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Racial/Ethnic Differences in the Provision of Health-related Programs among American Religious Congregations

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Using national data from the Faith Communities Today 2000 survey, the current study builds upon Lincoln and Mamiya's (1990) argument of the civically active Black Church. Originally used to assess the relative activism of Black and White congregations, the current study suggests that Black congregations are more likely to provide health programs than are predominantly White, Hispanic and Asian congregations. The greater involvement of Black congregations in the provision of health programs likely has much to do with the historical and continued cultural, spiritual, and political role that churches play in Black communities.

Key words: *congregations, health programs, race/ethnicity*

The current study assesses racial/ethnic differences in the health programs that American congregations provide. Church-based health programs play an instrumental role in providing health services, referrals, and information within many American communities (Chaves & Tsitsos 2001; Cnaan, Sinha & McGrew 2004; Ransdell & Rehling 1996; Taylor et al., 2000; Thomas, Billingsley & Caldwell, 1994). Data from the *Journal of Sociology & Social Welfare*, June 2009, Volume XXXVI, Number 2

Faith Communities Today 2000 survey suggests that seventy percent of American congregations participate in the provision of at least one health program in the form of counseling, substance abuse, nursing home/hospital care, or general health education (Dudley & Roozen, 2001). Religious congregations are in an advantageous position to respond to health concerns because they are located in almost all American communities. Additionally, religious congregations are seen as being amenable to health promotion because many faiths maintain tenets that are consistent with healthy lifestyles. Christianity, in particular, teaches that the human body is a temple in which God's spirit resides. Clergy that make the connection between religious teaching and health are likely to encourage their members to maintain a balanced diet, exercise, avoid illicit drugs, get regular physicals, and engage in other healthy behaviors. Additionally, many religious faiths maintain prophetic elements that recognize health care as a basic human right. While many American congregations attempt to address health concerns in their local communities, the racially and economically segregated contexts in which Americans live and worship likely impacts the ability of White, Black, Hispanic, and Asian congregations to do so.

In their seminal book, *The Black Church in the African American Experience*, Lincoln and Mamiya (1990) argue that Black Protestant churches are more civically active than are White churches because churches play a more central institutional role within Black communities than in White communities. The shared memory of Black churches fighting for Black civil rights and human dignity undoubtedly contributes to many African Americans believing that their churches should address their social, economic, and political concerns. Nearly every Black-led effort pushing for greater racial equality had its roots within the Black church and/or drew heavily from its resources and prophetic theology (Lincoln & Mamiya, 1990; Morris 1984). Indeed, the denial of health care to free Blacks from White secular and religious institutions led to the emergence of sick and burial societies within the African Methodist Episcopal and Black Baptist Churches during the 18th century (Lincoln & Mamiya, 1990). The disproportionate amount of poverty-related health concerns and the relatively few

non-governmental institutions addressing such concerns in Black communities today further contributes to many African Americans believing that their churches must address health and other social concerns (Lincoln & Mamiya, 1990).

Lincoln and Mamiya's (1990) argument is not to suggest that White Churches are uninvolved in community life. In fact, at the denominational level, there is seemingly parity along racial/denominational lines in the commitment of American churches to addressing health concerns. Black Protestant denominations such as the Progressive Baptist Convention (PBC), the National Baptists Conference (NBC), and the African Methodist Episcopal Church (AMEC) maintain health ministries and resources that encourage local congregations to address spiritual, mental, and physical health concerns (AMEC, 2007; NBC, 2007; PNBC, 2007). Similarly, the National Council of Churches (NCC), a political coalition of Mainline Protestant denominations, and the United States Conference of Catholic Bishops (USCCB) are both engaged in political campaigns to extend health care to all Americans (NCC, 2007; USCCB, 2007). While Evangelical Protestant denominational bodies maintain less of an institutional commitment than do other Christian churches, a recent survey indicates that concern for HIV/AIDS is the top social-economic issue of concern to Evangelical church leaders (Barrick, 2007).

However, at the local congregational level, a number of studies suggest that a church's racial composition may account for congregation-based social services generally and health care programs more specifically. It is unclear if Lincoln and Mamiya's (1990) argument applies outside of the Black-White landscape and within a broader multi-racial/ethnic context. The current study attempts to build from their work by assessing racial/ethnic differences in the health programs provided by White, Black, Hispanic, and Asian American congregations.

