The Characteristics of Northern Black Churches with Community Health Outreach Programs

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A B S T R A C T

Objectives. The Black church has a long history of addressing unmet health and human service needs, yet few studies have examined characteristics of churches involved in health promotion.

Methods. Data obtained from a survey of 635 Black churches in the northern United States were examined. Univariate and multivariate statistical procedures identified eight characteristics associated with community health outreach programs: congregation size, denomination, church age, economic class of membership, ownership of church, number of paid clergy, presence of other paid staff, and education level of the minister.

Results. A logistic regression model identified church size and educational level of the minister as the strongest predictors of church-sponsored community health outreach. The model correctly classified 88% of churches that conduct outreach programs. Overall, the model correctly classified 76% of churches in the sample.

Conclusions. Results may be used by public health professionals and policy makers to enlist Black churches as an integral component for delivery of health promotion and disease prevention services needed to achieve the Year 2000 health objectives for all Americans. (*Am J Public Health.* 1994;84:575–579)

Introduction

Growing disparities in life expectancy and health status of Black Americans compared with Whites threaten the well-being, economic productivity, and social progress of our society as we approach the 21st century. Differences in the health status of Blacks and Whites have been documented in the United States as long as health data have been collected. These differences have persisted in spite of large increases in life expectancy and improvements in the health status of the general population. Health status is profoundly affected by poverty and racism. Poverty is the single most profound risk factor for disease.[1,2] Poverty with its concomitant lack of adequate housing, nutrition, and access to health care contributes greatly to the death toll on Black Americans. Failure to close the gap in health status between Whites and Blacks can also be directly attributed to lack of access to health care. George Lundberg, MD, editor of the *Journal of the American Medical Association,* attributes this lack of access to long-standing, institutionalized racial discrimination.[3]

One must be mindful that race of an individual is not an independent risk factor. In other words, Blacks do not have higher morbidity and mortality rates than Whites because they are Black. The landmark Black Report in Great Britain demonstrated that after decades of universal access to health services, health status inequalities between Whites and Blacks not only persisted, but were increasing.[1] In response to this evidence, William McBeath, Executive Director, American Public Health Association, stated that in America, "[W]e must assure access, not only of medical care, but also to a better standard of living—assuring nutritious food, basic education, safe water, decent housing, secure employment, and adequate income—these are the prerequisites of a healthy life-style."[1] In the absence of these prerequisites, the health status of Black Americans will continue to be cause for righteous indignation well into the 21st century.

In 1990, Dr Louis Sullivan, Secretary of Health and Human Services, presented to the nation *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.*[4] These objectives include special population targets for decreasing the disparity in health status and can provide a framework for health promotion and disease prevention activities conducted through the Black church. In this article we focus on results obtained from a survey of Black churches in the northern United States and describe how the Black church can contribute to the goal of achieving health for all Americans by the year 2000.

The Black church has historically been a major focus of the spiritual,

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social, and political life of Black Americans. Billingsley and Caldwell[5] state that 84% of Black adults consider themselves to be religious and almost 70% are members of a church. Lincoln and Mamiya[6] estimate Black church membership at 24 million. It is also estimated that 65 000 to 75 000 Black churches of various denominations exist in the United States.[5]

The church has a long history of addressing unmet health and human service needs of the Black community.[7-9] As long ago as the 1920s, Mays and Nicholson[10] conducted a study of 609 urban churches and 185 rural churches. The authors found that community outreach programs included various activities aimed at addressing health needs, such as (1) programs to feed the unemployed, (2) free health clinics, (3) recreational activities, and (4) child care programs.

The existence of social networks and social support through the church provides the opportunity for health promotion programming.[8] Health programs that focus on behaviors that can be reinforced by social support are a natural arena for churches. Additionally, social and emotional support offered through church programs is perceived as an essential means to prevent the isolation that results from illness.

