

**A QUANTITATIVE ANALYSIS OF THE SYNERGY AMONG SELF-REPORTED
FAITH, HEALTH AND HEALTH CARE PRACTICES OF BLACK BAPTISTS: A
CULTURECOLOGY PERSPECTIVE**

by

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Abstract

In the Black community, faith, spirituality and religion appear to influence health and health care decisionmaking. Therefore, the purpose of this research was to investigate the synergy between faith, health and health care practices of Black Baptists using a Model of Authentic Cultureecology as the conceptual framework. The public health importance of this study relates to expanding the understanding of factors that influence health and health care decisionmaking.

The study objectives are related to communication between pastor and congregants about health and health care issues, prayer and rating of general health status, and belief in God/Jesus as a healer and health care utilization behaviors. A secondary analysis was conducted using a cross-sectional dataset of 1,327 African American men and women who attended the first Joint Black National Baptist Convention held in Nashville, Tennessee from January 24-28, 2005. A series of regression analyses were completed to determine the relationships regarding pastor-congregant communication, and faith and religious influences on health and health care decisionmaking.

Having been told that you have hypertension or asthma was a significant predictor for talking to a pastor when sick. Males and females differed significantly in talking to their pastor about personal health issues. Men communicated more often than women. Eating vegetables daily was a significant predictor for communicating with a pastor about physician interactions. Participants who pray before and/or after making a medical decision were more likely to report their health status as excellent or good. Additionally, the belief that God/Jesus is a healer was a significant predictor for the last visit to a physician when the respondent's sex was considered.

It appears that faith positively influenced the respondents' perception of health and health care decisionmaking, and their relationship with their pastors is an important factor. More research is needed for further clarification of these synergistic interactions.

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PREFACE

It is ironic that my research about the influence of faith on health and health care practices of Black Baptists would result in a true test of my faith in myself and others. I asked the Lord to lead my path toward His will; He has and continues to do so. I thank God for His eternal love and grace.

This doctoral process was a complex journey, one that I would not have accomplished without others' encouragement, guidance, love and/or support—emotional, spiritual, and financial. To my Committee Members, Dr. Warren, Dr. Thomas, Dr. Ricci, Dr. Rohrer and Dr. Butler, thank you for investing your time and energy in helping me. Dr. Rueben Warren, thank you for taking a chance with me and helping me beat tremendous odds to complete my dissertation and earned my doctorate. You became my navigator when I lost my compass...guiding me down complicated paths and nudging me over massive hurdles. Your gift of mentoring will never be forgotten!!! Dr. Thomas, thank you for being the Dissertation Chair I needed to move me from the rank of ABD to become Dr. Crystal Warren. To Dr. Alema-Mensah, you will forever be my honorary Committee Member. Thank you for helping me decipher the “world of statistics”.

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Crystal L. Warren
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1.0 INTRODUCTION

The 1985 Report of the Secretary’s Task Force on Black and Minority Health brought national attention to the fact that 60,000 excess deaths occurred annually because of health disparities among African Americans, compared to non-Hispanic Whites. The term “excess deaths” expresses the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if they experienced the same death rates for each age and sex in the non-Hispanic White population (DHHS, 1985). Eighty percent (80%) of the excess deaths occurred from six causes – heart disease and stroke, cancer, diabetes, cirrhosis, homicide and unintentional injuries, and infant mortality (DHHS, 1985). By 1991, Acquired Immune Deficiency Syndrome (AIDS) was added as the seventh excess death (DHHS, 1985). According to a recent study by Satcher et al. using 2002 data, the black-white mortality gap has increased to more than 83,000 excess deaths. This persistence of health inequalities in the United States has led to additional research suggesting a need for behavioral and social scientists and others to explore the risk factors that predispose African Americans to disproportionately high mortality rates, morbidity risk factors, and other adverse health conditions.

In the Black community, faith, spirituality and religion play an important role in daily living for many people. It is reasonable to suspect that these metaphysical factors may positively influence health and health care decisions for African Americans. Furthermore, research in minority health, suggests linkages between African Americans' perceptions on faith, spirituality, and religion, with health and health care (Dessio et al, 2004; Felix et al., 2003; Musgrave, Allen & Allen, 2002; Steffen et al, 2001; Strawbridge et al., 1997, vanOlphen et al., 2003).

The purpose of this research is to investigate the synergy between faith, health, and health care practices among African American Congregants attending the Joint National Black Baptist Conference, which took place from January 24-28, 2005 in the Gaylord Opryland Hotel located in Nashville, Tennessee. The public health implications of this study are broad and purport to explore a new research paradigm to improve African American health and health care and hopefully, eliminate the growing health disparity problem. The research will allow for a better understanding of health care patterns of decision-making, health financing, and health outcomes. The overall goal is to develop culturally appropriate strategies to improve the health, health care and the overall well-being of African Americans.

1.1 HYPOTHESES

The following five hypotheses were developed for this study:

Hypothesis 1: African American male and female participants who have been told by a doctor that they have a chronic health conditions (i.e. hypertension, diabetes, asthma, and/or cancer) are more likely to talk to their pastor when they are sick compared to when they are not.

Hypothesis 2: African American male and female participants who communicate with their pastors about personal health issues are more likely to engage in a healthy lifestyle.

Hypothesis 3: African American female participants are more likely to communicate with their pastors about personal health issues compared to African American male participants.

Hypothesis 4: African American female participants who pray before or after making a medical decision are more likely to rate their general health status as excellent or good.

Hypothesis 5: African American female participants who believe that God and/or Jesus is a healer are likely to visit their medical doctor more often than African American male participants who also have the same belief.

1.2 RESEARCH QUESTIONS

The following five research questions were investigated in this study:

1. To what extent is there a relationship between personal health conditions of African American male and female participants and their communication with their pastor when they are sick?
2. What is the relationship between risk behaviors (exercising, eating, smoking & drinking) of African American Baptist men and women, and communication with a pastor about personal health issues?
3. To what extent are there sex differences between African American men and women in communication with pastors about personal health issues?
4. To what extent is there a difference between African American male and female participants who pray before or after making a medical decision and their rating of general health status?

5. To what extent is there a difference between African American male and female participants who believe that God and/or Jesus is a healer and the last time they visited a medical doctor?

1.3 DEFINITION OF TERMS

Convention is the organizational unit by which Baptist churches are commonly grouped for purposes of fellowship, to carry on educational and missionary work, and to administer pension plans (Mead & Hill, 2001).

Faith is not always religious in its content and context (Fowler, 1981). "...the concept of faith does not require religion" (Warren, Lockett & Zulfiqar, 2002, p. 131). It is a person's or groups' way of moving into the force field of life (Fowler, 1981). Faith is a way of finding coherence in and giving meaning to the multiple forces and relations that make up people's lives. It is a way of seeing one's self in relation to others against a background of shared meaning and purpose. The root verb for faith may be translated "to believe, to commit, or to trust" (Hobbs, 1964, p.96). Faith is the most fundamental category in the human quest for relation to transcendence (the existence above and beyond the limits of material experience). (Fowler, 1981) It is a universal feature of human living, recognizably similar everywhere despite the remarkable variety of forms and contents of religious practice and belief. (Fowler, 1981) Faith can also be viewed as a state of being ultimately concerned (Tillich, 1957). That ultimate concern may center in our own ego or its extensions—work, prestige and recognition, power and influence, and wealth. One's ultimate concern may be invested in family, university, nation, or church.

Spirituality refers to a basic or inherent quality in all humans that involves a belief in something greater than the self and a faith that positively affirms life (Musgrave et al., 2002).

Religion is: (1) a system of symbols which acts to (2) establish powerful, pervasive, and long-lasting moods and motivations in men [and women] by (3) formulating conceptions of a general order of existence and (4) clothing these conceptions with such an aura of factuality that (5) the moods and motivations seem uniquely realistic (Geertz, 1966).

Health may be described as a relationship, a synergistic interplay between the physical, social, psychological, and spiritual elements that create the well-being of individuals and/or groups in their physical and social environment (Warren, 1999).

Disease can be described, from a biomedical perspective, as an impairment of the normal state of the living animal or plant body or any of its components that interrupts or modifies the performance of the vital functions. It is a response to environmental factors (e.g., climate, malnutrition, industrial hazards), to specific infective agents (e.g., viruses, bacteria, worms), or to a combination of these factors (Pilch, 2000).

Illness is the social and personal perception of socially disvalued states including but not necessarily restricted to what modern Western science would identify as disease (Pilch, 2000).

Sickness is the misfortune or irregularity in well-being that people recognize. It can be viewed from two perspectives and described by one of two explanatory concepts: disease and illness (Pilch, 2000).

1.4 FOCUS AND SCOPE OF MANUSCRIPT

This manuscript focuses on how faith provides a critical context for improving the health of African Americans. Specifically, it examines the concept of faith and its influence and interactions in relation to the health and healthcare practices of one group of African Americans. This paper aims to: (1) discuss faith and its similarities and differences from spirituality and religion; (2) review major morbidity and mortality trends among African Americans and the social and behavioral implications; (3) examine health and health care disparities and their social and behavioral implications; and (4) describe the synergy between faith, health, and health care.

2.0 CONCEPTUAL FRAMEWORK

The conceptual framework for this research is based on the Authentic Cultureecology Model developed by Lewis M. King, Ph.D. Dr. King is the Executive Director of the Fanon Research Center, and Professor of Human Development at Drew/UCLA Medical School in Los Angeles, California. The Authentic Cultureecology Model is the organized framework used to capture the cultural framing of people of color in relation to health. Culture framing is the idea that the individual's health is a relational event that can be best understood as a situationally bound unit of relationships (organic, psychological, family, social, political, and spiritual) in which culture is the unifying unit (King, 2002). A culturally framed event, is then defined in terms of its own reality, system of values and ways of knowing (King and Davis, 1999). Culture is defined as the customs, beliefs, values, knowledge, and skills that guide a people's behavior along shared paths (Linton, 1947). Operationally, culture includes the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people (Orlandi, 2000). Culture is foundational in influencing health behavior and learning theories related to health education.

2.1 HEALTH BEHAVIOR AND HEALTH EDUCATION THEORIES

Health behavior change is a dominant theme in public health approaches (King, 2002). The body of research in health behavior and health education is recognized increasingly as a way to meet public health objectives and improve the success of public health and medical interventions (Glanz, Lewis, & Rimer, 1997). Theories of health behavior identify the targets for change and the methods for accomplishing these changes (Glanz, Lewis, & Rimer, 1997). Great

emphasis is placed on lifestyle changes (King, 2002). However, little has been accomplished in changing the lifestyles of underserved populations particularly when many of the needed health changes are perceived to be beyond their locus of control. Illness prevention studies have relied heavily on models of behavior change (King, 2002).

Unfortunately, health outcomes related to these models have been disappointing. For example, the Transtheoretical or “Stages of Change” Model (Prochaska & DiClemente, 1983) focuses on cognitive behavior by using stages of changes to integrate processes and principles of change from across major theories of intervention. The Transtheoretical Model considers behavioral change as a process involving progress through a series of five stages – Precontemplation, Contemplation, Preparation, Action, Maintenance, and Termination. According to cognitive behavioral theory, change progresses as the individual moves from the precontemplation stage (has no intention to take action within the next six months), to the contemplation stage (intends to take action within the next six months), followed by a preparation stage (intends to take action within the next 30 days and has taken some behavioral steps in this direction), then to the action stage (has changed overt behavior for less than six months), and finally, to the maintenance stage (has changed overt behavior for more than six months).

The Health Belief Model (Becker, 1974) has been one of the most widely used conceptual frameworks in health behavior. The Health Belief Model proposes that individuals are most likely to take preventive action when they perceive themselves as susceptible to an adverse health condition. The Health Belief Model asserts that individuals believe that poor health outcome would be more severe for them, and see more benefits to make the change than barriers to making the change. The key concepts and definitions of the health belief model

include perceived susceptibility (one's opinion of chances of getting a condition), perceived severity (one's opinion of how serious a condition and its sequelae are), perceived benefits (one's opinion of the efficacy of the advised action to reduce risk or seriousness of impact), perceived barriers (one's opinion of the tangible and psychological costs of the advised action), cues to action (strategies to activate one's "readiness"), and self-efficacy (one's confidence in one's ability to take action) (Strecher & Rosenstock, 2002).

Social Learning Theory (Bandura, 1977) proposes that a person is more likely to take action in a particular way if they know that that action will result in a desirable outcome. The constructs of the Social Learning Theory include the environment, behavioral capability (knowledge and skill to perform a given behavior), expectancies (the values that the person places on a given outcome, incentives), self-control (personal regulation of goal-directed behavior of performance), observational learning (behavioral acquisition that occurs by watching the actions and outcomes of others' behavior), reinforcement (response to a person's behavior that increase or decrease the likelihood of reoccurrence), self-efficacy (the person's confidence in performing a particular behavior), and reciprocal determinism (the dynamic interaction of the person, the behavior, and the environment in which the behavior is performed) (Baranowski, Perry, & Parcel, 2002).

The Theory of Reasoned Action (Fishbein & Ajzen, 1975) asserts that the most important determinant of behavior is a person's behavioral intention. The direct determinants of individual's behavioral intention are his attitude toward performing the behavior and his subjective norm associated with the behavior. Attitude is determined by the individual's beliefs about the outcomes or attributes of performing the behavior, weighted by evaluations of those outcomes will result from performing a behavior will have a positive attitude toward that

behavior. (Montano, Kasprzyk, & Taplin, 2002). It describes the process and conditions under which health or other behaviors are acquired and modified, focusing on the importance of an individual's attitude toward performing an action, as well as the individual's perceptions of how a significant other feels about his or her performing that action (King, 2002).

King asserts that these preventive approaches are narrowly focused on individual behavior change, but despite this narrow focus, they should not be negated. He continues by emphasizing that these models are excellent exemplars of a culturally consistent "Eurocentric" public health approach, but unfortunately, they are applied to public health practice as "universal" models. King proposes that these models, which rely quite heavily on cognition or efficacy, underestimate the value and influence of culture. For example, in a study by Barroso et al. (2000), the Health Belief Model was used as a framework for a comparison study between African American women and non-Hispanic White women on their beliefs about breast cancer and their health locus of control. These researchers noted that there was no relation between health beliefs and years of education among African American women, and that cultural influences are more important than years of education. Additionally, Weinrich et al. (1998) used the Health Belief Model as a framework and found that the most significant factor influencing African American male participation in prostate education program was the presence of a previous church member with prostate cancer. In fact, these researchers noted that having heard about prostate cancer and having had previous screening was not a significant predictor of African American men's participation in prostate screening.

The line of approach, investigating predictors of behavior change among urban minorities, dominated by personal influence paradigms, has necessarily not produced desired public health results for African Americans (Altpeter et al., 1998). Attributing behavior change problems exclusively to the individual not only has biased providers against the poor and urban multi-cultural populations, but also unwittingly has limited providers' willingness to make needed changes in health care services (Weinstein et al., 1998).

The Social Ecology Model (Bronfenbrenner, 1979) involves intervention at the intrapersonal and interpersonal levels. The interpersonal level includes formal and informal social networks and social support systems, including family, workgroup, and friendship networks. The intrapersonal level involves the individual's personal attributes including knowledge, attitude, beliefs, experiences and values. Ecology describes the interrelation between organisms and their environment. Social Ecology refers to the social, institutional, and cultural contexts of people.

Existing ecological models are general statements that multiple levels of environmental variables exert widespread influence on a variety of outcomes related to human health and welfare. The existing models argue that multiple levels of variables are believed to be important, describe some of the principles of environmental influence, and indicate behaviors or outcomes likely to be influenced by environments.

According to Sallis and Owen (1997), three core assumptions of the Social Ecology Model are:

1. *Multiple dimensions of influence on behaviors.* Ecological models specify that intrapersonal factors, social and cultural environments, and physical environments can influence health behaviors.

