

Conducting Health Research in Korean American Churches: Perspectives from Church Leaders

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Abstract Korean Americans experience many challenges to obtaining adequate health care coverage and access to needed services. Because a large proportion of Korean Americans attend churches on a regular basis, churches may be a promising venue where health programs can be delivered. In order to gain an in-depth understanding of Korean American churches with respect to conducting future health intervention research, we conducted exploratory interviews and focus groups with 58 leaders from 23 Korean American churches and three community organizations. From these interviews and focus groups, we found that Korean churches and church leaders seek to meet a variety of social and health needs of their congregation and their surrounding community. Several leaders have stated that assisting with social and medical needs of their members is an important component of their current ministry. They described profound health needs of their congregations and have suggested various ways in which the university can partner with the local churches to help address these needs through research. Additionally, they described various resources churches can provide to researchers such as: their personal assistance, church volunteer base, church facility, and church network and

contacts. Our findings suggest that Korean churches have a high potential to serve an important role in the health of Korean Americans. On the basis of the promising results of the present study, we are planning to conduct a cross sectional survey of Korean church leaders and members in Los Angeles County to substantiate our findings in a larger representative sample.

Keywords Korean Immigrants ·
Church-based health research · Church leaders

Introduction

Although Koreans represent the seventh largest immigrant group in the United States [1], they are an underserved group with respect to health services, research, and policy. Koreans arrive in the U.S. to an environment very different from their homeland, where universal health coverage is in place [2]. They face challenges in adjusting to a new and complex society with unfamiliar institutions for health coverage and access to services. While many of these challenges are common to the immigrant experience, Koreans also face distinct challenges in accessing adequate health care, and more research is needed to address their particular needs. Approximately 80% of Koreans residing in the U.S. are foreign born [3], and over half aged 18 and older do not speak English well [3, 4]. According to the 2000 Census, the median household income for Korean Americans is one of the lowest among the Asian subgroups in Los Angeles County [5]. According to the 2005 and 2007 California Health Interview Surveys, a larger proportion of Korean Americans are uninsured than any of the other five Asian American and Pacific Islander groups in California [4].

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Among the distinctive characteristics of the Korean community is an unusually high church attendance. Over 70% of Koreans in the United States attend churches on a regular basis [6], in contrast to only 14–30% of Koreans residing in Korea [7]. Therefore, Korean churches in the U.S. may play an important role in health research for this immigrant population. As has been noted in sociological studies, in minority communities, churches are important social and educational centers that support the development and maintenance of relationships between individuals who speak the same language and share the same culture, thus providing group ties, identity, and acceptance [8]. We would therefore expect that Korean American churches may use their influence to provide access to needed information and services. Our prior work also indicates that Korean Americans prefer to receive health information in a church setting [9, 10]. Others have found that church was the most preferred location for attending a health education session (45%) versus a community center (31%), hospital (15%), or local school (11%) [11].

The majority of church-based intervention studies to date have targeted African and Latino American communities. These studies show that churches and health care organizations can collaborate to implement successful health promotion programs [12, 13] and health education interventions [8, 14, 15]. These studies are diverse, ranging across a wide variety of health topics from smoking cessation [16, 17], diabetes prevention [18, 19], and nutrition and physical activity [20–25] to cancer screening [26–28]. Health-related research studies focusing on Korean Americans in churches have primarily utilized the church venue as one of several recruitment sites for descriptive studies [9, 29–32]. Only one study utilized churches as an intervention site for a program to increase mammography screening [33]. This study found that a church-based intervention was successful in increasing screening among a small sample ($n = 141$) of Korean American women.

Given the paucity of studies conducted with Korean Americans, there are no published data on how best to conduct health-related research at Korean American churches, what it takes to successfully recruit participants and implement church-based interventions, and how to determine the most appropriate contents and formats of interventions among this population. Strategies that have been successfully used in other communities may need to be tailored to the this setting. Furthermore, there may be divergent research priorities between researchers and church leadership. Moreover, because churches are primarily religious institutions, there may be other unforeseen challenges to delivering health interventions and conducting health-related research. Challenges such as lack of motivation, lack of dedication or lack of time [20, 21], and

frequent change in leadership [20], high attrition rates and difficulty training church staff [34] are barriers frequently mentioned in the church-based literature.

The purpose of this study was to gain an in-depth understanding of Korean American churches from the perspectives of the church leaders in order to guide and facilitate future health intervention research at this venue.

Methods

The study protocol was approved by the UCLA Human Subjects Protection Committee.

