EXPLORATIONS INTO THE SYNERGY BETWEEN FAITH, HEALTH, AND HEALTH-CARE AMONG BLACK BAPTISTS

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Abstract

Background: U.S. health disparities are documented by race/ethnic, socioeconomic, gender, and geographic demographics. Since federal health record keeping began, regardless of other demographic factors, Black people continue to record statistical significant disparities. The complementary and alternative medicine (CAM) domain of mind-body medicine provides a method and language to assess the metaphysical constructs of faith, spirituality and religion and their influence on health and healthcare practices. Explorations into the synergy between faith, health and healthcare among a convenient sample of Black Baptist conventioneers provides an opportunity to better understand if and how faith can be used to enhance the health and wellbeing of Black people.

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Methodology: In 2005 a convenience sample of 2,500 Black persons among 10,000 Joint Baptist conventioneers participated in the study; 1,827 completed and returned an 80 item questionnaire. 500 surveys were lost due to computer malfunctions. Survey results covered: demographic, health/safety, health care, and faith/religion/health.

Results: 58.6% of respondents were women; 61% were married. Most (66.2%) reported good health and few were told by their physician they had a chronic disease. 33.5% never talk to their pastor about health problems or (42.7%) physician visits. Mental health responses: (98.7%) get along well with others; (93.6%) were satisfied with life; (92.8%) feel good about themselves; and (97.6%) were in good spirits most times. Many were in social organizations (40.6%). 96.1% felt religion was very important in their life; 91% thought religion affects physical/mental health; and 89.1% believed faith affects mental/physical health. 95.7% believe faith can change a health crisis. Most described religion and faith differently.

Discussion: The Black Church has history in social justice connected to community health. Responses to religion/faith affirm the interconnectedness of the synergy between faith-health. Empowered by religious fervor to interpret their health status as positive; they must also balance perceptions with evidence-based health decision-making, health practices, and sustained healthcare utilization.

Conclusion: A thoughtful scrutiny of the constructs of health and healthcare enable a new paradigm – Optimal

Health – to emerge[2] *The Black Church has and must forever be the institution that helps Black people to continue to grow and develop in journeying to reach their best possible emotional, intellectual, physical, spiritual, and socio-economic greatest state of aliveness, which is Optimal Health.*[3] *In order to maximize the synergy between faith, health and health care; individuals, groups, and communities must harmonize physical, social, psychological, and spiritual well-being.*[4] *The spiritual component can serve as the foundation on which the other three components rest.*[5] *Considering many in this study who attended church or religious services three (3) or more times within the past 30 days and they rarely talked to their pastor concerning health problems or what their physician told them; the religious/church service through sermons, Sunday school, Bible class and various ministries can serve as a platform for health promotion in the Black Church and the larger Black community.*

This article examines the synergy between faith, health and healthcare among a convenient sample of Black Baptist conventioneers. The overall goal is to better understand if and how faith can be used to enhance the health and wellbeing of Black people. In 2009, the Pew

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[2] See John Chissell, *Pyramids of Power: An Ancient African Centered Approach to Optimal Health* (Baltimore, MD: Positive Perceptions Publications, 1993).

[3] Ibid.

[4] Rueben Warren, "The Impact of Horizontal and Vertical Dimensions of Faith on Health and Health Care," *The Journal of the Interdenominational Theological Center* (2007): 71-85.

[5] Rueben C. Warren, Harold C.J. Lockett, and Adrian A. Zulfiqar. 2002. "The Social Context for Faith and Health" in *The Health Theory, Behavioral Education, Change and Practice in Imperative Diverse Populations*, ed. Jay Carrington Chunn,. New York: Kluwer Academic/Plenum Publishers. 127-151.

Foundation determined that black people in the U.S. are the most spiritual population group in the country.[6] The researchers presuppose that there is an interdependent relationship between spirituality, faith, and religion and, if scientifically explored, positive synergies in health and healthcare can be realized. The study uses self-reported responses from an 80 item questionnaire to determine any correlations between beliefs, attitudes and behaviors related to health and healthcare utilization and healthcare decision-making among a selected group of black Christians attending the first ever Joint Baptist Convention.

The continuous incidence and prevalence of indigence and health disparities among the black population is associated with being underserved, under-educated, unemployed, and racial, ethnic and gender bias. These historic challenges have resulted in lost faith in federal, state, and local governmental systems. In many instances, the only perceived refuge in the black community is within their tenets of faith which holds the belief that God is on the side of the oppressed; God will always vindicate on the behalf of those who are oppressed; and that trust can always be placed in such a God. Continuing experiences of racism, gender discrimination, and sociopolitical exploitation (classism) have often been countered by an African-American moral discourse resonant with themes such as the equality of all persons made in the *Imago Dei* (image of God). This theme has and continues, according to Clarice Martin, to strengthen the belief in liberation from all structures, systems and forms of oppression; continued