Black and White Congregations-based Health Activism

Given the greater risk for cardiovascular disease, HIV, infant mortality, hypertension, and virtually all other diseases in Black relative to White communities, it is sensible that

government and non-profit public health agencies are more likely to target Black relative to White congregations in an effort to reach at-risk populations (Ransdell & Rehling, 1996). Similarly, bivariate analyses from the Faith Communities Today 2000 data indicates that, on average, Black Protestant congregations are more likely than are White mainline Protestant, Evangelical, and Catholic congregations to provide general health and substance abuse programs (Dudley & Roozen, 2001). Tsitsos also found that congregations with a higher proportion of African Americans are more likely than are others to provide substance abuse programs (Tsitsos, 2003). Along the same lines, data from the 1996 Religion and Politics Study suggests that Black Protestants are more likely than are White Catholics, mainline Protestants, and Evangelicals to attend congregations that discuss the importance of health care reform (Kohut et al., 1996).

Black congregations' heightened commitment to health care may, in part, be linked to African Americans having worse health outcomes and being less likely than Whites to have any form of health insurance (Brown et al., 2000). Black Americans are also more likely than are all other ethnic groups to live in communities of concentrated poverty where access to grocery stores that sell healthier foods is limited (MCIC, 2005). Consequently, Blacks face greater obstacles than others in maintaining balanced nutritious diets. Furthermore, the stress of being poor and living in impoverished communities with fewer city services, illegal dumping, and dilapidated housing puts many Blacks at greater risk of depression, asthma, diabetes, and heart ailments (Berube & Katz, 2005). Areas of concentrated poverty also tend to have higher violent crime rates, which increase the risk of assault, murder, and other physical injury. Prolonged exposure to violence can also heighten stress levels, which over sustained periods can lead to hypertension (Foy & Goguen, 1998; Sanders-Phillips, 1997; Scheeringa & Zeanah, 1995).

Given the poor social-economic conditions within many Black communities, it makes sense that many socially active Black churches view their activism as a manifestation of their prophetic commitment to caring for the poor and marginalized within their communities (Barnes, 2004;

Billingsley, 1999). Even if individual African Americans and their congregations do not themselves live in communities of poverty, the collective memory of oppression and Blacks' continued disadvantaged position contributes to a Black consciousness that makes poverty and race-related issues salient to many Blacks (Gurin, Hatchett, & Jackson, 1989). It is therefore plausible that Black congregations are more likely than White congregations to provide health programs. Less clear, however, is whether, congregations of other racial and ethnic backgrounds are more similar to or different from Black congregations in their commitment to addressing health concerns. Because of similar social-economic circumstances between Blacks and Hispanics, there is reason to believe that Hispanic churches may be similar to Black congregations in their provision of health-related programs. Conversely, because Asian Americans tend to be better social-economically positioned than Blacks, Asian congregations may be less likely than Black churches to provide health programs.

Hispanic and Asian Congregation-based Health Activism

Hispanic and Asians' immigrant status is a key factor that distinguishes their congregations from those of Black and White Americans. Forty percent of Hispanics and sixty-nine percent of Asians are first generation immigrants (Ebaugh & Chafetz, 2000; Lien, Conway, & Wong, 2004; Ramirez & de la Cruz, 2003). As communities of immigrants, many predominantly Hispanic and Asian congregations serve as assimilation centers where newcomers can join friendship networks that share their native culture and language (Espinosa & Miranda, 2003). As such, Hispanic and Asian American congregations are important spaces for community members to discuss common ethnic experiences and remind younger generations of their history and culture (Cnaan, Sirha, & McGrew, 2004; Chalfant et al., 1990; Hurh & Kim, 1990; Min, 1992). Because immigrant congregations reinforce ethnic identity and strengthen social capital, church-based social networks can serve as an important source of health-related information. This is particularly the case for less acculturated immigrants, who are

more likely than native-born ethnic minorities to participate in church-based programs (Cao, 2005; Lopez & Castro, 2006). Along the same lines, a number of case studies suggest that health agencies rank churches high on their list of community institutions to work with in informing Hispanic and Asian immigrants about available health services (Cao, 2005; Lopez & Castro, 2006; Vassilev et al., 2005). For many first-generation Hispanic and Asian immigrants, congregations may serve as the chief liaison to the health care community, as well as an important source of health information.