Participant Selection and Recruitment

The goal of participant recruitment was to assemble a diverse group of church and community leaders involved in health-related work at Korean American churches from whom we could derive a comprehensive list of themes relevant to the aims of this study. We employed an iterative process of subject sampling, with serial analysis and comparison of initial interviews followed by recruitment for additional interviews and focus groups, until we felt confident that saturation of themes had occurred. After we conducted and analyzed 21 in-depth interviews and three focus groups, we had determined that saturation had occurred and stopped recruitment.

All of our recruitment activities were conducted in the Los Angeles area, and we were able to recruit a total of 58 leaders from 23 churches and three community-based organizations who work with the Korean church community. The aim of sample diversity was met by recruiting leaders representing various positions (pastors, pastors' wives, health program leaders, elders, deacons, and health care workers such as physicians who are active at their churches), church denominations (Catholic, Presbyterian, Seventh-day Adventist, Non Denominational, Church of Nazarene, and Pentecostal), geographic regions (Koreatown and outside of Koreatown), small and large churches, and both genders. In order to do this, we first consulted several leaders of the Korean community and community-based organizations for names and contact information of church leaders as well as individuals who conduct health-related work at Korean churches. We also asked each person we interviewed to name others who are involved in similar work. In order to identify smaller and less prominent churches, we also consulted local Korean language phone directories. All together, we recruited 14 leaders from existing contacts, five from directories, and 39 from referrals. We have summarized the data collection methods and leader characteristics in Table 1.

Table 1 Data collection method and church leader characteristics

		N (%)
Total recruited		58 (100)
Data collection method (language used)	In-depth interviews (English & Korean)	21 (36)
	Focus group 1 (Korean)	3 (5)
	Focus group 2 (Korean)	15 (26)
	Focus group 3 (English & Korean)	19 (33)
Gender	Male	41 (76)
	Female	17 (24)
Location of leader's home church	Los Angeles County	41 (71)
	Koreatown	11 (19)
	Outside of Koreatown	30 (52)
	Outside of LA County	17 (29)
Position	Pastors	33 (57)
	Elders and deacons	9 (16)
	Lay church health leaders ^a	7 (12)
	Pastors and elders' wives	5 (9)
	Church officers (i.e., treasurer, secretary)	2 (3)
	Church health program leaders	2 (3)

^a Do not have church appointments but are known by the community to voluntarily lead various health activities

Data Collection

The primary author, a bilingual bicultural Korean American clinician researcher with extensive experience in qualitative research, conducted all of the interviews and focus groups. Interviews took 40–90 min and focus groups took 90–120 min to complete. All of the interviews were conducted via telephone ($n = 6$) or in-person ($n = 15$) at the convenience of the leaders and in the language most

comfortable to the participant. Eight of the in-person interviews and two of the focus groups were completed at the leaders' respective churches. One focus group was completed at a pastors' retreat. The remaining in-person interviews were conducted at various locations including leaders' work places and coffee shops.

At the start of the interview, leaders were given written or verbal information regarding the study. Using the long interview method described by Crabtree and Miller [35], we gathered in-depth information from each of the leaders through several broad, open-ended questions and follow-up prompts. Using a common semi-structured interview guide (Table 2), we obtained perspectives on the potential role Korean churches can play in the health of the church-going community, as well as the health care needs of the community, the priority research areas for this population, and how Korean churches can play a part in health services research.

Although no monetary incentives were used to recruit participants, as a token of appreciation, a \$50 donation was made to the church at the conclusion of the interviews.

Data Analysis

Extensive notes were taken at each of the interviews and focus groups. When given permission, interviews were tape recorded and transcribed.

We analyzed our notes and transcriptions using the editing method [36], in which we examined and dissected each of the transcriptions and interview notes, identified the information most pertinent to the research question, and

Table 2 In-depth Interview Guide

- Please describe the role and function of your church.
- What is your role at your church?
- What are the health needs of your church congregation?
- What are the barriers that your church members face in obtaining adequate health care?
- What are the priority areas of health research among your church attendees?
- Do you think that your church can be utilized for health programs and health research? How?
- What kinds of programs or interventions would you like to see at your church?
- What kinds of health research would you like to see at your church?
- What resources do you or your church have that may assist in these health interventions/research?
- What are appropriate recruitment methods, incentives and reimbursements for the church and church members in participating in health related research?
- What are the preferred formats for health related work and research at your church?

then categorized, cut, and pasted the contents into a list of themes, first in the interview or focus group language and then translated. To ensure that relevant items were not overlooked or misunderstood, members of the research team, a clinician researcher and two medical students, individually scrutinized the data to extract pertinent themes. Themes were then compared and contrasted across investigators and synthesized into a final list of core themes. Any disagreements were discussed with the entire team until a consensus was reached.