2. *Multiple levels of environmental influences.* Ecological models specify multiple levels of environmental factors that directly influence behavior. The unique contribution of ecological models is the identification of physical environment factors. The healthfulness of a situation and the well-being of individuals are influenced by multiple facets of the physical and social environments.
3. *Environments directly influence behaviors.* Human environments are multidimensional and complex - Physical versus Social; Objective versus Subjective; and Proximal versus Distal. Ecological models include the proposition that environmental factors from intrapersonal theories, which sometimes hypothesize that selected environmental influences are mediated through psychological processes. An example of an ecological hypothesis is that factors in intrapersonal, social and cultural, and physical environments make unique contributions to the explanation of health behavior in addition to any health effects these environments may produce through interacting with one another.

The most basic assumption of the Social Ecology Model is the multidimensional nature of health and influences on health status. Personal attributes play a role. Participants and the environment can and should be studied at varying levels - individual, small groups, organizational level, and population level. People and their environmental transactions are characterized by cycles of mutual influence, known as reciprocal determinism.

The social ecological approach to health promotion (Moos, 1976; Stokols, 1992) suggests that interpersonal factors such as social support are conducive to health change. Additionally, social institutions with organizational characteristics (for example, schools and churches) and corporate culture are institutional factors that influence health promotion. Moreover, the relationships among these organizations and the public policies that influence them are the community factors that promote health.

The Ecological Model for Health Promotion states that the social and physical environments influence health. However, it does not explain specifically how culture influences health behavior. King argues that there are three dimensions of the cultural proposition that must be considered relative to the health of African Americans.

2.2 DIMENSIONS OF CULTURAL FRAMING

A conceptually different approach to viewing public health is depicted in Figure 1. According to King (2002):

“In this [alternative] view ‘public consists of people-I relationship’—individuals embedded in family, family rooted in community, community based in society. Health is viewed as quality of relationships that affect biological, psychological, social and spiritual well-being. The validity of epistemological claims depends on this understanding that health’s essential quality is in relationships. Health is represented in unity as one line, polarized to indicate negative (–) or optimum (+) health relationships.

However, both of these together do not complete the picture of public health. What is required is the ‘ground’, or context, on which they stand. Context permits the authentic relationship of the public with its existence—political, cultural, ecological, and economic. This is represented by a single line, again polarized into negative and positive, not as objective sum and substance but as perceptions of the ‘public’ of the context” (pp. 96-7).

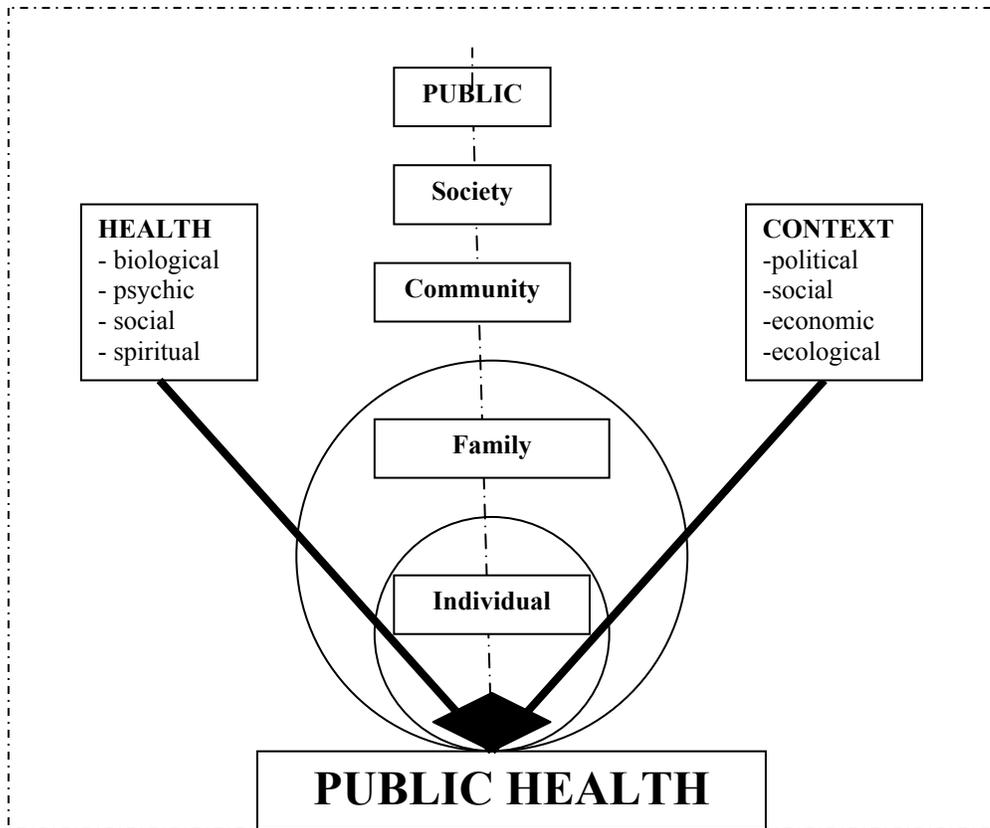


Figure 1. An Alternative View of Public Health as the Health of Relationships (King, 2002)

The first leg of the “public health stool” is culture (Gergen et al., 1997; Nobles and King, 2000). One dimension of cultural framing attends to the group as “public” (King, 2002). In this instance, the public refers to African Americans. There is an assumption in mainstream thinking that African Americans have no legitimate culture (King, 2002). However, African Americans, in anthropological, social, and political contexts, constitute culture (King, 2002). African Americans are a culturally distinct group of people bound by an ideological unity (Butler, 2000). Many cultural and historical factors distinguish African Americans from the rest of American society (Grace, 2000). Wade Nobles has defined three significant time periods that have been used to describe the experiential communality of Africans living in the Western world,

particularly in North America: (1) the African experience (prior to 1600), (2) the slavery experience (1600-1865), and contemporary Black America (1865 to the present) (Nobles, 1972). Moreover, slavery is considered the pivotal period and the one to have most profoundly affected the identity of African Americans and the unfolding of their true selfhood as men and women (Butler, 2000). According to Butler (2000), not only were African Americans removed from a strong cultural heritage and required to reestablish a cultural identity during slavery, but they were also denied the essence of their very nature as human beings. W.E.B Dubois (1903) has described the effects of transplantation and adjustment on the personhood of African Americans by characterizing the history of African Americans as a conflict of longing to attain self-conscious manhood, to merge his double self into a better and truer self.

More than four centuries separate the descendants of those persons who were dispersed from Africa to North and South America, and yet there remains a oneness, rhythmic unity (Asante & Asante, 1990), a depth of knowing and understanding that has been felt from that time to the present (Butler, 2000). In fact, over time African Americans have developed a set of values, beliefs, meanings and practices—and by extension, a way of health (King, 2002). Thus, the authentication of public health for African Americans requires an affirmation of the primacy of culture (King, 2002).

The second dimension focuses on the culture of public health, itself as health (King, 2002). Modern public health practice has adopted and reflected the culture of modern medicine (King & Nobles, 1996). The medical model is the dominant paradigm of modern medicine. Therefore, the emphasis of modern public health is on the individual “at-risk”, or the identification of biological intrapersonal factors (weak organ systems), or psychological intrapersonal factors (beliefs, cognitions, attitude, intentions, skills) as determinants of health

outcomes (King, 2002). Given that the health status of African Americans is influenced not only by the unique pattern of exposure to stressors based on the African Americans' social status in the U.S., but also by the way African Americans, given their historical values and meanings (culture), behave in response to stress and life's adversities in rapidly changing society (King, 2002). Consequently, the authentication of public health for African Americans aims in large part to move away from the emphasis of improving health outcomes solely through targeting change in the individual's personal characteristics and behaviors (King, 2002). The African Americans should be seen as the "subject" of interest not the "object", focusing less on the conditions that influence the individual's health at the expense of how they perceive or react to those conditions.

The third dimension spotlights the environment as context—political, ecological, economic and spiritual (King, 2002). In other words, the third dimension of culture is context, the web of relationships between the public and social reality (King, 2002). Culture is the mediating construct in the web of relationships (Nobles & King, 2000), and the force that maintains unity and coherence of the web of relationships (King, 2002). In the clash between the culture of public health dominated by "psychological genetics" and African Americans, if African American person's health circumstance is to be adequately understood and addressed, then it must be done from the vantage point of culture (King, 2002). Making explicit the core elements of African American culture and the unifying forces that give depth and dimension to the dynamics and character of this group will aid in differential attempts to design programs on the group's behalf (Butler, 2000).

According to the Institute of Medicine (1998), the real face of health problems in the U.S. is chronic illness. African Americans suffer disproportionately with chronic diseases such as diabetes, HIV/AIDS, high blood pressure, heart disease and stroke. When treating conditions of “unknown etiology” and particularly the complex life-process disorders that give rise to chronic problems, illness or disease, much broader systemic issues take primacy (King, 2002). It is fundamental that the social position of African Americans be addressed (King, 2002). There are three parameters that govern the cultural orientation of public health practice: ontology, which is the premise of defining the individual, singly, or collectively devoid of context and outside of the hospital setting; axiology, which is the value premise of the absence of disease construct; and epistemology, which is the search for the cause as genetic disease determinants, either biological or psychological (King, 2002).

2.3 PRIMARY ASSUMPTIONS OF THE MODEL

According to King and Nobles (1996, 1997), there are four primary assumptions of an Authentic Culturecology Model. The first assumption is that public health is a cultural phenomenon. The basis for all phenomena is relationship, or a person nested in a triadic set of relationships, known as a web of relationships, which consists of the person, his/her community and his/her environment (Haslam, 1994). Culture can be defined as the sum of relationships (unit or web of relationships) of any phenomenon; culture is the defining substance of all human action (Carruthers, 1995; Hilliard, 1976). Culture is a functional, internally consistent beliefs, attitudes, values, expectations and norms/patterns of conduct (King, 2002). In the person dimension, culture directs his/her level of autonomous capacity for self-organization as well as

that of self-restoration (King, 2002). In the community dimension, culture directs the level of social and economic support and the balance in relation to ecology and faith (King, 2002).

The second assumption is that bonds are the dimensions internal to culture. A bond is a historical-cognitive emotional structure (connection) that has clear functions in everyday functioning of a unit of relationships (King, 2002). The web of relationships reflects bonds to personal, conventional, social and spiritual order (King, 2002). If culture represents the structure of a system in unity, then bonds represent or are forms of “glue” that maintain the ties or attachments, and therefore the function or dysfunction of the web of relationships (King, 2002). The ties that bind African American together define their essential nature as a historically and culturally distinct group, and these ties provide the “cultural key” for interpreting, understanding, and making meaningful a description of African American life in American society (Butler, 2000). Cultural framing prompts the articulation of the organic set of bonds as the defining reality at any given moment for any given relation (King, 2002).

The third assumption is that there are four primary bonds (Fiske, 1993). According to King (2002), these bonds can be conceptualized as follows:

- Affinity bonds. The need for collective belonging, or solidarity, and intimacy based on memory. These bonds grow from the memory of childhood (feeding, comfort, protection) and are based on the need for security and trust.
- Obligation bonds. The drive to establish rules according to status markers such as deeds (good or bad), age, skill, knowledge, class, social position, race. These bonds are based on the meaning of power, order and control, and grow from the spirit nature of relationships and the need for accountability, duty, responsibility, and moral commitment.

- Assurance bonds. Bonds based on the organization on common sets of values of exchange, such as vocation, production, money, goods, materials, or intellectual work. The emphasis is on good return on investment or time. Social transaction is based on costs and benefits. Assurance bonds are based on the search or need for competence, mastery, and autonomy.
- Harmony bonds. These are the bonds governed by the search for fairness and rhythm. They are the ties organizing the construction and interpretation of relationships in strictly impartial terms. As an example of this is the search for equity (Nobles & King, 1997). These focus on reciprocity, fairness as primary values. Such bonds are based on the motivation for justice, fairness and balance.

Every relationship can be defined by these bonds (King, 2002). Bonds are present or absent (King, 2002). When they are present, they are either strong or weak, health-enhancing or health-compromising (King, 2002). Bonds characterize the nature of the event (King, 2002).

The fourth and final assumption is that the essence of an event/phenomenon is not the phenomenon itself, but in its web of relationships (King, 2002). This implies that the unit of analysis in the examination of any public health occurrence must be the web of health relationships in that event (King, 2002). Fundamental to understanding the event as a relationship is the nature of the bonds in the culturally framed web (King, 2002). Bonds constitute the essence (King, 2002). “It is within the framework the person’s (family’s, community’s) bond to a larger reality that factors (psychological, social, ecological, spiritual) central in setting the stage for modifying bonds and therefore conditions for behavior change—occur” (King, 2002, p.103).

2.4 PRINCIPLES OF THE MODEL

According to King (2002), there are three principles of the Authentic Cultureecology Model. The first principle is that the presence of strong health-enhancing bonds in all four bonding domains is necessary to optimum health and the prevention of illness (King, 2002). For the person, the stronger health-enhancing the bonds, the stronger the formation of a collective self-identity as a part of community. Therefore, it is less likely that the person will engage in relationships that involve risk factors for a host of negative health outcomes. The second principle is that the same statement is true and can be applied to the family and the community/society (King, 2002). The third principle is that the presence of health-compromising bonds, or the absence or weakness of autonomous bonds (to personal, spiritual and conventional social order), predict a greater likelihood of the person engaging in risk factors for a host of negative outcomes for him/herself, community or society (King, 2002). King and Nobles argue that African American health relations are significantly compromised by a society that has historically negated [Maafa] (Ani, 1994) African American bonds to society (conventional social order). What allows the African American to survive is the positive [Maafa] (Ani, 1994) remnants of historical bonds to cultural history (spiritual connections) (King, 2002).

2.5 METHODOLOGY OF THE MODEL

The methodology of the Authentic Culturecology Model focuses on the web of relationships as the unit of analysis and the subject for exploration with culture as the unifying link (King, 2002). The model suggests that the first step of design of intervention always begins with careful work in identifying or locating the smallest web of relationship or cultural event of the whole person in whole contexts (King, 2002). The second step is cultural framing, which requires both cultural sensitivity and competence (King, 2002). The frame consists of the representation of the types, strength and valence of bonds present in the web of relationships (King, 2002). The central methodology for the discovery of bonds with cultural framing is the use of narrative (King & Fluker, 1998). The third step is the participation of the subject in change, recognizing that what is to be changed are the nature of bonds within the web-of-relations, which maintain outcomes that are health compromising (King, 2002).

2.6 BASIC PROCEDURAL STEPS FOR THE FRAMEWORK

The first task is always to undertake a critical study of the nature and epidemiology of the basic units of relationships that produce high-risk behaviors and the converse, of relationships that preserve health and well-being (King, 2002). The critical search for the relationship must be consistent with seeing the relationship in the context (political, ecological, economic, and social) of the larger web of relationships (King, 2002).

The second intervention task begins with selecting and specifying the set of relationships, the relationship of primary focus (as subject) that produces the behavior leading to the outcome (as object) (King, 2002). Careful research must be undertaken to identify and define this basic unit of study, intervention, or discourse (King, 2002). Having specified the key relationship of interest, the task then becomes the thorough exploration in this dominant attributable of interest, the bonds that maintain both health indicators and the relative risk indicators (King, 2002).

The third task is one strategic goal setting (King, 2002). The public health approach always must seek to formulate goals and strategic direction for intervention in conjunction with the other relationship (national and community policies, and priorities for prevention and health promotion) in which the primary relations are embedded (King, 2002). This unit must be embedded in the community (King, 2002). The strategic direction should guide the development of goals for health promotion, health protection, prevention services, or clinical intervention (King, 2002).

The fourth task is to develop a culturecological intervention program appropriate to and in conjunction with, the subject population (King, 2002). This development is the cultural framing that should guide the intervention to include timing (primary, secondary, tertiary prevention; level personal relations, family relations, community relations, etc.) and desired outcomes (King, 2002). The desired outcome usually falls into one of three categories: changing the existing relational complex, establishing a new relational context, or both (King, 2002).

King's fifth task is to situate the entire enterprise in a research-based context to inform all relationships within and between units, and put in place intervention, implementation and evaluation protocols to include:

- a. Process research
- b. Pilot research
- c. Efficacy trial
- d. Effectiveness trial
- e. Data analysis and dissemination

2.7 CONCLUSIONS ABOUT THE FRAMEWORK

The Authentic Culturecology Model asserts that the public health approach should move away from its emphasis on individuals, scientific rationalism, and knowledge gained from objects, but rather focus on the study of relationships. The framework promotes a continuous critique to validate the importance of cultural understanding in the promotion of health in African Americans.