Not all immigrant groups, however, enter the United States with the same opportunities. Language barriers, access to human capital, and legal status influence the ease with which immigrants are able to assimilate into mainstream American society. While both Hispanics and Asians may experience language barriers, Asians are more likely to arrive legally and tend to have more social-economic resources when they arrive (Bishaw, 2005; U.S. Census Bureau, 2005). Indeed, as the most affluent ethnic minority group in this country, Asian Americans are closer to White Americans in income and wealth than they are to Black Americans (U.S. Census Bureau, 2005). Conversely, Hispanic Americans are more similar to African Americans—the poorest ethnic group in the country (U.S. Census Bureau, 2005). Hispanics, like Blacks, tend to live in communities with fewer health resources in the form of quality grocery stores, pharmacies, and safe walkable neighborhoods (Bishaw, 2005; MCIC, 2005; LaVeist & Wallace, 2000). Because they have lower incomes and are more likely to lack insurance, Black and Hispanic churchgoers tend to have more concerns about accessing health care than do White congregants (Pew, 2000; Suro & Passel, 2005). Like Blacks, Hispanics are also more likely than White churchgoers to believe that universal health care is a moral issue (Suro & Passel, 2005). Hispanic opinions about health care appear to be more heavily influenced by quality-of-life concerns than denominational teachings, as roughly three-quarters of Hispanic Catholics, Protestants, and other Christians support universal health care. A similar proportion of African Americans share this sentiment (Suro & Passel, 2005). The similar social-economic experiences of Blacks and Hispanics may contribute to Hispanic congregations being

similar to Black congregations in the extent to which they provide health-related programs. Conversely, we expect that Asian congregations are less involved than are Black churches in providing health-related programs.

The Present Study

Using data from the Faith Communities Today 2000 survey, this study will be one of the first to examine racial/ethnic and denominational differences in the health care services offered by American congregations. Generally speaking, studies conducted on the health services offered by Hispanic and Asian churches have not been nationally representative (i.e. Chalfant et al., 1990; Lopez & Castro, 2006; Ransdell & Rehling, 1996; Vassilev, 2005). Rather, this research mainly consists of case studies of programs offered by particular congregations. The handful of studies using nationally representative samples to examine differences in the health programs offered by Black and White congregations have either not implemented adequate controls (Dudley & Roozen, 2001), or have focused on only one form of health programs (Tsitsos, 2003). In an attempt to fill this gap in the literature, we test the following hypotheses:

1. White and Asian congregations are less likely than are Black congregations to provide health programs.
2. Hispanic congregations are as likely as Black congregations to provide health programs.

Sample

Carl S. Dudley and David A. Roozen of the Hartford Institute coordinated *The Faith Communities Today Survey* (FACT) in 1999 and 2000. The project represents a joint venture of researchers and forty-two denominations and faith groups. Each religious group was responsible for surveying a representative sample of their congregations using this common core questionnaire. Once the findings from these surveys were combined into a single dataset, it contained information on a total of 14,301 congregations via surveys of the senior clergy. In total, the survey maintained a 57 percent response rate. For the purpose

of this study, however, only Black, White, Hispanic, and Asian majority (51% or greater) congregations were included in the study. These groups constituted approximately 96% of the total sample. Because of the all-group-aggregate data, weights have been applied to the data set to adjust for the otherwise disproportionate-to-denomination/group-strata size.

Measures

Dependent variables: Health programs. Congregations' provision of health programs are dichotomous measures of whether congregations have in the past twelve months directly provided or assisted in the provision of: general health programs/clinics/health education, counseling services or "hot lines," and substance abuse programs.

Independent variable: Congregational racial composition. As mentioned above, the racial/ethnic affiliation of congregations is a nominal variable of the congregation's predominant racial composition. The FACT study itself constructed this variable such that a simple majority of a single racial/ethnic group constitutes that congregation as predominately Black, White, Hispanic, or Asian. Black churches serve as the reference category.