Results

Congregational Health: Beyond Spiritual

Almost all of the leaders we spoke to stated that Korean churches take on roles that are beyond spiritual and religious. These may include assisting members with their health, legal, and psychosocial needs. Several emphasized that churches that serve immigrant populations like many Korean churches in Los Angeles County should strive to be a center of health, legal, social, and financial information.

Church is not an entity that only provides spiritual nurturing. The ‘holistic’ purpose of the church is to provide spiritual, psychosocial, and physical nurturing to those served by it.

The church is important in addressing not only the spiritual needs of the congregation but also the physical, mental, and financial. The church needs to become a role model to the larger society. It is the church’s responsibility to promote prevention and give important information to the congregation to solve problems like family issues such as a spousal fight in front of the kids. Because we try to address not only the spiritual aspect but also the needs of the people, a lot of Non-Christian immigrants have come through here and converted to Christianity.

In fact, many of the churches we visited offered a variety of programs outside of religious and spiritual areas, including: healthy cooking classes, running classes, annual health fairs, weekly health clinics or dispensaries, overseas medical missions, smoking cessation programs, parenting seminars, anger management seminars, financial health seminars, legal workshops, field trips for the elderly, and fund raising events (e.g., yard sales, car washes, and fund drives) to help the needy with food and other material goods, both within and outside of their churches.

The leaders also pointed out that immigrant churches serve a key role in preserving their mother culture. Many churches offer programs such as Korean language classes,

Korean cultural dance or martial arts classes for the young, field trips, and mission trips to Korea.

Looking After the Flock: Meeting Health and Social Needs

Many of the pastors and church leaders (e.g., pastor’s wife, elders, deacons) stated that they spend a significant amount of time meeting the health and social needs of their members, some spending as much as 30–50% of their total ministerial time in this area. Such activities include: interpreting at doctors’ offices, hospitals, and schools; assisting with transportation and accompanying parishioners to hospitals, schools, and social security offices; helping with completing forms, answering health and legal questions (e.g., immigration issues, children’s education, and job related issues); and overseeing health and social programs such as health fairs or seminars at their own churches.

As a pastor for an immigrant church, it is my job to help anytime I am asked. It is essentially a 24-h job and is very time consuming.

Many mentioned that meeting immediate needs of their members, be they religious or non-religious, is a part of their ministry, as much as writing and delivering sermons on Sunday mornings or conducting prayer meetings. When asked why they place such a considerable focus on apparently non-religious areas, we obtained several perspectives. Some used the term “need-based ministry,” explaining that identifying and meeting the needs of a person is the very first step and starting point for effective ministry.

We believe in the principle of meeting the “felt need” in order to lead a person to spiritual health. In other words, meeting the social/psychological/health needs of the person is essentially bridging the person to spiritual health. This is called the “need-based ministry.”

Others focused on the connectedness of spiritual, physical, and mental health. They stated that ministering to the physical and mental health needs is essential because they can contribute significantly to a person’s spiritual health.

Health is a strong tenet of our belief. Physical health is influenced by spiritual health and vice versa. Helping someone with their health needs is essentially ministering to someone about God. This is what happens at our church clinic (held once weekly after services). We heal them and talk to them about God’s will for their healthful living. Through our work at the clinic, cooking classes, and running classes, about four to five end up coming to our church and getting

baptized every year. Although this is not a big number, we are sowing seeds.

Others stated that church leaders should follow the example set by Jesus who healed the sick and ministered to the poor.

During His time on Earth, Jesus devoted more time to healing the sick than to preaching. Meeting the needs of the sick and poor is a very important component of my job.

Health Needs of the Korean Church Memberships

Leaders stated that among the various challenges that face their membership, health is one of the dominant concerns. When asked to name some of the common health issues of their membership, the following were commonly mentioned: cancer, heart disease, stroke, high blood pressure, diabetes, lack of exercise, and poor diet.

Psychosocial problems (e.g., depression, anxiety, domestic violence, and substance abuse) were also frequently mentioned. A few spoke passionately and ardently about the need to address these issues.

Los Angeles is a hard place to live in and immigrant Koreans face a lot of problems trying to make a life here. I have seen a lot of family problems. For the children, there is a lack of self esteem as their parents are too busy working and they turn to gangs and drugs. Recently-immigrated children are a primary target for gangs. I have visited a lot of centers, and of the recently immigrated children that I've met, I think more than 20% are involved in illicit drug use.