3.0 REVIEW OF THE LITERATURE

Historically, there has been social and medical relationship between faith and health. Faith is a universal human concern (Tillich, 1957). Faith must not be viewed as synonymous with spirituality and religion. Health, as previously described, is a relationship, a synergistic interplay between the physical, social, psychological, and spiritual elements that create the well-being of individuals and/or groups in their physical and social environment (Warren, 1999). “Faith and health interact at the point of relationships. “There must be a relationship to define one’s ultimate concerns in life (faith). They both go hand in hand, with relationships between the physical, social, psychological and spiritual dimensions of one’s being, and relationships between the vertical, horizontal, and the personal dimensions of one’s faith” (Warren, Lockett & Zulfiqar, 2002, p.143). When these relationships are out of sync and disconnected, invariably ill health and doubt occur (Fowler, 1981). According to Epperly (1997), issues of health and illness are theological and spiritual issues, and how one takes care of themselves—body, mind, and spirit—is a matter of faith and unfaith. Health care is the provision of health services. Health care should not be confused with health.

3.1 FAITH, SPIRITUALITY, AND RELIGION

For the majority of people, the expression of faith is equated with religion (Al-Faruqi, 1974), however “the concept of faith does not require religion” (Warren, Lockett & Zulfiqar, 2002, p.131). Faith is a person’s or group’s way of moving into the force field of life. It is our way of finding coherence in and giving meaning to the multiple forces and relations that make up our lives. It is a way of seeing [oneself] in relation to others against a background of shared meaning and purpose. Faith is the most fundamental category in the human quest for relation to transcendence. (Fowler, 1981)

According to Tillich (1957), faith is a state of being ultimately concerned, and that ultimate concern may center in our own ego or its extensions—work, prestige and recognition, power and influence, wealth. He continues by indicating that one’s ultimate concern may be invested in family, university, nation, or church. “Human beings have the capacity of having faith in something while not prescribing to a particular religion.” (Warren, Lockett & Zulfiqar, 2002)

In Christian history, the thirteenth century is often identified as the period when religion was a powerful force in the entire society and thoroughly interwoven with other aspects of life—work, education, politics, family, and so on (McGuire, 2002). While religion and medicine were virtually inseparable for thousands of years (Te Velde, 1995), the advent of science created a chasm between the two. The term *spirituality* is a contemporary bridge that renews this relationship. According to Musgrave et al. (2002), “spirituality refers to a basic or inherent quality in all humans that involves a belief in something greater than the self and a faith that positively affirms life and religion refers to religious attendance, practice, or activity”.

Reflecting on the ancient word spirit, May (1982) writes, "Spirit implies energy and power." The word *spirituality* goes further and describes an awareness of relationships with all creation, an appreciation of presence and purpose that includes a sense of meaning (Musgrave, Allen & Allen, 2002).

In 1989, Burkhardt published an interesting formal concept analysis of spirituality, in which spirituality or "spiriting" was defined as a process involving the "unfolding of mystery through harmonious interconnectedness that springs from inner strength". He asserted that spirituality subsumes religiosity or religion, which may provide intellectual, behavioral, and social form to spiritual expression. However, spirituality continues to be used interchangeably with religiosity, particularly across academic disciplines of study (Newlin et al., 2002).

Clifford Geertz (1966) defines religion as "a system of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men [and women] by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations seem uniquely realistic". Religion is something that people do together to face urgent problems and to resolve them by appealing to truths that seem self-evident to them (Neusner, 2003). Religion is also defined as an institution consisting of culturally patterned interaction with culturally postulated superhuman beings (Spiro, 1966). All religious institutions include beliefs, patterns of actions, and value systems; the critical feature of religion is that the beliefs, patterns of action, and values referred to by Spiro (1966) as "superhuman beings".

3.2 POLYTHEISTIC AND MONOTHEISTIC RELIGIONS

Even when faith and religion are not used interchangeably, one cannot understand faith without first reviewing the major religious systems in different parts of the globe. (Warren, Lockett & Zulfiqar, 2002). There are numerous religions throughout the world. Religions are categorized as either polytheistic or monotheistic. Polytheistic means to worship many deities (gods), while monotheistic signifies the worship of one deity (God). The four major polytheistic religions are Hinduism, Buddhism, Taoism, and Confucianism. The three monotheistic religions include Judaism, Christianity (Protestants and Catholics combined), and Islam. Based on the size, for the purpose of this chapter, only these seven major polytheistic and monotheistic religions will be explored.

Hinduism did not originate from one founder, and is a collection of sacred writings that do not have rules as we know them (Al-Faruqi, 1974). Hindus worship one main deity at one time by choosing specific ones to give special reverence on particular days. For Hindu believers, Brahma is the creator God and is less widely worshipped since his mission is assumed to have been completed in the Creation; Vishnu, the sustaining God, who maintains order in the world and preserves values whenever and wherever they are threatened; and Siva, the God of consummation or destruction, is believed to bring disease and illness. Additionally, some Hindus may worship other gods or goddesses, of which some choose a personal god with whom they develop a relationship and worship. The ultimate concern for the Hindu believer is to reach Brahman, which is the holy word or sacred knowledge constituting holy power in the living moment. Believers seek salvation in a process of journey called samsara, which is a cyclical process of birth, death and rebirth until the believer's soul reaches the creator God Brahma. (Noss, 2003; Partridge, 2005; Sharma, 1993)

Buddhism is similar to Hinduism in many ways. Buddha is the main figurehead of Buddhism, however he is not the founder of the religion. Buddhists believe that “the teachings” that Buddha discovered are the way to be human. Thus, moral action will produce karma (the force that moves life forward); human existence is dukka (suffering); all of life is transient; and suffering is caused by attempting to hold on to the things of life that are transient. Moreover, the ultimate concern of the Buddhist is to reach Nirvana. Nirvana is Enlightenment, or the elimination of hatred, greed, and delusion, and the cessation of suffering. (Noss, 2003; Partridge, 2005; Abe, 1993)

Confucianism originated in China. It is a religion without a deity, however practice of the faith can include worship of spirits, or eternal human beings, such as the founders and ancestors. The ultimate concern for Confucians is Heaven, which is considered true integrity, at hand and unity with Heaven and Earth. In Confucianism, the way to gain reconciliation with the ultimate concern and to achieve the ultimate destiny is to become a holistic human being in four dimensions: self, community, nature, and Heaven. Moreover, Confucianism teaches that relationships are very important and precedence in relationships is given to status, age and gender. (Noss, 2003; Partridge, 2005; Wei-ming, 1993)

Taoism is influenced by Buddhism. It is a polytheistic system which involves the worship of gods, spirits, and ghosts. Taoism began with traditional Chinese ideas and religious practices and embraces almost every ancient Chinese practice, such as offering sacrifices to ancestors, praying for favorable weather, and dispelling evil spirits. The ultimate concern of Taoist is to reach the gods to ensure happiness and prevent disasters. Furthermore, Taoists believe that one transfers the consequences of one’s own conduct to one’s children. In other

words, there is a transmission of burdens, either merits or demerits, from ancestors. Lastly, Taoists believe in physical immortality. (Noss, 2003; Partridge, 2005; Xiaogan, 1993)

Judaism is considered the first of the monotheistic religions (Noss, 2003; Partridge, 2005; Neusner, 1993). According to the great sages, the Hebrew Bible, or the Torah (also known as the Old Testament of the Bible), defines Judaism. There are at least four organized forms of Judaism: Orthodox, Reform, Conservative, and Reconstructionist. Orthodox Judaism believes in the literal way that God gave the Torah, thus keeping the law as God-given. Reform Judaism considers the Torah a statement of eternal principles in historical language and terms, and consequently believes that it can be changed to respond to new conditions. Conservative Judaism affirms the God-given standing of the Torah, but accommodates change. Reconstructionist Judaism views their religion as the historical civilization of the Jews and identifies God in naturalist, rather than supernatural terms, thus moving further away from the Torah as the divinely inspired, authoritative text. (Noss, 2003; Partridge, 2005; Neusner, 1993) To be a Jew can mean a religious affiliation and/or belonging to an ethnic group (Noss, 2003; Partridge, 2005; Neusner, 1993). The ultimate concern of Judaism is to observe the agreement, or covenant, between Israel and God by leading a sanctified life (Noss, 2003; Partridge, 2005; Neusner, 1993).

Christianity is reported to have the largest contingency of believers when compared to other religions (Noss, 2003; Partridge, 2005; Neusner, 1993). Christianity sprung from the faith that in its founder, God was made manifest in the flesh as Jesus Christ and dwelt among humankind (Noss, 2003; Cox, 1993). Christians are followers of the principal teachings of Jesus, who in fact, was a practicing religious Jew (Noss, 2003; Cox, 1993). The doctrine of Trinity stands as the basis of Christian thought concerning God (Al-Faruqi, 1974). This doctrine

presents the belief that God is one, comprising three entities in the one: God, Jesus Christ, who is considered the embodiment of God on earth, and the Holy Spirit (Al-Faruqi, 1974). The Bible, which consists of both the Old Testament and the New Testament, is the holy book of the Christian religion. There are many denominations included in the Christian religion and their interpretation of the Bible may differ. However, the ultimate concern of Christians is to achieve eternal life in the Kingdom of God (Noss, 2003; Cox, 1993).

Islam is the second largest religion in the world (Buchsbbaum, 1993). The followers of Islam are called Muslims. Muslim means “one who submits to Allah” or “one who commits himself [or herself] to Islam” (Noss, 2003; Partridge, 2005; Nasr, 1993). The fundamental belief of Islam is the declaration of faith that states: “There is no God, but Allah, and Muhammad is the messenger of Allah.” (Al-Faruqi, 1982) The one basic scripture of Islamic believers is the Qur’ān (or Koran), which subscribes the articles of faith, good conduct, and religious duty of Islamic followers. The ultimate concern of Islam is to join Allah in the hereafter (after life) (Noss, 2003; Partridge, 2005; Nasr, 1993).

Faith and religion are not synonymous. However, to understand faith one must explore the various religious ideologies. As previously indicated, it is essential to investigate the connection between faith and health if improvements in health are expected. “Faith and health interact at the point of relationships, and there must be a relationship to define one’s ultimate concerns in life (faith). Holistic health will not be reached until one’s ultimate concerns are harmonized.” (Warren, Lockett & Zulfiqar, 2002).

3.3 HEALTH AND HEALTH CARE IN THE U.S.

According to the Health, United States, 2004 report, major changes in the U.S. population were the increasing racial and ethnic diversity of the Nation and the growth of the elderly population. The Hispanic population and the Asian and Pacific Islander population have grown more rapidly than other racial and ethnic groups in recent decades (DHHS, 2004). In 1980 the Hispanic population was reported as 6 percent and the Asian and Pacific Islander population as 2 percent of the total U.S. population (DHHS, 2004). In 2000 the Hispanic population was reported as 13 percent and the Asian and Pacific Islander population as 4 percent of the Nation's total population, thus indicating an increase of 50% or higher for both groups in two decades. Moreover, the non-Hispanic White population in the U.S. decreased from 80 percent in 1980 to 70 percent in 2000, and the African American population has increased only slightly from 11.5 percent in 1980 and 12.2 percent in 2000 (DHHS, 2004).

One of the goals of Healthy People 2010 is to eliminate health disparities among different segments of the population (DHHS, 2000). Since measures of disease and disability differ greatly by race and ethnicity, the current trends in racial and ethnic composition of the Nation's population will have important consequences for the goals of U.S. health policy to eliminate racial and ethnic health disparities by the year 2010 (DHHS, 2004). The growing population will require more health care resources. The United States spends more on health than any other industrialized country, and the annual growth rate for health care expenditures has accelerated since the millennium (DHHS, 2004). Given that information, national health care resources will continue to increase and consume a larger share of the gross domestic product (GDP).

Age is another demographic factor that has changed significantly in the past decades. The Health, United States, 2004 report indicated that the population of Americans age 75 years or

older doubled during the past four decades from 3 percent in 1950 to 6 percent in 2000. If this population trend continues, it is projected that 12 percent of the U.S. population will be 75 years of age or over by the year 2050 (DHHS, 2004). The aging of the U.S. population has important consequences for the health care system (DHHS, 2004). “Aging increases susceptibility to infection in the absence other underlying conditions. Some elderly people are more vulnerable to infectious diseases because of a breakdown in host defenses due to chronic disease, use of medication and malnutrition” (Walker, Mays, & Warren, 2004). As the older fraction of the population increases, more services will be required for the treatment and management of chronic and acute health conditions (DHHS, 2004). Providing health care services needed by people of all ages will be a challenge in the 21st century (DHHS, 2004).

Socioeconomic factors are population characteristics that significantly impact the health of individuals (Hayward et al., 2000; Rogers et al, 1996). In a study by House and Williams (2000), the relationship between and among socioeconomic status, racial/ethnic status and health was examined. They concluded that socioeconomic position is a powerful determinant of health because it shapes people’s experience of, and exposure to, virtually all psychological and environmental risk factors for health, past, present, and future, and that these in turn influence the incidence and major trends in disease and health.

The first increase in the U.S. poverty rate since 1993 occurred in 2000 (DHHS, 2004). At that time the percent of people living in poverty was 11.3 percent (DHHS, 2004). The poverty rate has continued to increase ever since, from 11.7 percent in 2001 to 12.1 percent in 2002 (DHHS, 2004). Additionally, in 2002 more than one-half of Black and Hispanic children under the age of 18 and more than one-half of African American and Hispanic adults age 65 years or older were either poor or near poor (DHHS, 2004).

Since the turn of the century, the overall health status of all people living in the U.S. has improved greatly (DHHS, 1985). However, health and health care are distributed unevenly in the United States, and under-represented minorities are likely to get less of both (Long et al., 2002). Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat, and cure disease, Blacks, Hispanics, Native Americans, and selected ethnic groups of Asian/Pacific Islander heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology (DHHS, 1985). For example, in 1900 the life expectancy for the United States population as a whole at birth was 47 years; for Blacks, it was much lower at 33 years (DHHS, 1985). In 1983, life expectancy reached a new high of 75.2 years for Whites and 69.6 years for Blacks, a gap of 5.6 years. In 1999, the life expectancy for the United States population at birth was 77.4 for all races. Nonetheless, a life expectancy gap of 5.5 years still existed between non-Hispanic Whites and Blacks, with rates of 77.9 years and 72.4 years respectively (DHHS, 2004).

Infant mortality is considered an indicator for the health status of a population. From 1983-2001 the infant mortality rate was highest for infants of non-Hispanic Black mothers (DHHS, 2004). Infant mortality rates were also high among infants of American Indian or Alaskan Native mothers, Puerto Rican mothers, and Hawaiian mothers (DHHS, 2004). Infant mortality rates have declined over the past decades for all racial and ethnic groups, but large disparities remain (DHHS, 2004). “The African American mortality rate has dropped by two-thirds over four decades, from 44.3 per 1,000 in 1960 to 14.1 per 1,000 in 2000, in parallel with a drop in the overall U.S. infant mortality rate from 26.0 to 6.9. However, the Black-White mortality gap as measured by standardized mortality ratios actually worsened from 1960 (1.970

for male and 2.073 for female infants) to 2000 (2,519 for male and 2.515 for female infants)” (Satcher et al., 2005).

Throughout the second half of the 20th century, heart disease was the leading cause of death and cancer was the second leading cause (DHHS, 2004). Stroke was the third leading cause of death and chronic lower respiratory disease (CLRD) was the fourth leading cause of death (DHHS, 2004). The fifth leading cause of death was unintentional injuries. Although the top causes and seven of the ten leading causes of death are the same for non-Hispanics Blacks and non-Hispanic Whites (the largest ethnic/racial populations in the United States), the risk factors and incidence, morbidity, and mortality rates for these diseases and injuries often are greater among Blacks than non-Hispanic Whites. (CDC, MMWR, 2005). In addition, three of the 10 leading causes of death for non-Hispanic Blacks are not among the leading causes of death for non-Hispanic Whites: homicide (sixth), human immunodeficiency virus (HIV) disease (seventh), and septicemia (ninth). Hypertension, HIV, diabetes, and homicide contributed most to racial disparities in potential life-years lost (years a person would have lived had they not died of a specific cause) (Wong et al., 2002). Furthermore, mortality data reported in the Health, United States, 2004 indicated that Black or African American people had a higher age-adjusted death rate for all causes of death than any other racial group in the U.S. from 1950 to 2002.