Historically, the Black church has been used by public health and medical professionals to gain access to those Blacks who are more difficult to reach through mainstream systems. The National Negro Health Movement, 1915 to 1950, represents the best historical example of how the Public Health Service utilized the church in a national strategy to bring modern public health practices to Blacks. The health status disparities that justified the need for a National Negro Health Movement are present today and demand that systematic research be conducted to determine how the vitality within Black churches may best contribute to reaching the objectives stated in *Healthy People 2000.*

Methods

The Black Church Family Project was a multiyear, national study of family-oriented, community outreach programs sponsored by Black churches. In 1979, the Sampling Section of the Survey Research Center of the Institute for Social Research at the University of Michigan designed a procedure to select the first nationally representative sample of Blacks for use in the National Survey of Black Americans. We assumed that the distribution of Black churches would reflect the distribution of Black households. The basic sampling frame included 76 primary sampling areas stratified by region. Data presented in this article are limited to a representative sample of 635 churches in the northern region of the United States that completed a computer-assisted telephone interview conducted during 1990 and 1991. Fifty-seven percent of the 1115 churches sampled completed the survey. Included in the category of nonrespondents were churches that were unreachable after three attempts and those churches that refused to participate.

Results

It must be noted that the Black church, like the Black community, is not homogeneous. Churches in the sample were drawn from a wide range of denominational affiliations. Baptist churches accounted for approximately 44% of the sample. Forty percent of these Baptist churches belonged to the National Baptist Convention—USA, Inc. Methodist churches represented 13% of the sample; of these, over 75% belonged to the African Methodist Episcopal, the African Methodist Episcopal Zion, and the Christian Methodist Episcopal denominations. Pentecostal churches represented 25.8% of the sample. Other churches—which included the Episcopalians, Presbyterians, the Church of God in Christ, Seventh Day Adventists, and smaller denominations—constituted 17.6%. Although the vast majority of churches (91%) had no paid female clergy, it is noteworthy that women constituted 50% to 100% of congregation members in 562 (88%) of the churches in the sample.

When senior ministers were questioned about the primary role of the contemporary Black church (membership service or community service), 5% emphasized serving the membership only and 9% indicated service to the community only, whereas the vast majority (86%) indicated that the role of the church was to serve church members and the community. The data revealed that 426 churches (67%) sponsored a total of 1804 community outreach programs. It was common to find multiple programs being operated by the same church. For example, 67% of churches operate one or more community outreach activities; 54% operate two or more community outreach activities; and almost 41% operate three or more community outreach activities.

An examination of the 1804 programs revealed that 51% were adult and family support programs, 31% were oriented to children and youth, 9% focused on community development, and 9% were programs for the elderly. Programs for children and youth addressed health issues including, but not limited to, human sexuality, acquired immunodeficiency syndrome (AIDS) education, drug abuse prevention, pregnancy prevention, and mental health.

Family programs focused heavily on the provision of basic human services like food, shelter, and child care. For those churches focusing on human service needs, the majority reported that participants were primarily low income. An examination of programs targeted to adults and families demonstrated a focus on counseling for AIDS risk reduction, drug abuse prevention, services to men and women in prison, and other health issues. Programs for the elderly focused on home health care, food delivery, medical care, and other basic human services. Furthermore, other health-related services included health clinics, screening for specific health problems, and health education workshops on various topics. Additionally, domestic violence programs for women and mental health programs for both youth and adults were sponsored. In detailed descriptions of 383 selected programs, we found that 94% of the programs providing basic human needs, counseling, and education were staffed primarily by volunteers.

An examination of data on the respondent's (typically the respondent was the senior minister) perceptions of community problems provides additional evidence that health issues are central to the mission of the church. Approximately 54% of ministers sampled considered drug abuse as the most serious problem in their community. Related programs included drug abuse counseling, AIDS support and prevention programs, drug education seminars, and sponsorship of Alcoholics and Narcotics Anonymous meetings.

The Black Church Family Project data also provide evidence that the churches sampled collaborate with secular service agencies and other churches. There were 450 churches (71%) identi-

TABLE 1—Ranking of Collaborations between Secular Agencies and 450 Black Churches

Secular Agency	% of Churches[a]
Local police	83
Local schools	82
Welfare departments	77
Hospitals	69
Local prisons	68
Health departments	65
Housing departments	65
Recreation departments	62
Youth organizations	56
Mental health departments	54
Employment agencies	51

[a]Percentages do not total 100 because respondents selected all categories that applied.