These leaders stated that addressing the psychosocial needs of their membership might be even more urgent than addressing the physical health needs. They elaborated that many of their members, especially recent immigrants, experience financial hardship, social isolation, and pressure from jobs or job-related issues. Over time, these circumstances contribute to not only depression, domestic violence, substance abuse, suicide and even homicide, but can also result in unhealthy lifestyles that lead to chronic diseases such as cancer and cardiovascular diseases.

It is very hard for Koreans to live within the American system and as a result, deal with a lot of stress. Depression is very prevalent, but due to stigma in our culture, Koreans try to ignore it or overcome it on their own. Those who are unable to do that become more depressed.

Barriers to Adequate Health Care Among Korean American Church-Goers

Church leaders frequently mentioned that their members face many challenges and barriers in maintaining health and obtaining adequate health care. Among those mentioned lack of health insurance and inability to pay predominated. Others included: language barrier, access barrier, fear of deportation, the Korean cultural view that illness is a result of “bad genes” or inherent weakness, and a religious view that illness is a result of sin or a punishment from God. A few elaborated that because some members view illness as a punishment from God, sick members may try to keep their illness to themselves, isolating themselves from the rest of the church community and the social support it can provide. For this reason, many patients delay seeking medical attention and support from the church until their illness is well advanced.

Often, beside close family members, pastors are the only ones who know about the patient's illness. A sick member will tell me not to say anything to anyone else. This is a challenge for me because I'm not a doctor or a nurse, and I don't know how best to help them, and I don't know where to take them or to where I should refer them.

Many of my members want access to health and social programs such as Social Security. I would like to inform them somehow, but I myself don't know too much about them. However, there is a sense of shame among Koreans attached to receiving aid. So, although there are a lot of sick parishioners, I don't mention or bring up hospitals or medical care in the church setting unless they bring it up first. If they have illegal status, it is even harder to help them.

How can Korean American Churches Participate in Health Research?

When asked whether they would be interested in participating in health related research with UCLA, almost all of the pastors and leaders showed a great amount of enthusiasm. They stated that they would be happy to participate and even offer their support through various resources as follows: their own personal assistance, church volunteer base, church facility, and church network and contacts. These are described below.

Personal Assistance

Pastors and leaders have stated that they themselves can assist with various aspects of collaboration, such as:

facilitating the recruitment and participation of other churches in their network by influencing the church board and other key leadership, directly recruiting volunteers from their church membership, giving their own professional expertise or service to the collaborators with intervention development and implementation of project protocols at churches.

Church Volunteer Base

Leaders stated that many of the churches have health care professionals such as physicians (Western and Eastern providers), dentists, nurses, and other professionals in their membership who may be willing to donate their time and expertise. They also have other lay personnel (young and old) who are willing to volunteer their time.

Church Facility

Many of the churches we visited were equipped with conference rooms, classrooms, kitchen and dining rooms. The main sanctuary may also be utilized for activities such as lectures and seminars. However, in the case of some very small churches with less than 50 members, services are held at private homes or small rental units in larger buildings.

Church Network and Contacts

We found that many of the churches belong to or are affiliated with larger organizations such as the Catholic Order, the Presbyterian Synod, or the Baptist Union. Some stated that they belong to a larger network of local churches or pastors' groups. They stated that a buy-in from these larger organizations and networks can lend credibility to a research project. Furthermore, they mentioned that these networks may play a vital role in facilitating dissemination of important health information.

Suggestions for Health Interventions and Research Strategies

When asked what kinds of programs or interventions would best suit their membership in addressing their health needs, they gave several suggestions as discussed below, and offered to host these programs at their churches.

Interventions that Address Prevention and Early Detection

Several pastors and leaders stated that cancer and other chronic diseases such as heart disease and stroke are important health concerns among their church congregation. They suggested that programs that promote healthy

life style and screening would be beneficial to their members.

Joining with the University to Offer Health Fairs and Health Seminars

A few of the leaders mentioned free health seminars that UCLA has offered in the community and health fairs offered by various organizations. They stated that health seminars and health fairs would be very helpful and effective in a church setting. They stated that they would be very happy to provide space and church volunteers to support such events. Furthermore, because many churches seek to reach and evangelize community members living near the church, such events would be an excellent opportunity for a wider outreach to those who may not attend churches.

Programs that Provide Pastors or Key Church Leaders with Health Information and Resources

Because the pastor is frequently one of the first people to whom a patient will disclose his or her illness (even prior to seeking medical care), a few leaders mentioned that programs that provide the pastor or key church leaders with health information and health resources would be helpful. Such programs could be in the form of seminars or resource guides/directories. Many of these pastors stated that they would be happy to attend such seminars and furthermore recruit their colleagues to attend.

