizational leader(s), or the convening organization(s); and (b) the individual leader(s) or the entrepreneur(s). According to Bailey and McNalley-Koney (1996), the power of effective leadership comes through cooperation with others.

Thus, wise and effective leaders remain open and attentive at the same time, following the lead of other stakeholders. Therefore, they should be both assertive (guiding and directing) and responsive, articulating the larger vision of the alliance while constantly being aware of its smaller elements and how all the elements relate to the whole (Bailey & McNalley-Koney, 1996).

Membership

Within the Bailey and McNalley-Koney framework, members are the remaining participants in the collaboration who commit to work with united leaders to accomplish its goals. The membership of an organizational unit actually comprises multiple affiliations (i.e., members participating on behalf of any agency and members representing themselves and/or their communities) (Bailey & McNalley-Koney, 1995). These leaders, members, and community groups represent the primary stakeholders of the collaborative (Bailey & McNalley-Koney, 2000). Stakeholders are those individuals and groups of the community who have a vested interest in the collaborative.

Interaction between leaders and members is critical in determining the degree of synergy within a collaborative effort, as leaders are the "vehicles" by which diverse members (partners) are engaged, productive interactions are fostered, and meaningful participation are facilitated (Gadja, 2004).

Environmental Linkages

Leaders and members should solicit the assistance of environmental linkages. Within this framework, Bailey and McNalley-Koney (2000) describe environmental linkages as the relationships between the leaders of a collaborative and members of other external organizations and individuals. These connections are designed to expand the collaborative's full range of stakeholders (Emery & Mamerow, 1986; Gentry, 1987; Sink, 1987).

Bailey and McNalley-Koney (2000) report that environmental linkages often contain the history of the community and its needs. As such, they can often be used to identify external environmental forces that support or oppose the development of strategic alliances. Consequently, as Bailey and McNalley-Koney (2000) note, it is essential that environmental linkages be functional and intentional.

The organizations and individuals involved in these linkages are not formal members; instead, they provide support for its efforts by donating meeting space, providing funding, or referring consumers (Bailey & McNalley-Koney, 2000). For these reasons, the environmental linkages may be critical to the collaborative's existence.

Structure

As stakeholders are identified, the collaborative alliance should develop a specific structure and strategies for achieving the collaborative's purpose. Within the Bailey and McNalley-Koney framework, structure refers to the way in which people and tasks are organized within the collaborative to achieve its purpose. These include how (sub)committees are arranged, the way decisions are made, the extent to which policies and procedures are formally defined, and the manner in which functions and services are assigned. The collaborative should adopt a task-driven structure in which specific activities are divided among the parties to operationalize the collaborative's strategy (Bailey & McNalley-Koney, 1996).

Formal structures, such as committees, are groups of participants representing individual organizations aligned with the collaboration to accomplish specific task (Griffin, 2011). Without a structure to manage the scope of work, collaboratives cannot identify what strategies and tasks positively contribute to goal attainment (Bailey & McNalley-Koney, 2000).

Strategy

Within the model, strategy refers to the means through which the collaborative seeks to achieve its purpose (Bailey & McNalley-Koney, 2000). Strategy includes the extent to which groups' stakeholders (i.e., leadership and members) agree on ideology, articulate activities and programs, and perform collaboratively (Gray, 1985; Roberts-DeGennaro, 1986). The fundamental strategy is to collaborate, or work together, to increase the impact of services and

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products provided (Bailey & McNalley-Koney, 2000). Therefore, the strategy should embody the shared values, purpose, and goals of the stakeholders.

Purpose

Bailey and McNalley-Koney (2000) argue that the purpose of the collaborative is whatever the alliance seeks to jointly achieve (i.e., allocate resources, provide services, or suggest policies). The purpose can also be described in the collaborative's mission and overall goal, with an emphasis on end result. Who the participants are, what they do, and how they all come together to do it are three different components in articulating the mission and goals of the collaborative. In essence, the purpose of the collaborative unit is to serve as the ground on which the unit is built, and embody the shared values that bond the collaborative together. Therefore, the purpose provides the foundation for the development of collaborative components as well as synthesis of its various components.