Control variables. To determine the independent effect of race/ethnicity on congregations' provision of health programs, this study takes into account factors that other studies have found associated with church-based community activism. All models also account for denominational affiliation, the social justice orientation of the congregation, congregational resources, community characteristics, and region where the congregation is located. The FACT study constructed the denomination variable based upon Steensland et al.'s (2000) classification of religious denominations. Membership status in national religious organizations such as the National Council of Churches or the National Association of Evangelicals were used to classify various Baptist, Methodist, Lutheran, Presbyterian, and Episcopal denominations into Mainline and Evangelical Protestant traditions. As such, congregations are divided into the nominal categories of *Mainline Protestant*, *Evangelical Protestant*, *Catholic*, and *Other Faith*. For the purpose of these analyses, *Other Faith* serves as the reference variable.

Social justice is measured by a two-item index that encapsulates clergy beliefs on how well social justice characterizes their congregations and how often they preach on social justice. The resource variable includes the following: number of congregants; educational status of congregants; paid staff; the financial health of congregations; the full time status of clergy; and the educational status of clergy. This study also controls for urbanicity, employment and educational rate and the racial/ethnic representation within the census block on which the congregation is located. The study also controls for region.

Since the dependent variables are dichotomous, our analysis is done using logit regression techniques, where an odds ratio that is less than one indicates a negative relationship and an odds ratio that is greater than one indicates a positive relationship. Missing values for all variables were replaced with an imputed regression score. Newly constructed variables were recoded to reflect the distribution of the original variables. The analyses presented below were not significantly or substantively altered by this technique.

Results

Bivariate analyses

Impact of race/ethnicity on congregations' provision of health programs. As expected, the cross-tabulation of congregation-based health programs by race/ethnicity presented in Table 1 provides support for the first hypothesis by suggesting that White and Asian congregations are less likely than are Black congregations to provide all forms of health programs. Unexpectedly, these analyses also suggest that Hispanic congregations also less likely than are Black congregations to provide such programs.

Multivariate analyses

Impact of race/ethnicity on congregations' provision of health programs. The multivariate analyses presented in Table 2 largely mirror the bivariate analyses. As expected, White congregations are less likely than are Black congregations to provide general health programs, substance abuse, and counseling programs.

Similarly, Asian congregations are less likely to provide general health and substance abuse programs. Unexpectedly, however, Asian congregations are also as likely as Black congregations to provide counseling programs. Although we expected no difference, Hispanic congregations are less likely than are Black congregations to provide both general health and substance abuse programs. As expected, however, Hispanic congregations are as likely to provide counseling programs.

Table 1. Cross tabulation of bivariate relationship between race/ethnicity and congregation-based health program provision: Chi-square analyses

| Race/ Ethnicity | Sample Size | Percentages | | |
|--------------------|----------------|-------------------|--------------------|------------|
| | | General Health | Substance Abuse | Counseling |
| Black | 2,303 | 59.62 | 48.81 | 62.66 |
| Asian** | 215 | 36.28 | 33.07 | 52.09 |
| Hispanic** | 257 | 29.57 | 30.45 | 45.91 |
| White** | 10,129 | 24.06 | 9.30 | 42.44 |
| <i>Total</i> | N=12,904 | 30.62 | 33.42 | 46.28 |

* $<.05$, ** $<.01$ (Significantly different from Black congregations). Black congregations serve as the reference category.

"Other" Religious Traditions serve as the reference category

Full Time Clergy is the reference category for No Sole Clergy Leader, Part-Time Clergy, Clergy that also work another job.

These analyses also suggest that while Mainline Protestant congregations are more likely to provide health programs, Evangelical Protestant and Catholic churches are less likely to do so. In addition, congregations that have a greater commitment to social justice and possess more resources are more likely to provide health programs than congregations that are less committed and have fewer resources. The social-demographic makeup of the community and the region where the congregation is located have a rather weak effect on a congregation's provision of health care programs.

Table 2: Effect of race/ethnicity on congregations' provision of health programs: Logit regression analyses: Odds ratio