3.4 HEALTH AND HEALTH CARE DISPARITIES IN THE U.S.

In April 1984, with full cognizance of the tragic dilemma of health disparities in the United States in the Secretary of Health and Human Services, Margaret Heckler, established the first Task Force on Black and Minority Health after submitting the Health, United States, 1983 report to Congress (DHHS, 1985). Thus, the Task Force on Black and Minority Health was conceived in response to a national paradox of phenomenal scientific achievement and steady improvement in overall health status, while at the same time, persistent, significant health inequalities exist for minority Americans (DHHS, 1985). This Task Force consisted of a group of 18 senior scientists and officials from various DHHS programs. It was a unique and historical assemblage in its own right because it was the first time that representatives from DHHS programs were joined in a common effort to carry out a comprehensive and coordinated study to investigate the longstanding disparity in the health status of Blacks, Hispanics, Asian Pacific Islanders, and Native Americans compared to the non-minority population (DHHS, 1985).

According to the 1985, Federal Report of the Secretary's Task Force on Black and Minority Health, six problem areas collectively accounted for more than 80% of the excess deaths among minority U.S. populations from 1979 to 1981. The term "excess deaths" expresses the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex in the White population (DHHS, 1985). The six areas of excess deaths included cancer; cardiovascular diseases and stroke; chemical dependency; diabetes; and homicides, suicides and unintentional injuries. In 1991 in recognition of the increasing severity of HIV/AIDS among minority communities, AIDS was added as the seventh leading health

problem among minorities (DHHS, 2000). In 2000 infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and immunizations were identified as the six areas in which racial and ethnic minorities experience serious disparities in health access and outcomes (DHHS, 2000). The elimination of these disparities will require a composite of strategies including efforts at preventing disease, promoting overall health, and delivering appropriate care (Taylor & Braithwaite, 2001).

Health outcomes are greatly impacted by health behaviors and risk factors. Epidemiologic and actuarial studies have shown that increased body weight is associated with excess morbidity and mortality (NIH, 1998). Among adults, overweight and obesity elevate the risk of heart disease, diabetes, and certain types of cancers. Additionally, overweight and obesity are also factors that increase the severity of disease associated with hypertension, arthritis, and other musculoskeletal problems (DHHS, 2001).

Lung cancer and chronic lower respiratory disease are strongly associated with smoking (DHHS, 2004). Furthermore, there is a strong correlation between cigarette smoking in adults and educational attainment (DHHS, 2004). The findings from the Health, United States, 2004 report indicated that adults with less than a high school education were three times as likely to smoke as were those with a bachelor's degree or more education.

According to Health, United States, 2004, the percent of Americans who smoke cigarettes has decreased only slightly in the past decade. In 1990, 27.3 percent of men and 22.6 percent of women were smokers. In 2002, 24.8 percent of men and 20.1 percent of women were smokers. Thus the decrease in cigarette smoking between men and women in the U.S. was at the same rate of 2.5 percent. Although cigarette smoking appears to be decreasing in the U.S., since

1965 African American men have maintained a higher rate of cigarette smoking than non-Hispanic White males and females as well as African American women (DHHS, 2004).

Data from the National Household Survey of Substance Abuse show men, more than women, tend to be abusers of substances (SAMHSA, 1993). White men have higher prevalence of alcohol use than Black men, non-Hispanic White women are higher than both Black and Hispanic women in alcohol use. White women are higher than men in cigarette smoking, regardless of ethnicity. However, Blacks are higher than other racial groups in the use of marijuana (SAMHSA, 1993).

“Overall, African Americans tend to have a lower rate of diagnosed psychiatric disorders, when compared to non-Hispanic Whites. The exception is in the areas of Post-Traumatic Stress Disorders (PTSD). On the other hand, African Americans tend to have a higher number of negative life events, a situation that doesn’t portend well for mental health.” (Mays, 2004)

Stressful life events in adulthood include breakup of romantic relationships, death of someone close to you, economic hardship, work overload, role overload, racism, discrimination, poor health, accidental injury and intentional assaults on physical safety (Holmes & Rahe, 1967; Lazarus & Folkman, 1984). These are the typical life events (Mays, 2004). In the African American community there are those who, as a function of limited opportunities and resources experience many of these stressful life events (DHHS, 2001). It isn’t the life event that causes the mental disorder, it is being vulnerable biologically, socially, and psychologically (Lazarus & Folkman, 1984; Brown & Harris, 1989; Kendler et al., 1995). “Statistically speaking, some African Americans, particularly those with limited opportunities and those from low income and dysfunctional environments, are at risk” (Mays, 2004).

Health disparities are “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States” (NIH, 2006). “Disparities in healthcare among racial and ethnic minorities are associated with poor outcomes” (Green & Kelley, 2004). Racism in healthcare remains a prevalent force in the United States today (Abrums, 2004). The history of racism toward African Americans in the U.S. healthcare system has been well-documented.

African Americans’ fear of exploitation by the medical profession date back to antebellum period and the use of slaves and free Black people as subjects for dissection and medical experimentation (Savitt, 1982; Humphrey, 1973). Two antebellum experiments illustrate the abuse that some slaves endured at the hands of physician (Gamble, 1997). In the first experiment, Georgia physician named Dr. Thomas Hamilton conducted a series of brutal experiments on a slave to test remedies for heatstroke. The slave named Fed was forced to sit naked on a platform in a pit that had been heated to a high temperature, with only his head above ground. This experiment was performed five to six times over a two to three week period. The sole purpose of this experiment was to make it possible for masters to force slaves to work longer hours on the hottest days (Boney, 1967).

Another example of human subject abuse is typified by the research of American gynecologist, Dr. J. Marion Sims (Gamble, 1993; Byrd & Clayton, 2000). From the 1830’s to the 1880’s, Dr. Sims conducted up to 30 surgical experiments on female slaves to develop an operation to repair vesicovaginal fistula (Gamble, 1993; Byrd & Clayton, 2000). These painful surgical procedures were performed without anesthetics because Sims believed slaves could not feel pain. Sims’ experiments allowed him to discover successful methods for vesicovaginal surgery as well as invent the vaginal speculum, vaginal catheters, and the utilization of wire

sutures for vaginal surgeries. Despite these abuses, Sims is revered as the “Father of Gynecology” in many medical textbooks and is known as the scientist who laid the foundation for the field of gynecology (Gamble, 1997; Byrd & Clayton, 2000).

One of the most publicized examples of human subject abuse in research is the Tuskegee Syphilis Study. In 1929, the United States Public Health Service (USPHS) and the Julius Rosenwald Philanthropic Fund partnered to engage in research to control the spread of venereal diseases (Clark, 1932). The purpose of the USPHS Syphilis Study at Tuskegee was to observe the natural progression of syphilis among Black rural males. The USPHS Syphilis Study at Tuskegee used four hundred syphilitic and two hundred and one uninfected men who served as controls (Jones, 1993). These men were between the ages of twenty-five and sixty at the time of enrollment in 1932.

The men in the Syphilis Study at Tuskegee were given thorough examinations which included painful spinal taps without anesthetic, in addition to placebos, tonic, aspirin, free lunches, x-rays, blood and full physical exams (Rivers, 1953; Reverby, 2000). The original study was scheduled to continue for approximately six months, however researchers encountered difficulty in sample collection. One of the principal reasons for participation problems was noted in the findings of a study physician, Dr. Vonderlehr, in which he “found that only the offer of treatment elicited the cooperation of men. They were told they were ill and were promised free care. Offered therapy, they became willing subjects (Reverby, 2000)”. However, the treatments that were given to these men were non-effective, inadequate, and/ or merely diagnostic procedures. In fact, study researchers administered mercurial ointments (a non-effective drug) or mercury rubs and “inadequate dosages” of neoarsphenamine to help retain

study men. Furthermore, the spinal taps were presented to the men as a diagnostic exam, to be given as a special treatment.

Examinations were conducted every five years (1932, 1938-39, 1948, 1952-1953 and 1968-70) except for ten-year period during WWII (Rivers, 1953; Caldwell, 1973; U.S. Department of Health Education and Welfare, 1973; Jones, 1993). The Study researchers wanted to make the Syphilis Study at Tuskegee a true observational study, therefore the men were prevented from receiving treatment for their ailments. In 1932 the standard treatment was mercury rubs and large doses of neoarsphenamine. By 1945 penicillin was the standard treatment for syphilis, however the USPHS argued that the men in the Study should remain untreated because the Syphilis Study at Tuskegee represented a “never again to be repeated opportunity (Jones, p.179, 1981; Thomas, 1991). Numerous efforts were made by the USPHS to exclude the men from receiving treatment. Thomas and Quinn (1991) describe efforts by the Study investigators to prevent treatment during World War II, when fifty of the syphilitic men were ordered to receive treatments by their local draft boards. The draft board agreed to exclude the men in the Study from its lists of draftees needing treatment, after USPHS researchers intervened.

Between 1969 and 1970 the Syphilis Study at Tuskegee was reviewed by the Centers for Disease Control and Prevention (CDC) and the USPHS because Dr. Irwin Shatz and Peter Burton complained about the Study. The Study was deemed bad science, but the decision was made to continue the Study (Reverby, 2000). Public scrutiny caused by Peter Burton, a USPHS employee who reported the Study to the Associated Press, led to the end of the Study in 1972.

Health insurance coverage is an important determinant of access to health care. (IOM, 2003). The men in the USPHS Syphilis Study at Tuskegee were offered free meals, one to two dollars per visit, free transportation, free visits by government doctors, fifty dollars to those who agreed to an autopsy at the time of enrollment, and burial plots for continuing to participate in the Study. These financial incentives led to their long-term, uninformed participation in unethical experimentation.

In 2002, 17 percent of Americans under age 65 years of age reported having no health insurance coverage (DHHS, 2004). According to the Health, United States, 2004 report, Hispanic persons and non-Hispanic Black persons were more likely to lack health insurance than non-Hispanic White persons. Moreover, persons with incomes below or near the poverty level were at least three times as likely to have no health insurance coverage as those with incomes twice the poverty level or higher (DHHS, 2004). Insurance status, perhaps more than any other demographic or economic factor, determines the timeliness and quality of healthcare, if it is received at all (IOM, 2001).

In a study by Schneider et al. (2002), an evaluation was conducted to determine how Black patients, compared to White patients, fared in Medicare managed care with respect to standard quality measures drawn from the Medicare-specific Health Plan Employer Data and Information Set (HEDIS) of 1997. Schneider and colleagues (2002) found that Black patients were less likely than White patients to receive diabetic renal examinations, post-acute myocardial infarction β -blockers, and post-hospitalization follow-up for mental illness. Additionally, they observed that Black patients received fewer appropriate services even with managed care plans that are systematically rated for performance quality. Thus, Schneider et al.

(2002) concluded that access is not the only driver of racial and ethnic health care disparities, and that quality improvement initiatives are unlikely to eliminate disparities in care.

Petersen et al. (2002) evaluated racial differences in the use of medication and invasive procedures for acute myocardial infarction (MI) in the Veterans Health Administration. The findings from their study indicate that Black patients were less likely than White patients to receive thrombolytic therapy on arrival. Additionally, Black patients were more likely to get bypass surgery in both the index admission and 90 days after acute MI. Furthermore, adjustments for patients' decisions not to undergo bypass procedures did not eliminate observed disparities in the receipt of bypass surgery.

Use of preventive health services helps reduce morbidity and mortality from disease. There has been an increase in several different types of preventive services. However, disparities in use of preventive health care by race and ethnicity, and family income, remain. (DHHS, 2004)

“Although ensuring access to high quality medical care for all Americans must remain an important public health objective, it is only one factor in the total equation for addressing racial/ethnic health status disparities” (Walker, Mays & Warren, 2004). Given that there is no magic bullet for addressing the complexity of issues, barriers, and challenges to the health disparity gap, a multilevel approach that draws on the talent and expertise of diverse perspectives will be required to change behavioral, institutional, and cultural norms designed to improve the quality of life for disenfranchised populations (Taylor & Braithwaite, 2001).

3.5 CHARACTERISTICS OF AFRICAN/AFRICAN AMERICAN FAITH

Spirituality is a prominent component of African American culture. Newlin et al. (2002) suggests that African American spirituality is:

- Faith in an omnipotent, transcendent force.
- Experienced internally and/or externally as caring interconnectedness with others, God, or a higher power.
- Manifested as empowering transformation of and liberating consolation for life's adversities.

The combination of these three components of African American spirituality inspires fortified belief in and reliance on the benevolent source of unlimited potential (Newlin et al., 2002). Although spirituality is integral to multiple aspects of African American culture, there is no overall consensus on the universal definition of spirituality for this group of people (Newlin et al., 2002).

Moreover, spirituality, or the religious practice in which it is expressed, has been shown to distinctly influence African American health beliefs, practices, and outcomes (Newlin et al., 2002). In a study by Felix Aaron et al. (2003), church attendance was found to be an important correlate of positive health care practices, especially for the most vulnerable subgroups such as those who live low-income communities as well as the uninsured and chronically ill. A study by Strawbridge et al. (1997) found that females and Blacks were more likely to attend religious services frequently and those frequent attenders had lower rates of mortality over nearly three decades compared with infrequent attenders, even with adjustments for mental and physical health during follow-up. The lower mortality rates for this study were partly explained by

improved health practices, increased social contacts, and more stable marriages occurring in conjunction with religious attendance.

“Black churches constitute a major institutional presence in the United States” (Wimberly, 2001). Presently, Blacks hold membership in most of the many Protestant Christian denominations in the world. These denominations include but are not limited to Baptist, Catholic, Church of God in Christ, Methodist, Episcopal, and Presbyterian. Based on the size, for the purpose of this manuscript, only the Baptist denomination will be discussed.

3.6 CHARACTERISTICS OF BAPTISTS

As previously stated, the Baptists belong to one of many denominations that practice the Protestant Christian religion. The Baptists comprise one of the largest and most diverse groupings of Christians in the United States (Mead & Hill, 2001). Baptists number over 37,000,000 members in more than 157,000 churches around the world (Maring & Hudson, 1991). Nine-tenths of Baptists reside in the United States, but they are divided into numerous groups based upon race, ethnicity, region, language, and doctrine (Maring & Hudson, 1991).

Doctrinal beliefs of Baptists include the doctrine of God, the doctrine of Christ, and the doctrine of salvation. According to Baptists, the doctrine of God can be defined in the following details: (1) God is One; (2) He is Spirit; (3) He is Person; (4) He is infinite; (5) He is perfect; (6) He is Creator; (7) and He moves history toward the destiny He planned (Edgemon, 1988). Baptists believe there is only one God. Moreover, He is a Spirit and too great to be depicted. The only known depiction of God to human eyes is Jesus, God incarnate (Edgemon, 1988). Baptists believe that God is a person because He is free, conscious of himself, exercises thought

and feeling, makes decisions, relates to us in a personal way, and acts in history. Baptists believe that God is infinite, which means He is eternal, immutable, omnipresent, omniscient, and omnipotent. Furthermore, Baptists believe that God is perfect. His perfection is evident in His supreme moral excellence in virtue of which all other moral attributes (i.e. holiness, righteousness, love and truth) have their ground in Him (Mullins, 1917). Moreover, Baptists believe “the doctrine of God as creator is broader than His action in creating the universe. It includes His continuing work in sustaining that which He created, and it includes His involvement in His creation as He moves it toward the destiny for which He created it” (Edgemon, 1988, p.30).