Interventions that Address Psychosocial Needs

As mentioned above, several leaders spoke passionately about the need to address psychosocial needs of their membership. They recommended programs such as anger management seminars, relationship seminars, and financial health counseling. They emphasized addressing these issues will no doubt help improve physical health of the church members in the long run.

Interventions for the Church Youth

Many leaders spoke about the need to focus on youth. They stated that because of the widening cultural gap between immigrant parents and their children, problems arise that may be very difficult for the parents to identify and address. Leaders suggested youth mentorship programs and drug and alcohol education and counseling.

We also asked the leaders to offer suggestions on culturally sensitive strategies on recruitment and incentives or reimbursements. These are summarized in Table 3.

Table 3 Leaders' suggestions on recruitment strategies and incentives/reimbursements**Recruitment strategies**

- Announcements in church program bulletins, newsletters
- Announcements in Christian newspapers
- Live announcements at church services and other activities
- Buy-in from church leaders
- Buy-in from larger church networks and conferences

Incentives/reimbursements

- Monetary or material donation to the church or church projects
- Monetary payment to the members
- Material goods such as T-shirts, caps/hats, umbrellas, shopping bags
- Free medical services (i.e., glucose, cholesterol screenings, flu vaccinations)
- Health lectures/seminars for members and leaders

Discussion

We learned from our interviews that many Korean American churches strive to meet diverse needs of the immigrant community. Apart from their religious and evangelical programs, they seek to address a variety of challenges facing their membership, including health, legal and psychosocial issues. We also learned that many church leaders are supportive and open to collaborating with the university to meet the needs of their congregation. During these interviews, they have willingly elucidated many ways in which they themselves and their churches can contribute to health research.

It is well known that churches function as “social centers” for African American and Latin American populations [8]. The results of our interviews and focus groups indicate that Korean American churches also serve this function. It was apparent that many Korean American churches we visited function as community centers that seek to buffer the harshness of the immigrant life to varying degrees.

Korean Americans are largely immigrants who have arrived to an unfamiliar country, often removed from their social network of extended family and friends. According to our interviews, many Korean churches seek to provide a familiar, safe, supportive place for them. This could possibly explain why a higher percentage of Korean Americans attend churches on a regular basis than do Koreans residing in Korea.

Many Korean church leaders we interviewed provide practical assistance to their sick members (i.e., accompanying a church member to physician appointments, providing translation, assisting with completing forms, etc.) and consider this a core component of their Christian ministry. Sometimes they act as “culture brokers” who

serve to bridge and mediate between groups or persons of different cultural backgrounds to effect change or understanding [37–39]. A few of the leaders expressed being overwhelmed with the amount of time they have to spend in this work, and some were frustrated that they were not well equipped with clinical knowledge or aware of available resources and have asked for programs that facilitate this aspect of their work.

Among the many health needs of the members that were mentioned, psychosocial issues (e.g., domestic violence and drug and alcohol problems in the youth) were often discussed more ardently than others and identified as issues that need more urgent attention. The prominence given to these psychosocial issues may reflect their greater disruption of the spiritual health and religiosity of their members than other prevalent health concerns such as diabetes, hypertension, heart disease, and cancer.

A few leaders mentioned that many church members view illness as a result of sin or punishment from God. This view may pose interesting challenges to certain types of health programs that could be offered at Korean churches. Many individuals may not wish to be identified as patients or admit that they had an illness in the past, and programs such as illness-centered psychosocial support groups (i.e., cancer support groups) or discussion groups that elicit personal illness experiences may not be welcomed. To these individuals, educational seminars and emphasizing the concept of disease prevention and health maintenance may be more appropriate.

Limitations

This is a qualitative study with a small convenience sample of church leaders in Los Angeles County. In addition, most of the church leaders were either known by the author (AJ) or were referred by a church leader who had completed the interview. As a result, all leaders that were invited to participate completed interviews or focus groups. All of the interviews were conducted by the primary author who is a physician and faculty at UCLA. Her position in the university may have prevented participants from expressing discontent or dissatisfaction toward collaboration with the university.

Next Steps

Our data suggest that many Korean American church leaders assume the responsibility of assisting church members with their health needs in addition to their spiritual needs. They were interested in hosting programs that address prevention and early detection of diseases, health

fairs and seminars, programs for youth, and programs addressing psychosocial needs. We are planning to conduct a survey of Korean church leaders and members to substantiate our findings in a larger representative sample.

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