TABLE 2—Univariate Analysis of Church Characteristics Associated with Conduct of Community Health Outreach Programs

	No.	% with No Outreach	P
Membership size			<.01
Little (1–70)	146	60.3	
Small (71–175)	185	36.8	
Medium (176–400)	157	22.3	
Large (>401)	145	11.7	
Denomination			<.05
Baptist	277	38.3	
Pentecostal	164	35.4	
Methodist	82	23.2	
Church age			<.01
Young (1–40 y)	339	38.3	
Mid-age (41–75 y)	156	28.2	
Old (>75 y)	132	22.0	
Economic class			<.01
Working class	194	41.2	
Middle and working class	370	28.9	
Middle class	49	20.4	
Ownership of church			<.01
Rent	44	59.1	
Own	589	30.9	
Number of paid clergy			<.01
None	188	51.1	
One	352	27.6	
Two	59	13.6	
Three or more	31	19.4	
Other paid staff			<.01
No	305	43.6	
Yes	322	22.4	
Education level of minister			<.01
Less than high school	57	59.6	
High school	109	52.3	
Some college	93	33.3	
College degree	107	25.2	
Master's degree or above	188	16.5	

fied as having cooperative relationships with secular agencies. Table 1 identifies the types of agencies involved. Additionally, over 60% of churches collaborate with other churches in the same denomination as well as with churches of other denominations.

The existence of church programs that have collaborative relations with agencies such as welfare departments and that provide basic human services such as shelter and food indicates an ability to reach potentially underserved, poorly served, and never-served segments of the Black community. Collaborative relations with secular agencies may be strategically used to provide social support for health promotion and disease prevention initiatives designed to meet the Year 2000 health objectives.

Characteristics that influence participation in community outreach activities include church size, denomination, church age, economic class of membership, church ownership, number of paid clergy, existence of other paid staff, and education level of the minister (Table 2). Examination of data on church size demonstrates that a greater proportion of medium-size (78%) and large-size churches (88%) were involved in outreach programs.

Baptist, Pentecostal, and Methodist churches constituted 82% of the entire sample. Although a majority of these churches were actively involved in community outreach programs, some denominational differences were observed. Although there were more Baptist churches in the sample, a greater proportion of Methodist churches (77%) conducted outreach programs compared with Baptist churches (62%) and Pentecostal churches (65%).

The number of years the congregation had existed was an important factor. Approximately 78% of the churches over 75 years old reported involvement in community outreach, compared with 72% of churches between 41 and 75 years old and 62% of churches younger than 41 years old.

Economic class composition of the congregation was another important factor. Eighty percent of churches with a majority of members from the middle class sponsored community outreach programs. This figure declined to 71% among churches with congregations composed of members from the working and middle classes and dropped again to 59% among churches with congregations composed predominantly of working-class members.

Church ownership appeared to be another important factor. Overall, 70% of churches with paid mortgages engaged in community outreach programs. However, only 41% of church renters conducted outreach programs. This finding highlights the importance of the availability of church resources that may help to sustain and expand outreach programs. Additionally, ownership is related to a sense of independence and pride, both essential to the continuation of self-help and community health outreach.

The number of paid clergy was also associated with the conduct of community outreach programs. Only 49% of churches with no paid clergy were

TABLE 3—Logistic Regression Model of Church Characteristics Associated with Conduct of Community Health Outreach Programs

	Odds Ratio	95% Confidence Interval
Size		
Large (>401)	Referent	
Little (1–70)	0.11	0.04, 0.27
Small (71–175)	0.35	0.16, 0.76
Medium (176–400)	0.69	0.32, 1.50
Church denomination		
Methodist	Referent	
Baptist	0.64	0.30, 1.38
Pentecostal	1.80	0.76, 4.28
Church age		
Old (>75 y)	Referent	
Young (1–40 y)	1.32	0.63, 2.75
Mid-age (41–75 y)	1.07	0.51, 2.24
Economic class		
Middle class	Referent	
Working class	0.46	0.17, 1.21
Middle and working class	0.70	0.27, 1.79
Ownership of church		
Own	Referent	
Rent	0.67	0.28, 1.63
Number of paid clergy		
Two	Referent	
None	0.49	0.16, 1.49
One	0.83	0.31, 2.24
Three or more	1.26	0.24, 6.54
Other paid staff		
Yes	Referent	
No	0.99	0.56, 1.74
Education level of minister		
Master's degree or above	Referent	
Less than high school	0.32	0.13, 0.78
High school	0.29	0.14, 0.60
Some college	0.66	0.30, 1.42
College degree	0.90	0.44, 1.86