The doctrine of Christ refers to Jesus as the incarnation of God in the flesh. Baptists believe Jesus was conceived by the Holy Spirit (Matthew 1:18) and born of a virgin, thus affirming that He is uniquely the Son of God. Moreover, Baptists believe that “Jesus came to this earth to complete a threefold work as a prophet, priest, and king. As a prophet, Jesus reveals and announces God to humankind” (Edgemon, 1988, p.53). Jesus’ work as a priest is demonstrated in the offering up of sacrifice and mediating between God and persons (Edgemon, 1988). According to Baptist doctrine, “as a king, Jesus is ruler over all. In His first coming He founded His kingdom and claimed His authority as the Messiah. He called for perfect obedience, spoke with authority, worked miracles, called forth His church, established the ordinances, died on a cross, conquered the grave, ascended to the right hand of God, and will reign until all His enemies are subdued. He now commissions His followers to preach the gospel to the world, intercedes for His people, sends His presence to fill the church with power, and will come again to receive His people, who will live and reign with Him forever and ever” (Edgemon, 1988, p. 53).

Salvation is commonly regarded as the redemption from sin, however “in the New Testament it is used in the sense of rescuing from danger or destruction (Matt. 8:25; Acts 27:20) and of healing (Matt. 9:22)” (Hobbs, 1964, p.90). The doctrine of salvation is rooted in the fact that “salvation is wholly the result of God’s love” (Edgemon, 1988, p. 76). It is through faith that salvation is received as a gift of God’s grace (Hobbs, 1964). This saving faith calls for a total response of the mind (intellect), emotions, and will of the believer (volition) (Edgemon, 1988). Moreover, salvation is an all-encompassing, three-fold experience, which includes: becoming a believer of Jesus at the point when a decision is made about Christ, the process of Christian growth through a continuing life of discipleship, and the final redemption of sin when Christ is met in eternity (Edgemon, 1988; Hobbs, 1960; Hobbs, 1964).

In addition to the aforementioned doctrines, it is important to clarify other characteristics that are distinct to Baptists. According to Maring & Hudson (1991), a typical list of Baptist distinctives includes the following seven principles of faith:

1. The Scriptures, or the New Testament, as the supreme authority for faith and practice;
2. The priesthood of believers;
3. Freedom of conscience, soul liberty, and the right of private interpretation;
4. Congregational polity and the autonomy of the local church;
5. Religious liberty and the separation of church and state; believers’ baptism by immersion; and
6. Regenerate church membership.

Some of these characteristics are the beliefs of Protestants in general, while others are variations of some valid Baptist emphases, and a few are closely related to the true uniqueness of Baptists (Maring & Hudson, 1991).

The principles previously listed, guide Baptist theology. Baptists are loyal to the New Testament, thus affirming the Scriptures as their rule of faith and practice (Maring & Hudson, 1991). The Bible is the source book of the Christian faith (Hobbs, 1960). Baptists believe that the Bible is an inspired book of religion and authority. In terms of the Bible as an inspired book, Baptists believe the inspiration is the inbreathing of the Holy Spirit whereby the human messenger is divinely guided in delivering or recording God's message (Hobbs, 1960). Furthermore, Baptists believe that the Bible is not a book of history, science, or literature given that it does not tell them all that they want to know, but it does tell them all they need to know (Hobbs, 1960).

Baptists believe that the Bible is a book of faith, doctrine, morals and religion because it speaks of redemption, judgment, and Christian duty. Moreover, Baptists believe that the entire Bible is the authoritative Word of God because Jesus Christ authenticated the Old Testament as he gave the New Testament (Hobbs, 1960). In fact, "a cardinal rule of biblical interpretation for Christians is that the Old Testament is interpreted by the New Testament" (Edgemon, 1988, p. 12). Although Baptists may defer in certain minor details, Baptists generally agree about the inspiration and trustworthiness of the Bible as the sole rule of life (Mead & Hill, 2001).

The doctrine of the priesthood of believers is an important factor of Baptist faith and practice (Edgemon, 1988). "The priesthood of believers means that every believer in Christ is a priest... A priest stands between God and man to bring them together in reconciliation" (Hobbs, 1964, p. 71). W.A. Criswell in *The Doctrine of the Church* (1980) clarified this concept:

“Despite the diversity in gifts and functions, the church is one body, and all its members have the same relationship to Christ. Access to God’s presence was once the exclusive privilege of priests. It still is. But the change is that believers are made priests unto God and enjoy direct access through Christ’s death and resurrection (Romans 5:1-2; Revelations 1:5-6) so that priesthood now includes all believers... The belief that every believer is a priest is functional in Baptist worship services, church government, and ministry...” (p. 372).

Biblical “scriptures provide those at worship with the resources to search the mind of God by using remembered moments of God’s revelation. Prayer provides those at worship with an opportunity to communicate themselves into the presence of God and to prepare for God’s response” (Goodwin, 1995, p.110). “Man is made in the image of God (Gen. 1:27). Thus he is capable of fellowship with God. The highest expression of this fellowship is found in religion. And prayer is central in this relationship” (Hobbs, 1964, p. 72). “In worship, prayer is a vital and important component” (Goodwin, 1995, p.110).

With regard to “freedom of conscience”, “soul liberty” and “the right of private interpretation”, currently this characteristic is often taken to mean that individuals are free to adopt whatever views they will, without any restraints (Maring & Hudson, 1991). Indeed, Baptists insist on freedom of thought and expression in pulpit and pew (Mead & Hill, 2001). Furthermore, for most people, the most prized doctrine of Baptists is “the autonomy of the local church”, which was adopted as a result of the belief that it would promote the possibility of fuller obedience to God, who is the only Lord of conscience (Maring & Hudson, 1991). Baptists preserve the absolute autonomy of the local congregation by insisting that each church arranges its own worship and examines and baptizes its own members. The characteristics of soul liberty, the right of private interpretation, and the autonomy of the local church, culminate into another

distinctive of the Baptist thought, the doctrine of “religious liberty”, along with its corollary: the separation of church and state (Maring & Hudson, 1991).

The most important difference between Baptists and other Protestants is the practice of baptism by immersion, and believers’ baptism (Maring & Hudson, 1991). Believers’ baptism is the restriction of baptism to persons who make a personal profession of faith (Maring & Hudson, 1991). In this instance, Baptists believe that New Testament baptism signifies faith and repentance, and therefore it is administered only to those who are old enough to make responsible decisions (Maring and Hudson, 1991). The issue of believers’ baptism also leads to the notion of regenerate church membership. There is no age requirement for membership, but the candidate is usually of an age to understand and accept the teachings of Christ (Mead & Hill, 2001). By confining baptism to persons who have made personal professions of faith, the churches guard the entrance to membership and try to maintain regenerate churches (Maring & Hudson, 1991).

In addition to the common characteristics of Baptists, the identification of some distinct differences among the various “churches” within the Baptist denominations needs clarification. Technically, there are no such things as Baptist denominations, because Baptists are strongly congregational in polity: Each congregation is independent of the others (Mead & Hill, 2001). However, Baptist churches are commonly grouped into larger associations for purposes of fellowship (Mead & Hill, 2001). Furthermore, national conventions have been established to carry on educational missionary work and to administer pension plans (Mead & Hill, 2001). Most state and regional conventions meet annually with delegates from all Baptist churches in a given area (Mead & Hill, 2001). These conventions receive reports, make recommendations, and help to raise national mission budgets; but they have no authority to enforce their decisions

(Mead & Hill, 2001). For the purpose of this manuscript, these national Baptist conventions will be considered denominations.

In the United States, the Baptist movement grew out of English Puritanism in the seventeenth century (Mead & Hill, 2001). The first churches were General Baptist churches, which mean that they believed in a general atonement for all persons (Mead & Hill, 2001). However, it is believed that Baptist churches have existed in practice, though not in name, in every century (Mead & Hill, 2001).

3.7 CHARACTERISTICS OF BLACK BAPTISTS

The Black church often occupies a central place in the lives of African Americans (Felix Aaron et al., 2003). According to Mead and Hill (2001), “the great majority of Blacks in pre-Civil war were either Baptist or Methodist. Slaves usually practiced the faith of their owners because they were allowed to attend white churches by sitting in the galleries of these places of worship. Furthermore, white preachers, who were sometimes assisted by Black helpers, would move from one plantation to another to hold religious services. Occasionally a Black preacher was liberated to give full time religious work among Blacks.”

The roots of Black Baptist beginnings in South Carolina, Georgia, Canada, Africa, and the West Indies may be traced to an organized effort as early as the 1780’s (Fitts, 1985). Historians have not agreed upon the place of the first independent Black Baptist church in America. Some historians claim that the first Black church was organized at Silver Bluff, across the Savannah River, near Augusta, Georgia, in 1773 (Mead & Hill, 2001). While others argue that the oldest Black Baptist church in America is the First Colored Baptist Church, which was organized on January 20, 1788 in Savannah, Georgia, by Andrew Bryan along with a few slaves

of Jonathan Bryan, Esq., who indulged him to preach on his plantation (Fitts, 1985). Nonetheless, the oldest tradition seems to substantiate the primacy of the Georgia plantation movement as the foundation for Black Baptist churches in America (Fitts, 1985). Other churches that followed were established in Petersburg, Virginia, 1776; Richmond, Virginia, 1780; Williamsburg, Virginia, 1785; and Lexington, Kentucky, 1790 (Mead & Hill, 2001).

According to Mead and Hill (2001):

“The slave rebellion led by Nat Turner in 1831 appears to have been fueled by Christian rhetoric of freedom and divine justice. Whites were so frightened that laws were passed in some sections of the South prohibiting Blacks from becoming Christian or building meeting houses. However, slaves continued to conduct their own meetings hidden from sight and sound of the masters in the “invisible institution”. After the Civil War, numerous Black Baptist congregations emerged and organized their own conventions. Aided by the Freedman’s Aid Society and various Baptist organizations, nearly one million Black Baptists were worshipping in their own churches by 1880. Currently, there are four Black Baptist conventions in the United States: National Baptist Convention of USA, Inc., National Baptist Convention of America, Inc., Progressive National Baptist Convention, Inc., and National Missionary Baptist Convention of America.”

The first Black Baptist group, the Providence Baptist Association of Ohio, was formed in 1836, and the first attempt to be organized as a national organization occurred in 1880 with the creation of the Foreign Mission Baptist Convention at Montgomery, Alabama. In 1886, the American National Baptist Convention was organized at St. Louis, and in 1893 the Baptist National Educational Convention was begun in the District of Columbia (Mead & Hill, 2001). All three of these conventions merged into the National Baptist Convention of America in 1895 at Atlanta (Mead & Hill, 2001). The National Baptist Convention of America, Inc., has its greatest strength in Mississippi, Texas, and Louisiana, with large numbers of members also in Florida and California. It holds an annual convention, and officers are elected each year (Mead

& Hill, 2001). There is no central national headquarters, but Nashville, Tennessee, is the home of the publishing house (Mead & Hill, 2001).

In 1915 a division arose in the National Baptist Convention of America (NBCA) over the adoption of a charter and the ownership of the publishing house (Mead & Hill, 2001). The group that rejected the charter continued to function as the National Baptist Convention of America, and the group that accepted the charter became known as the National Baptist Convention, USA, Inc. (NBCUSA) (Mead & Hill, 2001). In 1990 the National Baptist Convention of USA opened its World Headquarters in Nashville, Tennessee, where a section of the publishing industry has been located since the 1890s (Mead & Hill, 2001). This convention holds an annual meeting, and its officers are elected each year.

From 1953 to 1982, Joseph H. Jackson was the leader of the National Baptist Convention of USA. Jackson's motto, "from protest to production", was rooted in the theory and practice of racial uplift in the tradition of Booker T. Washington (Mead & Hill, 2001). Jackson encouraged the National Baptist Organization of USA to avoid political and social involvements of a large scale, thus placing this organization outside the civil rights movement of the period 1954-1972 wherein Black Baptist pastors and lay leaders worked for racial justice (Mead & Hill, 2001). In 1961 after several years of tension and debate, the group of Baptists that supported taking an active role in the civil rights movement broke away from the National Baptist Convention of USA., Inc. (Mead & Hill, 2001). These individuals formed the convention known as the Progressive National Baptist Convention, Inc. Once the convention was established, it became a focal point of the civil rights movement, and many leaders of that movement assumed significant positions in the new convention (Mead & Hill, 2001). In fact, famous preachers such as Dr.

Martin Luther King, Jr., Ralph David Abernathy, and Benjamin Mays were among the leadership of this convention.

The National Progressive Baptist Convention, Inc. (NPBC) is headquartered in Washington, D.C. It is organized into four national regions—Southern, Southwestern, Midwestern, and Eastern. This convention is comprised of eight departments including women, laymen, young adult women, young adult men, ushers, youth, moderator's council, and Christian education.

The National Missionary Baptist Convention of America (NMBCA) is the most recent organized body of Black Baptists. This convention was established in 1988 as a result of disagreements over the control of denominational publication ventures. This new fellowship opposed the private ownership and leadership of the Convention's Sunday School Congress and Publishing House (Mead & Hill, 2001). Therefore, it sought an organizational plan by which the Convention itself would control the congress and publishing activities (Mead & Hill, 2001).

Since the four distinct Baptist conventions were established, each convention has held separate annual conventions. As a response to the dream of Dr. Gardner C. Taylor, former president of NPBC, three African American Baptist Convention presidents, Dr. C. Mackey Daniels of NPBC, Dr. E. Edward Jones of NBCA, and Dr. William J. Shaw of NBCUSA met in 1999 to discuss the possibility of a joint meeting. In 2004 the present presidents of the four African American Baptist Conventions, Dr. Major L. Jemison, President of NPBC; Dr. William J. Shaw, President of NBCUSA; Dr. Stephen J. Thurston, President of NBCA; and Dr. Melvin V. Wade, President of NMBCA, met to organize a historic meeting of African American Baptists.

From January 24-28, 2005, The Progressive National Baptist Convention, Inc.; National Baptist Convention USA, Inc.; The National Baptist Convention of America, Inc., and National Missionary Baptist Convention of America, Inc. gathered in Nashville, Tennessee to work on a myriad of issues relevant to the African American community. The leadership of these conventions represents over 15 million African Americans.

The meeting's theme was "Building Better Bridges for Ministry." The four African American Baptist Conventions came together to celebrate, worship, and work to set an agenda for African American Baptists. Central to this Joint Meeting are the forums. These forums provided an opportunity for attendees to participate in collective dialogue about the issues that are important to the survival of the African American community. The forum topics included African American Perspectives on Education and Health, African American Economic Development and Its Effect upon Political Empowerment, and African American Spirituality and Its Effect upon Social Justice and Global Issues. The goal of these forums was to provide a framework for the four conventions to work over the next five years to address the needs of the African American community. These forums grew out of a joint committee of the four conventions chaired by Dr. Otis Moss, Jr., Chairperson of the Progressive National Convention's Civil Rights Commission and Pastor of the Olivet Institutional Baptist Church in Cleveland, Ohio. (National Council of Churches USA, 2005)

3.8 FAITH-BASED HEALTH INTERVENTIONS

Faith-based organizations were defined by President George W. Bush in Rallying the Armies of Compassion as religiously affiliated providers, civic groups, and foundations, and grant-givers. “The term is generally considered to encompass churches, synagogues, and other communities of faith. Local FBOs have historically played a key role in communities by providing social support through community outreach programs, moral structure around life-style choices, and spiritual support through ideologies of hope and faith practices” (Zahner & Corrado, 2004).

Many FBOs are active in health promotion education and activities (Freudenberg, 2000). For example, The Witness Project is a faith-based program to train cancer survivors to promote mammography and breast self-examination among rural African American women (Erwin et al., 1999). A government and faith-based partnership between the Surgeon General, the Congressional Black Caucus, and gospel artists, called the HIV Prevention Faith Initiative of the Centers for Disease Control and Prevention, was developed to dispel myths and encourage audiences to take HIV tests (Quander, 2000). Body and Soul was a collaborative effort among two research universities (Emory University and Baylor University), a national voluntary agency (American Cancer Society), and the National Institutes of Health to disseminate and evaluate the impact of two successful research-based dietary interventions conducted in Atlanta-based, African American churches for African Americans (Resnicow et al., 2004). “Religious institutions have long been important sites for public health interventions” (Musgrave et al., 2002).