Tasks

Bailey and McNalley-Koney (2000) suggest that neither the purpose nor the strategy of a collaborative can be achieved without first identifying the tasks appropriate to fulfilling the objectives. Accordingly, tasks within the Bailey and McNalley-Koney (2000) framework are the specific activities that collectively enable the collaborative to operationalize its strategy and accomplish its purpose. This includes the number of issues to be addressed by the collaborative and the degree to which the means for accomplishing the task(s) are imposed (Gray, 1985; Harris, 1984; Schopler, 1987). The outcomes of the tasks are the basis for achievement of the larger goals of the alliance. The collaborative body is ultimately responsible for the oversight of tasks in pursuit of the shared goal(s) (Bailey & McNalley-Koney, 2000).

Systems

The final part of the Bailey and McNalley-Koney (2000) collaborative framework are the systems. Systems are the operating ties that hold the collaborative structure together. Within the collaborative, systems include the established mechanisms for budgeting and resource allocation, inter- and intra-collaborative information flow, decision making, communication, planning, administration, human resource management, and evaluation. Stakeholders' assessment of the degree to which these systems are functioning successfully is a further consideration (Pascale & Athos, 1981).

Using these eight components, the Bailey and McNalley-Koney (2000) framework emphasizes the building of an alliance that is both dynamic and interdependent. It posits that all components within the collaborative alliance being implemented as suggested offer the potential for a greater impact in relationship building, information sharing, service delivery, and policy reform (Bailey & McNalley-Koney, 2000; Flynn & Harbin, 1987; Haynes & Mickelson, 1997).

Integration of the Bailey and McNalley-Koney Framework into Building Collaboratives with Rural African American Churches

Social workers often must assist individuals and communities in recognizing the many possibilities available to them. This includes assisting individuals, groups, and communities in

identifying their strengths and employing the empowerment perspective to help them obtain desired goals and outcomes necessary to reach their fullest potential. Below, we have synthesized four action-oriented measures from the eight core components within the Bailey and McNalley-Koney (2000) framework to aid in the integration of strategies for building collaboratives between human service agencies and southern rural African American churches. Because the constructs in the Bailey and McNalley-Koney model are closely aligned, many components have been merged to develop the action-oriented measures.

Leadership and Membership

At the center of Bailey and McNalley-Koney's (2000) construct regarding leadership and membership for building of rural collaboratives are influential church members who are frequently sought out for advice. In many rural African American communities, residents place total confidence in the advice or guidance of their pastors and church leaders regarding their spiritual, financial, mental, and physical well-being (Adkison-Bradely et al., 2005). Taylor et al. (2000) and Richardson and June (1997) found that the number of collaborative relationships an African American minister had with community agencies was closely associated with the number of referrals clergy made to health professionals. Since church leaders are potential resources for bridging the gap between formal social service agencies with informal services provisions (Wilson & Netting, 1989), collaboration between agencies and religious organizations can offer new opportunities to meet the needs of rural community members.

Action-centered leadership measures. To meet the objectives of the Bailey and McNalley-Koney model regarding establishing a leadership structure and soliciting members, social workers can initiate communication by facilitating public meetings between the agency and the rural community church leaders regarding their vision to address needed services. Member parties (church leaders and agency personnel) can then develop a formal process for collaboration. Membership should be a formal alliance including not only church leaders and social workers or interorganizational contacts, but also organizational staff and administrators (Bailey & McNalley-Koney, 2000).

An example of this was noted by Sutherland et al. (1989) in an examination of a collaborative partnership in rural Jackson County, Florida. This collaboration demonstrated how health-related programs can be organized and operated by churches with the support of public health agencies. In rural Jackson County, Florida, officials from county health and social service agencies determined, through data on health-related behaviors, that there were various health disparities within the African American community. Consequently, officials recognized that a targeted health promotion effort was needed. Local and area health and social agency officials felt it important to join with local church leaders, to formulate an initiative based on a culturally appropriate version of the Planned Approach to Community Health (PATCH) program model, which was developed by the Centers for Disease Control and Prevention (CDC) and geared toward planning and implementing community-based public health strategies (Lancaster & Kreuter, 2002). One of the initial steps taken by Jackson County was to establish a Health Advisory Council composed of 16 primarily African American Jackson County churches plus representatives of relevant agencies to establish public health goals. The outcomes of this partnership included increased community awareness regarding health promotion as evidenced by increasing program participation over the course of several years. More specifically, the

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program appeared to produce improved nutritional behaviors of some people (e.g., decreases in consumption of fatty and high-sodium foods, and increases in consumption of healthful foods) and decreases in blood pressure among some high-risk individuals (Sutherland et al., 1989). This alliance demonstrates the value of creating true partnerships.