| | General health | Substance abuse | Counseling |
|--|--------------------|--------------------|--------------------|
| <i>Congregation Race/Ethnicity¹</i> | | | |
| White congregation | 0.245 (0.025)** | 0.470 (0.046)** | 0.651 (0.061)** |
| Hispanic congregation | 0.454 (0.082)** | 0.593 (0.103)** | 1.005 (0.165) |
| Asian congregation | 0.536 (0.096)** | 0.102 (0.026)** | 0.956 (0.162) |
| <i>Denominational Affiliation²</i> | | | |
| Mainline Protestant | 1.106 (0.085) | 1.589 (0.119)** | 1.030 (0.072) |
| Evangelical Protestant | 0.622 (0.056)** | 1.185 (0.100)* | 0.706 (0.055)** |
| Roman Catholic | 0.540 (0.064)** | 0.662 (0.075)** | 0.312 (0.033)** |
| <i>Social Justice Orientation</i> | | | |
| | 1.195 (0.018)** | 1.219 (0.017)** | 1.143 (0.015)** |
| <i>Congregational Resources</i> | | | |
| Clergy Education | 1.105 (0.035)** | 1.034 (0.030) | 1.007 (0.027) |
| Full Time Clergy /Works | 1.084 (0.106) | 0.965 (0.089) | 1.180 (0.098)* |
| Part Time Clergy | 1.056 (0.077) | 1.023 (0.069) | 0.996 (0.062) |
| No Sole Clergy Leader ³ | 0.876 (0.063) | 0.791 (0.053)** | 0.579 (0.036)** |
| Number of Congregants | 1.520 (0.033)** | 1.405 (0.029)** | 1.391 (0.027)** |
| Proportion of Poor Congregants | 1.014 (0.021) | 1.028 (0.020) | 1.014 (0.018) |
| Number of Paid Staff | 1.227 (0.039)** | 1.214 (0.037)** | 1.212 (0.036)** |
| Congregation's Financial Health | 1.040 (0.029) | 0.893 (0.023)** | 1.013 (0.024) |

Standard errors in parentheses * $<.05$, ** $<.01$

¹Black congregations serve as the reference category

²"Other" Religious Traditions serve as the reference category

³Full Time Clergy is the reference category for No Sole Clergy Leader, Part Time Clergy, Clergy that also work another job.

Table 2: Effect of race/ethnicity on congregations' provision of health programs: Logit regression analyses: Odds ratio (continued)

| | General health | Substance abuse | Counseling |
|---|--------------------|--------------------|--------------------|
| <i>Community Characteristics</i> | | | |
| Proportion of Blacks in census track | 1.024 (0.012)* | 0.999 (0.011) | 1.003 (0.010) |
| Proportion of Hispanics in census track | 0.953 (0.021)* | 0.969 (0.020) | 0.986 (0.020) |
| Proportion of Asians in census track | 0.842 (0.060)* | 0.890 (0.061) | 0.799 (0.052)** |
| Employment Rate in census track | 0.907 (0.048) | 0.952 (0.047) | 0.903 (0.042)* |
| Educational Level of census track | 0.983 (0.024) | 1.093 (0.025)** | 1.054 (0.022)* |
| Urbanicity | 1.030 (0.029) | 1.102 (0.028)** | 1.083 (0.026)** |
| <i>Region</i> | | | |
| Northeast | 0.983 (0.183) | 1.464 (0.269)* | 1.461 (0.251)* |
| South | 1.013 (0.186) | 1.115 (0.203) | 1.284 (0.218) |
| North central | 0.923 (0.170) | 0.937 (0.171) | 1.235 (0.210) |
| West | 1.106 (0.207) | 1.721 (0.317)** | 1.604 (0.276)** |
| Weight | 0.550 (0.019)** | 0.708 (0.019)** | 0.713 (0.017)** |
| Observations | 12,904 | 12,904 | 12,904 |

Standard errors in parentheses * $<.05$, ** $<.01$

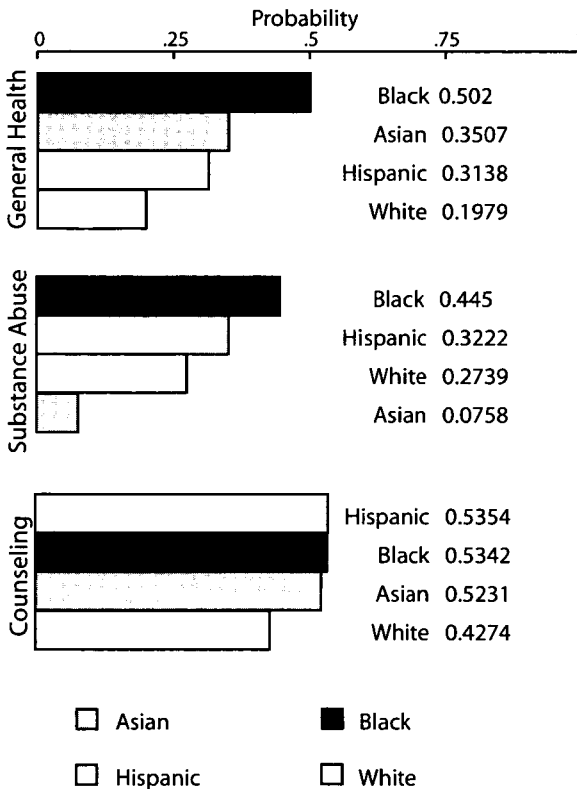
*Rest of the Country serves as the reference category for Region.