There are approximately 190 distinctly Black-oriented and Black-controlled church bodies and church networks, with more than seventy-five thousand Black congregations including parishes in predominately non-Hispanic White denominations (Billingsley, 1992; Dilulio, 1998). It is estimated that more than 40 percent of the total Black population attends church, with seven out of ten holding church membership (Scandrett, 1996; Staples & Johnson, 1993). “Because of the prevalence of Black churches and the active pattern of Black people’s church attendance, black churches are regarded as indispensable participants in the current burgeoning national and worldwide faith and health movement. Black churches have a special stake as partners in this movement because of Black people’s continuing “struggle for life” in a society that has often given less than adequate care to them” (Wimberly, 2001).

4.0 METHODOLOGY

The following hypotheses were developed for each of the five research questions:

Hypothesis 1: African American participants who have been told by a doctor they have a chronic health conditions (e.g. hypertension, diabetes, asthma, and/or cancer) are more likely to talk to their pastor when they are sick.

Hypothesis 2: African American participants who communicate with their pastors about personal health issues are more likely to engage in a healthy lifestyle.

Hypothesis 3: African American female participants are more likely to communicate with their pastors about personal health issues compared to African American male participants.

Hypothesis 4: African American female participants who pray before or after making a medical decision are more likely to rate their general health status as excellent or good.

Hypothesis 5: African American female participants who believe that God and/or Jesus is a healer are likely to visit their medical doctor more often than African American male participants.

4.1 SAMPLE POPULATION

The sample population consisted of persons attending the Joint National Baptist Convention held from January 24-28, 2005 in the Gaylord Opryland Hotel located in Nashville, Tennessee. The eligibility criteria included being African American, 18 years of age or older and a Joint National Baptist Conference attendee. The underlying assumption is that every survey participant is African American.

A convenience sample of 2,000 African American persons from among the 10,000 convention attendees participated in the study. Exactly 1,327 of those surveys returned were actually completed. Five hundred persons completed surveys via personal interview using the same questionnaire, which was stored in a hand-held Personal Digital Assistant (PDA) device. However, none of the information from the PDAs was retrievable due to a computer data storage error. All survey respondents were volunteers and no incentives were offered for their participation.

When comparing the faith-health research literature, this study's sample size of 1,327 African American respondents is particularly large. Many of the studies in this area of research have utilized sample populations much smaller than the sample size in this study. For example, in a 2001 study by Steffen et al., 77 African Americans participated in an investigation of the relationship between religious coping, ethnicity, and ambulatory blood pressure. A 2002 study by Ang et al. examined the ethnic differences in the perception and use of prayer in the treatment of arthritis and its role in patients' decision making toward surgery with a sample of 596 patients, with approximately 262 of them being African American. Religious activities and spiritual experiences among 318 African Americans were examined in a study by Koenig et al. (2004) on the impact of religion and spirituality on acute care hospitalization and long-term care in older patients. In 2005, Harrison et al. investigated the role that religiosity/spirituality plays in sickle cell patients' pain experience with a sample population of 50 African Americans. Overall, this study's sample size of 1,327 Black Baptists potentially minimizes Type II errors; that is, it prevents the researcher from making wrong decisions about the research hypotheses.

4.2 DESCRIPTION OF THE INSTRUMENT

The Faith, Health, and Health Care Practices Survey was used for data collection. The survey took an average of ten minutes to complete. The assessment tool is a 14-page, 80-question survey consisting of three major sections and includes demographic information (Appendix B). Many of the Health and Safety, and Health Care Practice questions used for the survey were adapted from the Centers for Disease Control and Prevention's 2004 Behavioral Risk Factor Surveillance System State Questionnaire. Furthermore, survey questions found in the Faith, Religion, and Health section were developed by a team of researchers and consultants from the Institute for Faith-Health Leadership at The Interdenominational Theological Center. Additionally, the Authentic Culturecology Model (King, 1996) was used as a conceptual framework for the development of the survey.

Demographic variables included sex, marital status, number of persons living in the household, educational level, employment status, and yearly household income. Section 1 of the survey instrument included 31 items to determine knowledge, attitudes and behaviors regarding health and safety issues such as general health status, exercise, eating and drinking habits, smoking, sleep behavior, emotional and/or psychological well-being, social involvement, seatbelt usage, and the environment. Section 2 of the survey consisted of 19 items that measured knowledge, attitudes and behaviors about health care practices including access to health services, health utilization and finance, screening patterns, and prevalence of reported health conditions. Section 3 of the survey instrument included 22 questions and assessed the knowledge, attitudes, and behaviors relative to faith, religion, and health influences and decision-making.

4.3 VARIABLES

Table 1 displays the independent and dependent study variables and their corresponding survey question. There are eight independent study variables, nine dependent study variables, and four study variables which act as independent variables for one research question, and dependent variables for another research question.

Table 1. Study Variables and their Corresponding Survey Questions

Independent Variables	Survey Questions
Sex	What is your sex?
Hypertension	Has a doctor ever said you had high blood pressure?
Diabetes	Has a doctor ever said you had ‘sugar’?
Asthma	Has a doctor ever said you had asthma or shortness of breath?
Cancer	Has a doctor ever said you had cancer?
Pray before medical decision	Do you pray before making a medical decision?
Pray after medical decision	Do you pray after making a medical decision?
Belief in God/Jesus as healer	Do you believe that God and/or Jesus is a healer?
Dependent Variables	Survey Questions
General Health Status	How would you rate your general health?
Description of Weight	How would you describe your weight?
Exercising	Do you currently exercise?
Healthy Eating	Do you eat healthy?
Eating Three Meals per Day	Do you eat breakfast, lunch, and dinner every day?
Eating Fruit Daily	Do you eat fruit daily?
Vegetables Daily	Do you eat vegetables daily?
Eating Salt	Do you add salt to your meals at the table?
Last MD Visit	When did you last see your medical doctor?
Both Independent and Dependent Variables	Survey Questions
Talk to Pastor about Health Problem	Do you talk to your pastor about health problems?
Talk to Pastor about Physician’s Comments	Do you talk to your pastor about what your physician tells you?
Talk to Pastor about Dentist’s Comments	Do you talk to your pastor about what your dentist tells you?
Seek Advice from Pastor about Major Health Decisions	Do you seek advice from your pastor regarding major health decisions?

4.4 DATA COLLECTION

A cross-sectional design was used to determine the knowledge, attitudes, and behaviors of African American Baptist Congregants regarding faith, health and health care practices. Prior to administering the survey, a letter from the President of The ITC was sent to the convention planners and the research team from The ITC met with the leadership to discuss the purpose of the research and expected outcome. They subsequently granted permission for the research to be conducted. Additionally, approval was obtained from the Institution Review Board of the Meharry Medical College in Nashville, Tennessee on January 20, 2005. The research was conducted as part of an alliance between State Farm Insurance Companies, The Center for Optimal Health at Meharry Medical College, and the Interdenominational Theological Center in Atlanta, Georgia.

Three types of survey methods were used: self-administered paper surveys, one-on-one, personal interview using paper survey, and one-on-one personal interview using the survey questionnaire on a hand-held personal digital assistant device (PDA). The methodological approach was determined by each survey participant.

Five graduate theological students from The ITC and five graduate public health students from Meharry Medical College participated in pilot-test sessions prior to the convention to assure consistency in the administering of the instrument. These student researchers distributed 2,000 self-administered survey questionnaires, and conducted 500 personal interviews using the same questionnaire formatted on a Personal Digital Assistant (PDA) device. These investigators sought study participants by approaching convention attendees at on-site registration, and as they entered or exited the meeting sessions held from January 25-27, 2005 (see Program in Appendix A). Additionally, an announcement was made during a plenary session on the third day of the

Joint National Baptist Convention by Dr. Michael Battle, President of The ITC, to explain the purpose of the survey and to encourage all conference attendees to complete the questionnaire. Immediately following Dr. Battle's statement, all 10 research team students distributed surveys to persons attending the session and collected them as they left the meeting that day.

4.5 DATA ANALYSIS

The data from the self-administered surveys were entered into electronic format using survey questionnaire software, Questionnaire Development System (QDS). These data were exported into SPSS 12.0 for Windows to conduct for data analysis. The data were cleaned using range checking (to verify that only valid ranges of numbers were used in coding the answers to the questions asked in the survey), and contingency checking (to compare responses between related questions, i.e. skip questions). Additionally, reliability analysis was used to estimate the internal consistency or intercorrelation among several different questions that are supposed to reflect the same concept. The Cronbach's alpha reliability coefficients were calculated for questions reflecting eating habits, prevalence of chronic disease, and communication with pastor.

Descriptive statistics were computed to determine frequencies and percentages of responses of the participants on each survey item. Of the seventy-two main questions, 23 questions were selected as most relevant to the investigator. Regression analyses were used to determine: (1) the relationship between personal health conditions and communication with a pastor when sick, (2) risk behaviors and communication with a pastor about personal health issues, (3) the difference between African American male and female respondents in their communication with a pastor about personal health issues, (4) the difference between African

American respondents who pray before or after making a medical decision and their rating of general health status, and (5) the difference between African American male and female respondents who believe that God and/or Jesus is a healer and the last time they visited a medical doctor.

4.6 LIMITATIONS OF THE STUDY

A number of qualifications may limit the interpretation of the findings from this study. A sample of convenience was used for this study. The use of a nonrandom sample limits the generalizability beyond the sample of African American attendees at the 2005 Joint National Black Baptist Conference. The sample consists of a higher proportion of participants of high socioeconomic status than does the national population of African Americans.

5.0 RESULTS

Sample Characteristics

The demographics for the African American survey respondents who attended the 2005 Joint National Baptist Conference in Nashville, Tennessee, are presented in Table 2. Exactly 1,327 participants completed the Faith, Health, and Health Care Survey for this study. The survey response rate was 66%. Of the 1,290 respondents who answered the question pertaining to their sex, 760 were women (58.6%) and 537 were men (41.4%). There were 1,292 participants who responded to the question regarding their age, with the majority (85.1%) of the respondents indicating that they were age 45 or older. Of the 1,283 participants who reported their marital status, almost two-thirds were married (61.1%). More than half (53.4%) of the 1,248 respondents who responded to the question regarding their yearly household income levels (before taxes) reported their income at or above \$50,000. There were 1,274 responses reported for the question pertaining to education level, with over half (55.9%) indicating having at least a college education level.

Table 2. Demographics of Survey Respondents

Variable	Value Labels	n (Percent)
Sex	Male	537 (41.4)
	Female	760 (58.6)
Marital Status	Single	166 (12.9)
	Married	784 (61.1)
	Partnered	3 (0.2)
	Divorced	129 (10.1)
	Separated	17 (1.3)
	Widowed	184 (14.3)
Age	18-24	14 (1.1)
	25-34	59 (4.6)
	35-44	119 (9.2)
	45-54	278 (21.5)
	55-64	388 (30.0)
	65-74	326 (25.2)
	75-84	98 (7.6)
	85 and over	10 (0.8)
Education level	Some grade school	12 (0.9)
	Some high school	35 (2.7)
	High school graduate/GED	133 (10.4)
	Vocational or Technical school	56 (4.4)
	Some college/associate's degree	325 (25.5)
	College	313 (24.6)
	Graduate or professional school	399 (31.3)
	Other (i.e., RN, LPN)	1 (0.1)
Yearly household income, before taxes	Less than \$25,000	185 (14.8)
	\$25,000 - \$49,999	376 (30.1)
	\$50,000 – \$74,999	337 (27.0)
	\$75,000 - \$99,999	214 (16.1)
	\$100,000 – \$149,999	99 (7.5)
	\$150,000 and over	37 (2.8)

The demographic variables, representing the socioeconomic status of the respondents, were selected based on the research questions for this study. These socioeconomic variables have been documented as influencing health and health care, for instance the prevalence of diabetes, hypertension, heart disease and other chronic diseases increases with age (DHHS, 2005). Poverty is associated with income level, and persons living in poverty are considerably more likely to be in fair or poor health, and to have disabling conditions, and less likely to have used many types of health care (DHHS, 2005). Furthermore, certain subgroups of adults age 55-64 years including unmarried persons and women are at greater risk of living in poverty, lacking health insurance, or being disabled (DHHS, 2005). Additionally, education level has been linked to death and infant mortality rates. In 2002, data indicated that as a mother's level of education decreases, the infant mortality rate increases (DHHS, 2004).

5.1 RESEARCH QUESTION ONE

To what extent is there a relationship between personal health conditions (such as high blood pressure, diabetes, asthma, or cancer) of African American male and female participants and their communication with their pastor when they are sick?

An ordinal logistic regression analysis was conducted to determine factors influencing the participant's communication with their pastor when they are sick and the existence of health conditions. This statistical method was selected because it is used to find out the degree of relationship existing between an ordinal dependent variable and a set of independent variables. There were 1,144 observations selected by the statistical program for use in this analysis. The regression model included the demographic variable, sex, and the existence of any of the

following health conditions: hypertension, diabetes, asthma, or cancer, as predictors; and communication with a pastor when sick as the dependent variable. Approximately 1.3% of the variance in communication with a pastor when sick was explained by this model ($R^2 = 0.0128$, $p = 0.0000$), with having been told you have asthma (Beta [β] = 0.4916474, $t = 3.36$, $p = 0.001$) and having been told you have hypertension ($\beta = 0.3754917$, $t = 3.37$, $p = 0.001$) having the greatest impact. Sex ($\beta = 0.4856912$, $t = 4.39$, $p = 0.000$) (see Table 3). Therefore, the factors that significantly impact communication with a pastor when sick were the sex of the participant, having been told that you have hypertension, or having been told that you have asthma. The factors that were not statistically significant included having been told that you have diabetes and having been told that you have cancer.

Table 3. Factors Influencing Communication with Pastor When Sick and Personal Health Conditions

Predictor Variable	Communication with Pastor When Sick		
	β	z	p
Sex	.4856912	4.39	0.000*
Hypertension	.3754917	3.37	0.001*
Diabetes	-.1053141	-0.79	NS
Asthma	.4916474	3.36	0.001*
Cancer	.1029369	0.52	NS

*, Significant at $\alpha = .05$

5.2 RESEARCH QUESTION TWO

What is the relationship between risk behaviors (exercising, eating, smoking and drinking) of African American male and female participants, and communication with a pastor about personal health issues?

The frequency distribution for the risk behaviors of the survey respondents who attended the 2005 Joint National Baptist Conference are presented in Table 4. Out of 1,215 responses, 916 survey participants (73.2%) reported that they eat healthy. There were 610 out of 1,282 respondents (47.6%) who indicated that they eat breakfast, lunch, and dinner every day. Of 1,282 respondents, 709 participants (55.3%) indicated that they eat fruit daily. There were 1,014 out of 1,276 respondents (79.5%) who indicated that they eat vegetables daily. Of 1,281 respondents, 715 participants (55.8%) indicated that they never add salt to their meals at the table. There were 741 out of 1,289 respondents (57.5%) who have never smoked and 632 out of 1,263 respondents (50.0%) who have never drank alcohol. There were 192 out of 1,263 respondents (15.2%) who were current alcohol drinkers and 67 out of 1,289 respondents (5.2%) who were current cigarette smokers.

Table 4. Frequency Distributions for Risk Behavior Variables

Variable	n (Percent)
Eat Healthy	916 (73.2)
Eat Breakfast, Lunch and Dinner Every Day	610 (47.6)
Eat Fruit Daily	709 (55.3)
Eat Vegetables Daily	1,014 (79.5)
Never Add Salt to Meals at the Table	715 (55.8)
Never Smoked	741 (57.5)
Never Drank	632 (50.0)
Currently Drink Alcohol	192 (15.2)
Currently Smoke	67 (5.2)

A multivariate regression analysis was conducted to determine factors influencing the participant's communication with their pastors about personal health issues and risk behaviors. This statistical method was selected because it is used to find out the degree of relationship existing between more than one dependent and independent variable. There were 1,003 observations selected by the statistical program for use in this analysis. The model included exercising, eating, and drinking behaviors as predictors (currently exercise, eat healthy; eat breakfast, lunch, and dinner; eat fruit daily; eat vegetables daily; currently smoke; and currently drink alcohol). The dependent variables used for this analysis included communication with a pastor about health problems, communication with a pastor about what your physician tells you,

communication with a pastor about what your dentist tells you, and communication with your pastor regarding major health decisions. Table 5 presents the factors influencing communication with a pastor about personal health issues and risk behaviors. There was a significant relationship determined for participant's communication with a pastor about health problems and about what their physician tells them, and eating vegetables daily. Approximately 1.5% of the variance in communication with a pastor about health problems and about what the physician tells them was explained by this model ($R^2 = 0.0146$), with eating vegetables daily having the only significant impact ($\beta = 0.197$, $t = 1.93$, $p = 0.05$; $\beta = 0.270$, $t = 2.51$, $p = 0.01$, respectively). Therefore, the factor that significantly impacts communication with a pastor about health problems and what their physician tells them is eating vegetable daily. There were no significant relationships found for any other types of communication with a pastor about personal health issues and risk behaviors.