Environmental Linkages

Also critical to the success of collaboratives in Bailey and McNalley-Koney's (2000) model are environmental linkages among community members. Because economic conditions faced by pastors and church leaders in rural communities usually reflect to some degree the economic conditions of church members, they are frequently aware of community issues (i.e., poverty, medical and mental health issues, and incarceration) and can oversee the needs of community constituents of the interorganizational alliance (Lewis & Trulear, 2008). These can be employed to identify key individuals within the community who can provide informational, as well as emotional and tangible support, to collaborative members (Eng & Hatch, 1991).

Because the collaborative's formation often stems from both groups' desire to address certain community issues or public concerns, organizations thusly motivated often respond from the model's social responsibility perspective. Accordingly, social responsibility deals with the desire to contribute to the resolution of broad community issues while increasing goodwill. Here, an organization may establish itself as a member of the collaborative to enhance its reputation with its clientele and local residents, as well as with constituents of the rural African American community. By participating in the collaborative, social workers, their administrators, and agencies' personnel can demonstrate to the community that they are concerned about and active in responding to the community's needs (Bailey & McNalley-Koney, 2000). For this reason, successful partnerships result from establishing trust, credibility, and open communication (Torrence et al., 2005). Identifying environment linkages can aid in this effort.

Action-oriented practice measures. To create this connection, social workers and agencies should invest considerable time and energy in cultivating relationships with the rural African American community and its leaders (Adkison-Bradely et al., 2005; Alter, 1990; Benson, 1975; Knoke, 1990; Warren, 1967). This includes working with rural church leaders to identify environmental linkages (i.e., community stakeholders) that understand community strengths and needs. This will promote equitable relationships between social workers, agencies, rural African American church leaders, and community members, where all become stakeholders by jointly developing change strategies.

An example of this is provided by Centra and McDonald (1997) who documented the efforts of the Thurston County Public Health and Social Services Department of Olympia, Washington. Proponents of this initiative worked to identify community leaders and cultivate relationships during the initial stage of their Assessment Protocol for Excellence in Public Health (APEX/PH) project. In an effort to cultivate relationships for the purpose of strengthening their community health assessment and planning capabilities, the Thurston County Public Health and Social Services Department worked to establish a County Community Health Task Force to identify "key community informants." These key informants were individuals considered to represent important constituencies through their knowledge of or experience with the health issues of the community.

To cultivate relationships, agency personnel convened a breakfast meeting with community leaders, and asked participants to provide the names of appropriate individuals to participate in the Task Force. In essence, participants were asked: "Whose name would you have to see on a health plan to believe it was valuable?" Task Force members were then selected from among the names that appeared frequently in the responses (Centra & McDonald, 1997).

Structure and System

For social work professionals concerned with addressing the needs of underserved individuals in southern rural communities, the interorganizational community-based collaborative can become an important tool to develop and maintain. Social work professionals are in key positions to lead efforts in forming collaborative, community-guided initiatives. As advocates for social justice as well as individual and community empowerment, social work professionals bring essential skills of developing and implementing strategies for enhancing the quality of programs extended within the interorganizational community-based collaborative.

Many in the social work profession have had concerns about churches' involvement in social welfare service delivery because of the lack of trained and certified church workers (Torrence et al., 2005). Since many African American congregations lack experience in strategic planning, or since their plans and ideas may be inappropriate or unrealistic according to human service organization standards (Cnaan et al., 2004), church leaders and interorganizational contacts may enter the alliance to share knowledge and work together in developing appropriate strategic action plans.

Action-oriented measures. To address Bailey and McNalley-Koney's (2000) constructs regarding a system and structure establishment for successful work with these rural churches, collaboratives can consult on how best to strategically access resources and research funding designed to increase the church's capacity to improve the quality of programs it offers, as well as identify and influence unfair social welfare policies or practices that impede effective service delivery (Lewis & Trulear, 2008). Social workers can further assist in this effort to increase capacity by improving the quality of their programs. Because the social work profession depends on key skills and knowledge essential to address the needs of individuals, families, and communities, starting up, aligning, or expanding programs using proven strategies, including technical expertise and grant and proposal writing skills for funding, would help rural African American churches improve outcomes for parishioners and community members and ensure the long-term sustainability of programs (Cnaan & Bodie, 2001).