Figure 1 presents the adjusted probability estimates of Black propensity to provide general health, counseling, and substance abuse programs. These estimates illustrate the greater odds that predominately Black congregations will offer these programs than the other congregations. These estimates also show the parity among non-White congregations in their provision of counseling programs.

Discussion

The current study extends Lincoln and Mamiya’s (1990) argument of the civically active Black church in three important respects. First, consistent with their argument, Black congregations are more likely than are White congregations to address health concerns within their communities. Going a step further,

Figure 1. Probability estimates of congregation-based health programs by race/ethnicity of congregation (adjusted for denomination, social justice, congregational resources, community characteristics, and region).



Black congregations are also more likely than are Hispanic and Asian congregations to address general health and substance abuse concerns. However, Hispanic congregations and Asian

congregations are as committed as are Black congregations to addressing counseling concerns within their communities.

The collective memory of Black church involvement and success in bringing about sweeping social change in this country during the modern day Civil Rights Movement may account for Black congregations' heightened provision of health related programs. Indeed, Lincoln and Mamiya (1990) point out that today over three-quarters of Black clergy report that their church-based community activism is informed by the efforts of Black churches during the Civil Rights Movement. The prophetic tradition of many activist Black congregations continues to resonate today because of continued concerns with concentrated poverty, illegal drugs, advertisement for cigarettes and alcohol, and lack of quality grocery stores and general lack of health resources for African Americans (MCIC, 2005; LaVeist & Wallace, 2000). Moreover, for many Black congregations, the provision of health programs is recognized as an important strategy to bring about structural changes in the Black community. Although White, Hispanic, and Asian Americans have histories of working through their religious institutions to push for societal reform, it is arguable that no other church has had as defining a moment in characterizing themselves as the central community institution within their respective communities as did the modern day civil rights movement for Black churches.

Our study shows that congregational differences on the basis of race remained even after accounting for denominational tradition and the racial and socio-economic composition of the congregation's surrounding community. Predominantly Black congregations are more likely to offer general health and substance abuse programs regardless of their religious tradition or the community needs where the church is physically located. These findings suggest that the Black church's interest in providing general health and substance abuse programs appear to be motivated by the historical struggles of the Black people, rather than affiliation with a denomination that has a history of providing health programs or the economic or racial composition of the local community where the congregation is located.

This study also suggests that Asian and Hispanic

congregations maintain a similar commitment to the social-psychological well being of their communities as do Black congregations. Case studies on the social service commitment of immigrant Hispanic and Asian communities suggest that congregations play a key role in assisting Hispanic and Asian American immigrants adjust to American life (Cao 2005; Espinosa & Miranda 2003). To the extent that Asian and Latino congregations provide any social programs, they likely invest resources into programs that address the assimilation-related needs of their congregants. Moreover, the counseling efforts of clergy in Hispanic and Asian congregations likely involves helping congregants handle stressors associated with experiencing ethnic discrimination, finding employment, accessing health care, finding culturally sensitive schools for their children, and other assimilation-related issues. To that end, it is somewhat sensible that Hispanic and Asian congregations are as likely as Black congregations to provide counseling programs.

In sum, this study suggests that Black congregations are more likely than are White, Hispanic, and Asian congregations to address the general health and substance abuse related concerns of their communities. Black congregations are also more likely than are White congregations to address social-psychological concerns within their communities. Nonetheless, the health concerns confronting many African Americans are too pervasive for Black congregations to adequately address by themselves. Unless there are structural changes that reduce the racial and economic isolation of African Americans, it is unlikely that Black churches, as committed as they are, can make a long-term and lasting impact on the health conditions within poor Black communities.

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