Table 5. Factors Influencing Communication with Pastor about Personal Health Issues and Risk Behaviors

Predictor Variable	Communication with Pastor											
	About Health Problems			About What Your Physician Tells You			About What Your Dentist Tells You			Regarding Major Health Decisions		
	β	t	p	β	t	p	β	t	p	β	t	p
Currently exercise	.061	0.78	0.44	.046	0.55	0.58	.047	0.64	0.523	.075	0.90	0.37
Eat breakfast, lunch and dinner	.021	0.28	0.78	-.076	-0.93	0.35	.080	1.10	0.271	.013	0.16	0.87
Eat fruit daily	.105	1.25	0.21	.020	0.22	0.82	.014	0.17	0.865	.009	0.11	0.92
Eat vegetables daily	.197	1.93	0.05*	.270	2.51	0.01*	.164	1.69	0.091	.121	1.12	0.26
Eat healthy	-.096	-1.03	0.30	.017	0.17	0.86	-.006	-0.06	0.950	.020	0.20	0.84
Add salt to meals	-.062	-1.02	0.31	-.064	-1.01	0.31	-.021	-0.36	0.719	-.033	-0.51	0.61
Having ever smoked	-.083	-1.30	0.19	-.123	-1.83	0.07	-.055	-0.92	0.359	-.062	-0.92	0.36
Currently drink alcohol	-.055	-1.07	0.28	-.004	-0.07	0.94	.013	0.27	0.790	-.041	-0.75	0.46

* statistically significant

5.3 RESEARCH QUESTION THREE

To what extent are there sex differences in communication with pastors about personal health issues?

Using the multivariate regression method, differences between men and women in their communication with a pastor about personal health issues were analyzed. Significant differences are presented in Table 6. This procedure selected 1,126 observations for this analysis. There

was a significant difference between males and females who talk to their pastor about health problems ($\beta = .401486$, $z = 5.92$, $p = 0.000$). Furthermore, there was a significant difference between males and females who talk to their pastor about what their physician tells them ($\beta = .4398141$, $z = 6.24$, $p = 0.000$). Additionally, there was a significant difference between males and females who talk to their pastor about what their dentist tells them ($\beta = .2428057$, $z = 3.78$, $p = 0.000$). Moreover, there was a significant difference between men and women who seek advice from their pastor regarding major health decisions ($\beta = .3417125$, $z = 4.79$, $p = 0.000$).

Table 6. Significant Differences in the Sex of Participants and Communication with Pastors about Personal Health Issues

Survey Questions	R ²	β	t	p
Do you talk to your pastor about health problems?	0.0302	.401486	5.92	.000
Do you talk to your pastor about what your physician tells you?	0.0334	.4398141	6.24	.000
Do you talk to your pastor about what your dentist tells you?	0.0125	.2428057	3.78	.000
Do you seek advice from your pastor regarding major health decisions?	0.0200	.3417125	4.79	.000

In addition to multivariate regression analysis, Chi-square tests were used to determine if the observed frequencies for males' and females' communication with their pastor about personal health issues were significantly different from expected frequencies. Table 7 presents the results of the Chi-square test.

Table 7. Chi Square on Frequency of Responses by Gender

Response	Female n (Percent)	Male n (Percent)	Chi square	p
Do you talk to your pastor about health problems?				
Most of the time	105 (14.89)	123 (26.00)	35.2190	.0001
Some of the time	205 (29.04)	159 (33.62)		
Hardly ever	123 (17.42)	68 (14.38)		
Never	273 (38.67)	123 (26.00)		
Do you talk to your pastor about what your physician tells you?				
Most of the time	105 (15.0)	126 (27.04)	40.4481	.0001
Some of the time	143 (20.43)	111 (23.82)		
Hardly ever	107 (15.29)	77 (16.52)		
Never	345 (49.29)	152 (32.62)		
Do you talk to your dentist about what your dentist tells you?				
Most of the time	75 (10.85)	73 (15.63)	20.1890	.0002
Some of the time	49 (7.09)	46 (9.85)		
Hardly ever	90 (13.02)	86 (18.42)		
Never	477 (69.03)	262 (56.10)		
Do you seek advice from your pastor regarding major health decisions?				
Most of the time	105 (15.24)	116 (24.79)	31.3923	.0001
Some of the time	123 (17.85)	85 (18.16)		
Hardly ever	91 (13.21)	86 (18.38)		
Never	370 (53.70)	181 (38.68)		

There were 310 out of 706 female participants (43.9%) and 282 out of 473 male participants (59.6%) who indicated that they do talk to their pastors about health problems at least some of the time ($p = 0.0001$). There were 124 out of 691 female respondents (17.9%) and 119 out of 467 male participants (25.5%) who talk to their pastor about what their dentist tells them at least some of the time ($p = 0.0002$). There were 248 out of 700 female respondents (35.4%) and 237 out of 466 male participants (50.9%) who talk to their pastor about what their

physician tells them at least some of the time ($p = 0.0001$). There were 228 out of 689 female respondents (33.1%) and 201 out of 468 male participants (43.0%) who seek advice from their pastor regarding major health decisions at least some of the time ($p = 0.0001$).

5.4 RESEARCH QUESTION FOUR

To what extent is there a difference between African American male and female participants who pray before or after making a decision and their rating of general health status?

The multivariate regression method was used to determine the relationship praying before or after making a medical decision and rating of general health status. Table 8 presents the factors influencing praying before or after making a medical decision, and rating of general health status. This procedure selected 1,191 observations for this analysis. Less than 1% of the variance in rating of general health status was explained by this model with both praying before making a medical decision ($R^2 = 0.0036$, $\beta = 0.0432046$, $t = 2.06$, $p = 0.040$) and praying after making a medical decision ($R^2 = 0.0042$, $\beta = 0.0440858$, $t = 2.23$, $p = 0.026$) having a significant impact. Therefore, the factors that significantly impact rating of general health status are praying before or after making a medical decision.

Table 8. Factors influencing Rating of General Health Status

Predictors	R ²	β	z	p
Pray before making a medical decision	0.0036	.0432046	2.06	0.040*
Pray after making a medical decision	0.0042	.0440858	2.23	0.026*

* significant at $p < .05$

The frequency distributions for survey respondents' indication of prayer before or after making a medical decision are presented in Table 9. Of the 1,224 participants who responded to the questions: "Do you pray before making a medical decision?" and "Do you pray after making a medical decision?", there were 1,125 respondents (91.9%) who indicated that they pray before making a medical decision, and 1,143 respondents (93.4%) indicated that they pray after making a medical decision.

Table 9. Frequency Distributions for Prayer and Making a Medical Decision

Variable	Value Labels	n (Percent)
Do you prayer before making a medical decision?	Yes	1,125 (91.9)
	No	35 (2.9)
	Sometimes	64 (5.2)
Do you prayer after making a medical decision?	Yes	1,143 (93.4)
	No	25 (2.0)
	Sometimes	56 (4.6)

5.5 RESEARCH QUESTION FIVE

To what extent is there a difference between African American male and female participants who believe that God and/or Jesus is a healer and the last time they visited a medical doctor?

An ordinal logistic regression analysis was conducted to determine factors influencing participant's belief that God and/or Jesus is a healer and the last time they visited a medical doctor. There were 1,166 observations selected by the statistical program for use in this analysis. The regression model included the demographic variable, sex, and the belief that God and/or Jesus is a healer as the independent variables, and the last time the participant saw a medical doctor as the dependent variable. Table 10 presents the factors influencing the last visit to a medical doctor. The sex of the participant ($\beta = -.335175$, $z = -3.08$, $p = 0.002$) had a significant impact on the last time they visited their medical doctor. Alone, the belief that God and/or Jesus is a healer did not have a significant impact on the last visit to a medical doctor ($\beta = 1.448763$, $z = 1.44$, $p = 0.149$). Collectively, the sex of the participant and the belief that God and/or Jesus is a healer had a significant impact on the last visit to a medical doctor, with less than 1% of the variance in the last visit to the doctor explained by this model ($R^2 = 0.0035$, $p = 0.0033$). Therefore, the belief that God and/or Jesus is a healer alone, did not have a significant impact on the last visit to the medical doctor. Nonetheless, when both the sex of the participant and the belief that God and/or Jesus is a healer are included in the model, these factors did have a significant impact on the last visit to a medical doctor.

Table 10. Factors Influencing Last Visit to a Medical Doctor

Predictor Variable	Last visit to a Medical Doctor		
	β	z	p
Sex of the Participant	-0.335175	-3.08	0.002
Belief that God and/or Jesus is a Healer	1.448763	1.44	0.149

Model: $R^2 = 0.0035$, $p = 0.0033$

There were 1197 participants (99.0%) who indicated that they believe that God and/or Jesus is a healer. The frequency distribution for survey respondents' last visit to their medical doctor by the sex of the participant, are presented in Table 11. Of those surveyed, 256 participants indicated that they saw their medical doctor last week; 480 respondents last saw their medical doctor last month; 383 participants saw their medical doctor six months ago; 99 respondents last saw their medical doctor a year ago; and 38 participants last saw their medical doctor 3 or more years ago.

Table 11. Frequency Distributions for Last Visit to the Medical Doctor by Gender

	Females	Males
	n (Percent)	n (Percent)
When did you last see a medical doctor?		
Last week	163 (63.67)	93 (36.33)
Last month	296 (61.67)	184 (38.33)
Six months ago	215 (56.14)	168 (43.86)
A year ago	50 (50.51)	49 (49.49)
3 or more years ago	21 (55.26)	17 (44.74)

6.0 DISCUSSION

This study provided valuable information on the influence of faith on health and healthcare decisionmaking of Black Baptists who attended the 2005 Joint National Black Baptist Conference. Data from this study propose there is a relationship between Black Baptists who have been told that they have certain personal health conditions and their communication with their pastor when they are sick. These results are statistically significant with regard to respondents who have been told they have asthma or shortness of breath, or hypertension. Although having been told that you have asthma or hypertension was a significant predictor for communication with a pastor when sick, they are not strong predictors. Nonetheless, these findings further the understanding of how blood pressure can be used as one potential mechanism by which faith, spirituality and religion is related to health (Levin & Vanderpool, 1989). A number of research studies have found that higher levels of religiosity are related to lower levels of blood pressure (Larson, Koenig, Kaplan, Greenberg, Logue & Tyroler, 1989; Livingston, Levine & Moore, 1991; Hixson, Gruchow & Morgan, 1998; Koenig, George, Hays, Larson & Cohen, 1998). Moreover, researchers found that seeking religious help and comfort is particularly important for blood pressure (Hixson, Gruchow & Morgan, 1998; Koenig, George, Hays, Larson & Cohen, 1998). Although faith and religiosity are not synonymous, however for the purpose of influencing hypertension, they seem to have similar influences.

Since the findings from this study suggest a significant communication relationship with their pastors when the congregants are sick from health conditions such as hypertension or asthma, the opportunity exists for pastors to intervene in the healthcare decisionmaking of their congregants. Both hypertension and asthma are health conditions that can lead to acute

symptomatic episodes which require immediate medical attention; otherwise, severe medical complications may occur, even death. Furthermore, one common linkage between these two health conditions is stress. Stress can lead to symptoms such as elevated blood pressure, tightening of the chest, and shortness of breath. The pastor plays an important part in stress management for his/her congregants. A pastor has several roles, which includes leader of worship, preacher, teacher, counselor, and administrator. The term “leadership” implies authority. In fact, in typical African American Baptist churches, “the pastor is commander-in-chief by virtue of his call by God and the people, and often by virtue of his training” (Massey & McKinney, 1976, p.35). Consequently, pastors are leaders with the authority to implement religious problem-solving styles to improve the ways in which African Americans can effectively manage their stress levels.

Religious problem-solving styles are culture-specific resources reflective of a religious orienting system (e.g. religious beliefs, feelings, and connection to a Higher Power) that can be said to influence the way crises or stressors are anticipated, interpreted, and handled (Pargament, 1997). Religious problem-solving is a multidimensional phenomenon that serves a variety of purposes aligned with individuals’ perceptions of the roles of religion and spirituality (e.g. providing meaning, gaining control, comfort, etc.) in the lives of African Americans when faced with problems (Pargament et al. 1988; Pargament, Koenig, & Perez, 2000). A religious orienting system has particular relevance in the African American community where the Black Church historically has been one of the only resources available in the fight against social injustice (Moore, 1992).

Another important finding is there is a significant difference between men and women in their communication with their pastor about personal health issues. However, the sex of the

participant was not a strong predictor of communication with a pastor. Furthermore, it is interesting to note that more men reported communicating with their pastor most or some of the time than female respondents, with regard to all four areas of interest, including talking to their pastor about health problems, talking to their pastor about what their physician tells them, talking to their pastor about what their dentist tells them, and seeking advice from their pastors regarding major health decisions. This finding conflicts with literature on the subject of how women communicate about health care because researchers found that women talk about health problems more often than men (Hall et al., 1994; Kaplan et al., 1995; and Street et al., 2005). Furthermore, those researchers found that women are more likely to communicate with a female physician about their health issues than a male physician. Since Baptist denominations have a pastoral leadership which is disproportionately male, the female congregant is most likely to have only opportunities to communicate with a male pastor. This male pastor-female congregant communication occurrence agrees with the research about male physician-female patient communication about health issues. Nonetheless, this finding suggests that Black Baptist pastors have the opportunity to positively influence the healthcare decisionmaking of their male congregants by communicating health-enhancing messages during these interactions.

There were two statistically significant relationships between risk behaviors (e.g., exercising, eating, drinking, smoking habits) and communication about personal health issues. The findings from this study propose that eating vegetables daily has a significant impact on talking to a pastor about health problems and about what the physician tells you. Research indicates that African Americans consume fewer than five servings of fruits and vegetables per day (Foerster, S.B. et al., 1995 and Krebs-Smith, S.M. et al., 2000). Some faith-based health interventions have been successfully implemented to increase the fruit and vegetable

consumption of African Americans (Resnicow et al, 2001 and Resnicow et al., 2004). While eating fruit daily was not a significant predictor of communicating with a pastor about personal health issues, the findings from this study support future research activities that include vegetable eating habits and communication between the congregant, the congregants' pastor and the congregants' physician.

Although participants' communication with their pastor about personal health issues was not significantly related to other risk behaviors such as drinking alcohol or smoking, research indicates that religious adherents may be more likely to adopt healthy practices because of the church's emphasis on respect for the body (Steffen et al., 2001 and Wholley et al., 2002). In fact, data for this study showed that at least half of the respondents have never smoked or drank alcohol. Consequently, it may be that cultural influences from other relations are more important than pastoral relations alone. The Authentic Culturecology Model suggests that the web of health relationships is determined by a person's bonds with the relationship of concern. In this instance, the respondents' relationship to cigarettes, alcohol, food sources, and exercise resources is embedded in a larger reality in which factors including psychological, social, ecological, and spiritual, lead to the essence of health-enhancing or health-comprising bonds to those risk behaviors. These bonds are also influenced by the respondents' political, cultural, ecological, and economic context.

The findings from this study propose that there is a significant relationship between African American participants who pray before or after making a medical decision, and their rating of general health status. In fact, it is interesting to note that most of the respondents rated their general health status as excellent or good, even those participants who had been told that they have a health condition such as hypertension or diabetes. Although praying before or after

making a medical decision was not a strong predictor for the respondents' rating of general health status, these results are consistent with previous research on the relationship between religious practice and perception of health. For instance, religious individuals tend to perceive themselves as being healthier than the average person (Steffen et al., 2001). In fact, there is some evidence that prayer and meditation can enhance one's ability to cope with stress inherent in managing chronic illness (Brown, 2000). Moreover, religious or spiritual beliefs and activities can enhance one's sense of control over health outcomes (Quinn, Cook, Nash, & Chin, 2001). Additionally, studies have shown that religious activity among African Americans is positively related to a sense of control over health (Wollinsky & Stump, 1996; Bekhuis, Cook, Holt, et al., 1995). Baptists believe that no sincere prayer goes unanswered (1 John 5:14-15, KJV) and God has three answers to sincere prayer: yes, no, and wait (Hobbs, 1964). The results for this study suggest that prayer before and/or after making a medical decision can serve to promote optimism about general health status regardless of the existence of a health condition.