As an example, in the Jackson County, Florida health promotion partnership that established the Health Advisory Council, church council members underwent a period of training and planning to acquire the skills and resources necessary to design, implement, and evaluate health promotion programs in their communities and teach other local churches how to do the same (Sutherland et al.,1989).

Strategy, Purpose, and Tasks

Because geographic and economic factors may create practical problems for rural communities, including the need to travel longer distances to receive care using unreliable or

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inadequate transportation, and limited economic resources, thereby making services inaccessible (DHHS, 1999), African American churches and social service agency professionals can coordinate strategy, purpose, and tasks to address these needs (Lewis & Trulear, 2008). Leaders, members, and other stakeholders recognize that the strategy, purpose, and tasks of a collaborative are all connected. In order to achieve the purpose and implement the strategy, the appropriate tasks need to be identified and executed (Bailey and McNalley-Koney, 1996).

Action-oriented measures. To effectively achieve collaborative objectives, rural African American churches and the local social service agencies within the rural community can work together to create information centers on church grounds to assist parishioners and residents in connecting with existing services offered by agencies serving that community (Lewis & Trulear, 2008). The collaborative can work to arrange services such as health screening for mental and physical illnesses, nutritional services, and immunizations on church grounds.

For example, agencies located in the same county but some distance away from one another and their constituents can increase the efficiency of service delivery by offering a variety of services in one conveniently located facility. Community consumers will then be able to obtain all of the needed services through a single point of access. Instead of having to maintain their own facilities, each alliance member would contribute to the costs associated with offering services, as well as several staff members. In this way, they are able to use their limited resources to achieve greater benefits than each could have done individually. This creates a single service site that streamlines the client referral process and reduces administration and overhead costs for the member agencies (Bailey & McNalley-Koney, 2000).

An example of a single service site is provided by Eng and Hatch (1991) who developed one of the most notable rural church sponsored programs, collaborating with area service agencies to use rural churches in North Carolina as a focus for health promotion activities. Eng, Hatch, and Callan (1985) documented the development and impact of church health care programs in which pastors asked congregants to identify people within the congregation who could serve as health advisors. These "natural helpers" received training in resource mobilization, preventive and primary self-care skills, organization of educational and service-oriented activities, and interaction with health professionals. The roles of lay advisors were shaped by the needs and opinions of the congregation and were successful in fostering social support, connection with formal care systems, and promotion of general well-being (Eng et al., 1985). Through arrangements such as these, the church can serve a two-fold purpose, functioning as a spiritual haven as well as a sub-outlet for parishioners and community members to connect with existing agency services.

In a study in rural Jackson County, Florida, Sutherland et al., (1989) showed how a council made up of agency personnel and church leaders organized workshops to provide church participants with basic cardiovascular and health information and to help them plan and operate church-based programs. Church leaders then encouraged community members to participate in health promotion activities conducted at the churches and other community gathering places. The activities included blood pressure monitoring, direct health instruction, exercise programs, and other special health programs. A core of church leaders and members fulfilled a variety of functions, from taking blood pressure readings to serving as peer facilitators. Program planners

also emphasized the integration of health promotion activities with existing church events, for example, by scheduling an activity immediately after worship services.

These methods can work to increase what Bailey and McNalley-Koney (2000) term operational efficiency. The goal of operational efficiency according is to improve productivity relative to the available resources as well as to increase efficiency directed toward reducing duplication of services for a targeted population in a particular program area.

Conclusion

Implications point to the need for social work education and practice to begin focusing on collaboration and the development of interorganizational community-based collaboratives (Gray, 1989). Collaboration creates an understanding of the importance of culturally responsive engagement. The agency must obtain an initial understanding of the historical context and current importance of the African American church in the life of the African American community. Social workers should see the future clients' spiritual or religious beliefs as a source of strength. Through the use of culturally responsive practice, practitioners can develop a self-awareness that will aid in reducing personal bias, and consequently moving toward making more appropriate assessments and providing better quality care.

The social work profession risks losing relevance if it fails to acknowledge the usefulness of African American church leaders and congregations as a unique "context for action" (Wineburg, 1996). Therefore, the agenda for the coming decade must include efforts to link social work with the church.

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