

Church-Based Health Care Initiatives in East Baltimore, Maryland

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Abstract

A qualitative case study that investigated the perceptions of clergy regarding their roles, and those of the church, in health care advocacy. Questions emanating from the research literature were piloted to 4 expert jurors before distribution to 17 main participants. The results indicated that barriers to health care access was predicated on clerical perceptions of the role of the church, severed relationships between collaborators, and several faulty and systemic factors of prior partnerships.

Problem

Research on **health equity** and **religion** has rarely focused on the perceptions of clergy and their roles in reducing barriers to health care (Kotin et al., 2011). Additionally, prior studies have focused mainly on Black communities, with little regard for the growing and disparate Hispanic neighborhoods. In fact, empirical findings of government-funded welfare programs in low socio-economic Black communities have dominated social and religious literature (Austin & Claiborne, 2011; Tuggle, 2000).

The Hispanic community represented the second largest underserved health recipients in America with an increase of 50% between 2008 and 2009, (Bhandari, 2006).

A 2010 report from the Baltimore City Health Department claimed that Hispanics had significantly led Blacks in poverty rates by 17% since 2007. Three-quarters reported having no health insurance; with fewer than half declaring they had alternative health care coverage. The special relevance of Baltimore to this study is that a major church-based health study was conducted here, and it provided a platform for this research project.

Purpose

To investigate the perceptions of clergy on their roles, and those of the church, in health care advocacy.

To identify unknown barriers to health care access for underserved in Baltimore City, Maryland.

To determine avenues for successful church-based health care initiatives.

Relevant Literature

The **conceptual framework** was predicated on the outcomes of faith-based health care initiatives, as they relate to systems theory (von Bertalanffy, 1968/1971). These outcomes unveiled a plethora of relational problems between clergy and other collaborators, who advocated for health access among the uninsured and underinsured.

Clergy are the lynchpins of society, due to their ability to mobilize groups and influence the behaviors of congregants. Their input concerning approaches to meeting the needs of these groups is highly valued in health research literature. Therefore, systems theory research was appropriate for investigating the perceptions of clergy concerning church-based health initiatives. It was also useful in identifying important criteria for promoting successful collaborations between churches, government, and research institutions, in the future.

An important resource of background information for this study is a report by the Baltimore City Health Department on faith-based healthcare collaborations (BCH, 2010). An initial attempt to create long-term health programs through local churches yielded some success, but was short-lived.

The results of this study chronicle reasons for the decline.

Research Questions

The following five research questions emerged from an investigation of the literature.

1. How did clergy perceive their roles and those of the church in social advocacy? (Catanzaro et al., 2007; Kaplan et al., 2006).
2. What were the potential hindrances to churches participating in faith-based activities?
3. What inhibitors of religious and political orientations existed against interfaith collaborations, and those between church and state?
4. What were the perceived educational, historical, political, or religious inputs of faith communities that potentially affected health policy decisions in faith-based welfare?
5. What future value did mentoring and modeling, between experienced and novice clergy, have on increasing involvement of churches in faith-based programs?

Procedures

Instrument prepared from the literature review

Demographic questionnaire

Preliminary questionnaire

Bilingual research documents

Translators

Face to face recorded semi structured interviews

Field notes and observations

Triangulation of research questions for rigor

Expert Jury for validation of research questions

Selection of sample

Data Analysis

Coded and transcribed semi-structured interviews

Nvivo software for analysis of data.

Extracted themes and categories to saturation.

Findings

Clerical perception is that **advocacy is a duty**.

Barriers to health care access include:

- Competition among clergy
- Disconnections
- Distrust of political systems
- Doctrinal differences
- Environmental reconstruction
- English-incompetence among immigrants
- Increasing homelessness
- Fractured relationships between clergy, government, and researchers
- Knowledge deficits
- Lack of cultural sensitivity of local government
- Minimal support, especially funding

Limitations

Small target

Accessibility of clergy to the researcher

Availability of interpreters

Limited responses of participants to protect vulnerable groups

Conclusions

Future investigators could expand this study to understand the affects of reconstruction on church-based social welfare

Further evaluation of assets, skills, and resources within churches may contribute to increased capacities to serve

Unresolved issues between old partners remain sources of contention for future collaborations, and potentially hinder avenues for social change in health care disparities.

Social Change Implications

Identified health care barriers

Increased health care access through culturally sensitive and flexible systems of advocacy

Increased community capacity

Restored relationships between advocates

Symbiotic partnerships between advocates

Replication of this study

Clerical and government interest in results of study for education and direction