involved in outreach. For those churches with two paid clergy, over 86% offered outreach programs.

In addition to clergy, other paid staff are human resources who also contributed toward greater involvement in community outreach. Overall, 56% of churches with no additional paid staff engaged in outreach, whereas 78% of churches with paid staff conducted outreach programs.

Finally, it is noteworthy that the minister's level of education was strongly associated with church outreach activities. For example, only 40% of those churches whose minister had less than a high school education offered outreach programs compared with 83% of those churches whose ministers had a graduate degree.

The eight variables described in Table 2 were entered simultaneously into a logistic regression model. In this multivariate model (Table 3), church size and education level of the minister remained independent predictors of church outreach activities. Based on these variables, the logistic regression model correctly classified 88% of churches that conduct community health outreach programs and 51% of churches that did not participate in outreach activities. Overall, the model correctly classified 76% of churches in the sample.

Discussion

In summary, this study identified eight church characteristics that may be used by public health professionals to identify churches that conduct community health outreach programs. When these characteristics were analyzed in a multivariant model, church size and education level of the minister proved to be the strongest predictors of church-sponsored community health outreach programs.

Although the institution of the Black church has traditionally been sustained largely by volunteers, this study suggests that the availability of paid clergy and other paid staff to provide consistent leadership to various programs is a necessary factor that will determine the extent to which the church can continue the provision of community health outreach programs. Additionally, health professionals who belong to churches could provide a critical source of expertise and could be mobilized as volunteers to guide and implement community health programs. Although women comprise the majority of church members, they remain underrepresented in the ranks of paid clergy. However, their contribution as volunteers in sustaining church programs must be acknowledged.

Some may argue that the church may be unable to reach those populations most adversely affected by pressing public health problems such as tuberculosis, human immunodeficiency virus (HIV), violence, and substance abuse. However, results of our study demonstrate that Black churches work in collaboration with secular agencies such as prisons, local police departments, welfare departments, and public housing offices. This finding suggests that churches are already involved in delivery of services to poorly served, underserved, and never-served segments of our society. Unfortunately, there has been little systematic evaluation of the quality and efficacy of these efforts, nor have they been acknowledged in the public health literature.

Many churches struggle with moral issues related to the sexual and drug behaviors at the root of health problems such as substance abuse, HIV disease, and violence. For example, substantial opposition to needle exchange and condom distribution programs has been generated by Black churches in various cities.[11] In such cases involving controversial issues that conflict with church tenets, secular agencies may provide appropriate resources. This can free the church to focus on services that are more congruent with its mission.

This study identified characteristics associated with community health outreach that may be used by public health professionals to identify those Black churches most likely to be supportive of efforts to expand health promotion and disease prevention activities. Public health professionals should collaborate

with these churches by helping them focus community health outreach programs on specific *Healthy People 2000* objectives relevant to the target population and within the capability and scope of church resources and expertise.

It is noteworthy that graduate education of the minister is strongly associated with community health outreach. The Black clergy has historically provided social, political, and religious leadership to the Black community. Therefore, joint degree programs between schools of theology and schools of public health could train a cadre of ministers who could expand their sphere of influence to provide leadership on public health issues.

Finally, closing the health status gap between Black and White Americans will require public health professionals to draw on the strength, commitment, and credibility of the Black church supported by an adequate infrastructure. As the movement for national health care reform continues to grow, it will become necessary for public health professionals and policymakers to incorporate the Black church as an integral component for delivery of health promotion and disease prevention services needed to achieve the Year 2000 health objectives for all Americans.[11,12] □

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