The findings indicate that there is a significant difference between African American female and male participants who believe that God and/or Jesus is a healer and the last time they saw a medical doctor, with more female respondents visiting a medical doctor more recently than male respondents. This finding is consistent with data about gender differences with respect to health care visits, as women have a greater percentage of health care visits within a given year than men (DHHS, 2006). However, alone, the belief that God and/or Jesus is a healer, does not significantly impact the last visit to a medical doctor. Nearly all of the respondents indicated that they believe that God and/or Jesus is a healer. Baptists believe that healing is a gift of the Holy Spirit and Jesus healed out of compassion and as evidence that the power of God was in his work (Luke 5:17, KJV; Hobbs, 1964). Baptists believe that healing was "an evidence of God's

presence in the Christian movement in its early or “child” stage (1 Cor. 13:11, KJV) to further the early advancement of the gospel. After the apostolic age, Christianity was firmly established and needed no such ecstatic evidence. “Medical and surgical healing still serves as an aide in missions, but it is through normal therapeutics” (Hobbs, 1964, p. 56). Baptists believe that all healing is divine healing, and it is not a question of whether or not God heals, but how he chooses to do so (Hobbs, 1964).

The common spiritual bonds for this particular group of African Americans created homogeneity. In this instance, the homogeneity is with respect to the religious variable, belief that God and/or Jesus is a healer. However, this variable does not appear to create significant variation relative to the respondents’ visits to a medical doctor. This finding supports research suggesting that the African Americans’ relationships with their physicians are rooted in a greater truth in which psychological, social, ecological, and spiritual factors lead to the essence of health-enhancing or health-comprising bonds to health care behaviors.

Additionally, research indicates that even when people have equal access to health care, daily practices in institutions differentially affect racial/ethnic groups (Institute of Medicine, 2003). These studies point to factors beyond socioeconomic status to explain disparities, including time pressures on physicians resulting from the organization and financing of health care (particularly managed care), provider bias against minorities, as well as the location of health care facilities. It is possible that psychological, social, and ecological factors, which are beyond the scope of the data collected for this study, are needed to detect significant differences for these participants’ visits to their medical doctor.

7.0 CONCLUSIONS

Based on the results of this study at least five recommendations can be made for future research and application towards understanding the influence of faith on health and health care practices of African American Baptists. These recommendations are in the areas of improved eating habits, management of hypertension, management of asthma and communication about health issues.

First, activities that are known to reduce hypertension outcomes could be incorporated with faith principles, or tenets of religious practice, to positively influence the health of hypertensive African American Baptists. This study suggests that pastor-congregant communication may influence health care decisionmaking among African American Baptists, particularly among those congregants who have hypertension, or asthma or shortness of breath. Given this finding, health care professionals and clergy have an opportunity for health education, known as a “teachable moment”, in which instruction can focus on hypertension or respiratory problems. Hypertension management activities should include lifestyle modifications such as maintaining a normal weight, reducing sodium in your diet, exercise, such as jogging or brisk walking, limiting alcohol consumption, getting potassium in your diet every day, and eating a diet that is rich in fruits, vegetables, and low-fat dairy products. Asthma management activities should include information about the types of triggers for asthma symptoms and how to minimize symptoms by avoiding the factors that trigger those symptoms, and by working with a physician to develop an effective management and treatment plan.

Second, since the findings from this study indicate that African American Baptist males communicated more often with their pastors than African American females, but visited the doctor less frequently, future interventions that are designed with the role of the pastor as an explicit partner would be beneficial for this group of African American males. Third, the results of this study propose that eating vegetables daily is a significant predictor of communication with a pastor about health issues, future interventions should include information about the importance of healthy eating habits. The public health community and the Black Baptist community should work together to collaborate in faith-health interventions to address diet and exercise. “Real Men Cook” is an example of an opportunity for African American men to participate in improving the eating habits of men and their families. It is the largest and longest running annual Father’s Day celebration of Real Men and families. Real Men Cook events are a national crusade to positively change the way the world views men in relationship to their families and the community. The crusade includes events, which take place all on the same day, Father’s Day; in Atlanta, Chicago, Dallas, Detroit, Houston, Miami, Los Angeles, New Orleans, New York, Philadelphia and Washington, DC. Other faith-health interventions such as “Eat for Life” and “Body and Soul” are additional opportunities to address diet and exercise. A common religious tenet of Protestant Christians is that the human body is a vessel in which the Holy Spirit, the Third Person of the Trinity, abides in Christians. Therefore, in caring for the body, some Christians believe they are caring for the Temple of the Holy Spirit. Given this concept, education efforts could instruct Baptists on how poor diet and lack of exercise are harmful to the body, thus damaging to the Holy Spirit’s dwelling place.

The implications for future collaborations between the faith and public health communities are evident. Since there was a significant relationship between communication with a pastor when sick and those congregants who have hypertension or respiratory disorders, special attention should be paid to health messages delivered by pastors to hypertensive and asthmatic congregants. Public health training to instruct pastors on how to deliver health presentations on such topics as hypertension, smoking cessation, and healthy eating and active living, could make a difference in the health experience of their congregants, thus helping to eliminate health disparities and promote health-enhancing relationships.

Fourth, since this study used a convenience sample, the results of this study are not generalizable to the entire Black population, hence a recommendation for future research includes replicating this study using a random sample of African Americans. Lastly, to broaden our understanding of the influence of faith on healthcare decisionmaking in African Americans, a study should be conducted to examine the relationship between the sex/gender of the faith leadership and communication about health issues.

APPENDIX A

The Official Program of the Joint National Baptist Convention

The mission and purpose of the four National Baptist Conventions consists of four major objectives:

- 1.) Service to God through cooperation with one another, other Christian denominations, and other agencies;
- 2.) Proclamation of the truth of God's message to America and to the world;
- 3.) Addressing issues of concern that adversely affect people and that compromise social justice, human dignity, and human brotherhood;
- 4.) Acting and ministering as God's agents of love and reconciliation.

These Conventions and their leaders have come together with vision and foresight in an effort to stimulate Dr. Martin Luther King's dream of a "Beloved Community." His dream presented a vision of a community of people living out their lives in human cooperation, brotherhood, and fellowship while acknowledging the sovereignty of God.

The leadership of the conventions expresses their appreciation to the many churches, pastors, ministers, messengers, state conventions, district associations, and all others who worked diligently to make this historic event meaningful and successful.

May God Bless the:

National Baptist Convention of USA, Inc. (NBC USA, Inc.)

National Baptist Convention of America, Inc. (NBCA, Inc.)

National Missionary Baptist Convention of America (NMBCA)

Progressive National Baptist Convention, Inc. (PNBC, Inc.)

Monday, January 24, 2005

10:00 AM – 5:00 PM Individual Convention On-Site Registration...NBA USA, Inc.
NBCA, Inc.
PNBC, Inc.
NMBCA

12:00 PM – 8:00 PM Exhibits open

6:00 PM Unity Banquet – Delta Ballroom
Dr. C. Mackey Daniels, Toastmaster
Pastor, West Chestnut MBC, Louisville, KY
Past President PNBC, Inc.

Dr. E. Edward Jones, Sr., Speaker
Pastor, Galilee MBC, Shreveport, LA

Tuesday, January 25, 2005

9:00 AM **Opening Session**
National Baptist Convention USA, Inc.
Dr. Julius Scruggs, Vice President At Large, NBC USA, Inc.
Presiding

Individual Convention Call to Order

National Baptist Convention USA, Inc.
Dr. William J. Shaw, President

National Baptist Convention of America, Inc.
Dr. Stephen J. Thurston, President

Progressive National Baptist Convention, Inc.
Dr. Major Lewis Jemison, President

National Missionary Baptist Convention of America
Dr. Melvin V. Wade, Sr., President

“A Time to Celebrate”

Devotional Celebration
Reflections, Overview, Historical Perspective
ALL CONVENTIONS PARTICIPATE

Welcome Program – Local Committee

10:00 AM

Fraternal Greetings

10:45 AM

Worship Music – American Baptist Choir, Nashville, TN
Introduction of the President.....Mr. Timothy Shaw
Hymn of Preparation
Sermon.....Dr. William J. Shaw, President, NBC USA, Inc.
Invitation to Discipleship.....Dr. James Adams
Offertory Period.....Dr. Melvin V. Wade, Sr., President, NMBCA
Benediction

12:30 PM – 2:00 PM

Lunch

Tuesday Afternoon Session

2:00 PM – 5:00 PM

Individual Board Meetings – Parent Body
NBC USA, Inc. – Delta Ballroom
NBCA, Inc. – Tennessee Ballroom
PNBC, Inc. – Governor Ballroom

~ Individual Auxiliary Meetings as designated by each convention ~

Tuesday Afternoon Session

National Baptist Convention of America, Inc.
Rev. William T. Glynn, 1st Vice President – Presiding

6:30 PM

Devotional Period – Dr. Frank Davis, NBCA, Inc, National
Prayer Director

Focus Forum Presentation
Dr. Otis Moss II – Moderator

6:40 PM

Biblical Expositor – Dr. Mac King Carter, NBC USA, Inc.

7:00 PM

Theological presenter – Dr. John Kinney, Dean
Virginia Union University, Richmond,
VA

- 7:30 PM** The African-American Baptists Faith Experience and its Global Issues
Dr. Clarence Newsome, President, Shaw University, North Carolina
- 8:00 PM** Response by Panel of Representatives from each Convention
Dr. Gary Simpson, PNBC, Inc.
Dr. Isaac Mwase, NBC USA, Inc.
Rev. Terry Anderson, NBCA, Inc.
Mr. Calvin Donald, NMBCA
- 8:30 PM** Worship Music.....Tennessee State Convention Choir
Rev. Richard Sibert, President
- Introduction of the President.....Dr. Wallace Hartsfield
Vice President at Large, NBCA, Inc.
- Sermon.....Dr. Stephen J. Thurston, President, NBCA, Inc.
- Invitation to Discipleship.....Rev. Timothy Woods
Chairman Evangelical Board
- Offertory Period.....Dr. E. Edward Jones,
President Emeritus, NBCA, Inc.
- Benediction

Tuesday Late Night Session

National Baptist Convention of America, Inc.
Rev. Dennis Jones, Sec. Treas., Evangelical Board – Presiding

- 10:00 PM** Music.....Greater Grace Temple Church
Rev. Breonus Mitchell, Pastor
- Sermon.....Rev. F.D. Sampson, Pastor
Friendship Baptist Church, Houston, TX
- Invitation to Discipleship
- Offertory
- Benediction

Wednesday, January 26, 2005

National Missionary Baptist Convention of America
Dr. C.C. Robertson, Vice President at Large – Presiding

- 8:30 AM** Devotional Period — Mrs. Edith McKinney, NMBCA
- Focus Forum Presentation
Dr. Dezo McGill, Vice President, NMBCA – Moderator
- 8:45 AM** Biblical Expositor – Dr. Jim Holley, NMBCA
- 9:00 AM** Theological Presenter – Dr. Forrest Harris, President
American Baptist College, Nashville, TN
- 9:15 AM** African American Perspective on Education and Health
Dr. Stephanie White Perry
Dr. Marion Wright Edelman – Children’s Defense Fund
- 10:00 AM** Response by Panel of Representatives from each Convention
Dr. Fred Lofton, PNBC, Inc.
Dr. Claude Young, M.D., NBC USA, Inc.
Dr. Michael A. Battle, President, ITC, NBCA, Inc.
Mrs. Von Johnson, NMBCA
- 10:45 AM** Worship Music.....NMBCA Music Team
- Introduction of the President.....Dr. Joe Black
Chairman Educational Board
- Worship Music.....The Williams Brothers, Mississippi
- Sermon.....Dr. Melvin V. Wade, Sr., President, NMBCA
- Invitation to Discipleship.....Dr. T. Lynn Robinson
Chairman Evangelical Board
- Offertory Period.....Dr. William Lott, Treasurer
- Benediction.....Dr. J.K.L. Alexander
- Wednesday Afternoon Session**
- 2:00 PM – 5:00 PM** Individual Board Meetings — Parent Body
NBC USA, Inc. — Delta Ballroom
NBCA, Inc. — Presidential Ballroom
PNBC, Inc. — Tennessee Ballroom
NMBCA — Governor Ballroom

2:00 PM – 5:00 PM

Joint Auxiliary Meetings
Women’s Auxiliary – Arlene Tyler, PNBC, Inc.
Brotherhood/Laymen Auxiliary – Harold Simmons, NBC USA,
Inc.

Wednesday Evening Session

Progressive National Baptist Convention, Inc.
Dr. T. Dewitt Smith, 1st Vice President – Presiding

7:00 PM

Devotional Period. Kenneth Kilgore and Merdene Fielding Gayle
Worship Music. Ambassador Concert Choir, Oklahoma City, OK
Introduction of the President
Sermon.....Dr. Major Jemison, President PNBC, Inc.
Invitation to Discipleship.....Dr. Otis Moss III
Offertory.....Dr. Charles Adams
Benediction

Wednesday Late Night Session

National Missionary Baptist Convention of America
Rev. Denny Davis – Presiding

10:00 PM

Worship Music.....Shabach, New York, NY
Sermon.....Rev. Dale Sanders, Pastor
5th African Baptist Church, New Orleans, LA
Invitation to Discipleship
Offertory
Benediction

Thursday, January 27, 2005

National Baptist Convention USA, Inc.
Dr. William J. Shaw, President – Presiding

8:30 AM Devotional Period – Rev. Ronald Terry, Music Director, NBC USA, Inc.

Focus Forum Presentation
Rev. Wendell Griffin, NBC USA, Inc. – Moderator

8:45 AM Biblical Expositor.....Dr. Wallace Hartsfield, NBCA, Inc.

9:00 AM Theological Presenter.....Dr. Suzan J. Cook, PNBC, Inc.

9:15 AM African American Perspectives on Economic Development and Political Empowerment
Rev. Jesse J. Jackson, Sr., Rainbow /Push Coalition

10:00 AM Response by Panel of Representatives from each Convention
Dr. Benjamin Watts, NBC USA, Inc.
Dr. Harvey Clemons, NBCA, Inc.
Dr. Marc H. Morial, PNBC, Inc.
Rev. Earl Young, NMBCA

10:45 AM Worship Music

Introduction of Speaker

Sermon.....Rev. Alyn Waller, Pastor
Enon Tabernacle Baptist Church, Philadelphia, PA

Invitation to Discipleship

Offertory Period

12:30 PM – 2:00 PM Lunch

Thursday Afternoon Session

2:00 PM – 5:00 PM Individual Board Meetings
NBC USA, Inc. — Baptist World Center, Nashville, TN
NBCA, Inc. — Presidential Ballroom
PNBC, Inc. — Tennessee Ballroom
NMBCA — Governor Ballroom

~ Auxiliary Meetings with Parent Body ~

Thursday Evening Session

~ Celebratory Communion Fellowship ~

Progressive National Baptist Convention, Inc.
Dr. Major Jemison, President – Presiding

7:00 PM

Devotional Period. Kenneth Kilgore and Merdene Fielding Gayle

Worship Music.....Joint Convention Choir
Rev. Ronald Terry, Music Director, NBC USA, Inc.

Special Joint Fund Appeal.....Dr. Stephen J. Thurston
President, NBCA, Inc.

Special Music

Introduction of Speaker.....Dr. William J. Shaw
President, NBC USA, Inc.

Hymn of Preparation

Sermon.....Dr. Gardner C. Taylor
Pastor Emeritus, Concord MB Church, Brooklyn, NY
Past President, PNBC, Inc.

Communion Period.....Brotherhood and Laymen

Invitation to Discipleship

Remarks

Benediction

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