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-[6] Pew Forum on Religion & Public Life. (26 October 2009). "Pew Forum." 29 September 2010. from A Pew Forum, Web Online: http://pewforum.org/docs/?DocID=389

empowerment in psychosocial, political, and economic arenas; and provides the foundation of the rich and diverse cultural and intellectual contexts of African-American people's lives and faith.[7]

Despite the efforts from health science and biomedical research to improve overall health status of the U.S. population, racial and ethnic health status disparities remain. Public policies and programs to eliminate health disparities are elusive. The programs are not supported with sufficient monetary and human capital to reach intended objectives. For example, since the late 1980s the United States Department of Health and Human Services has published national health objectives each year called *Healthy People*. These objectives are designed to focus attention on critical health changes based upon epidemiology and other forms of data collection. However, few of the objectives are ever met. Nonetheless, the objectives are consistently revised, new targets are set and new health concerns are added. The essential critics ask why the *Health People* objectives are many times the seldom shared with the communities most at risk.

Measurable disparities also exist in the areas of; education, employment, and psychological wellbeing with regards to health. All of these disparities can be attributed, in part, to the historic and current adverse effects of slavery, Jim Crow, and segregation in the United States.[8] Until these

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[7] Clarice J. Martin, "Normative Biblical Motifs in African-American Women Leaders' Moral Discours: Maria Stewarts' Autobiography as a Resource for Nurturing Leadership from the Black Church Tradition," in *The Stones that the Builders Rejected: The Development of Ethical Leadership from the Black Church Tradition* (ed. W. E. Fluker: Harrisburgh: Trinity Press International, 1998), 47-72, esp. p. 49.

[8] Walter Earl Fluker, "Introduction: The Failure of Ethical Leadership," in *The Stones that the Builders Rejected: The Development of Ethical*

challenges have been fully addressed by federal laws, regulations, policies and programs, attempts to ameliorate the root causes of health disparities will continue to have little effect.

Using 1979-1981 data, 80% of the six major leading causes of excess deaths for black people were; cancer, cardiovascular disease and stroke, chemical dependency (measured by deaths due to cirrhosis), diabetes, homicide and accidents (unintentional injuries), and infant mortality. In 1985, these six causes resulted in 60,000 excess deaths.[9] In 1991, HIV/AIDS became the seventh leading cause of excess deaths.[10] Excess death is a term that was coined in the *1985 Report of the Secretary's Task Force on Black and Minority Health* to describe preventable mortality when comparing the observable death rate of a minority group to the measured age/sex adjusted death rate of their non-Hispanic white counterparts.

In a 2004 follow up article, using 2002 data, David Satcher reported that excess deaths among black people had risen to 83,570.[11] Given the worsened health status among African Americans, creative and novel approaches must be devised to address widening heath disparities. If health improvements are expected, then a culturally

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Leadership from the Black Church Tradition (ed. W. E. Fluker: Harrisburgh: Trinity Press International, 1998), 1-22, esp. p. 7.

[9] U.S. Department of Health and Human Services, *Report of the Secretary's Task Force on Black and Minority Health* (Washington: U.S. Government Printing Office, 1985), 5.

[10] U.S. Department of Health and Human Services. *Health, United States 1990* (Washington: U.S. Government Printing Office, 1991), 30.

[11] David Satcher, G.E. Fryers Jr., J. McCann, A. Troutman, S. H. Woolf, & G. Rust, (2005). "What if We Were Equal? A Comparison of the Black-White Mortality Gap In 1960 And 2000." *Health Affairs(2005):* 459-464, esp. p. 461.

conducive and complimentary alternative methodological approach must be explored. Ironically, in the 1985 Secretary's Task Force Report, culture innovation was recommended as a mechanism to be considered for Department of Health and Human Services (DHHS) health information programs to reach minority populations.[12]

The Institute for Faith-Health Leadership/Inter-denominational Theological Center research efforts embraced the recommendation and developed a research agenda to assess the knowledge, attitudes, and behaviors related to health and healthcare decision-making among black congregants associated with spirituality, faith and religion. Forms of spirituality, faith and religion are essential parts of most, if not all cultures. Thus these constructs should be considered as cultural considerations are explored. Lewis M. King's Culturecology model argues that black people have developed a set of values, beliefs, meanings and spiritual practices that are culturally based and can be used to enhance health.[13]

FOUNDATIONS OF FAITH-HEALTH RESEARCH

Several studies have investigated the association between faith, spirituality, religion and health. Fourteen of the sixteen studies by Harold G. Koenig on religion and its

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[12] U.S. Department of Health and Human Services, *Report of the Secretary's Task Force*, 10.

[13] Lewis M. King, "Development of Authenticity in Public Health: A Culterecology Model as a Culture Critique," in *The Health Behavioral Change Imperative: Theory, Education, and Practice in Diverse Populations* (ed. J. C. Chunn : New York: Kluwer Academic/Plenum Publishers, 2002), 91-111, esp. p. 98.

impact on blood pressure found reduction of blood pressure levels among the religiously active.[14] However, it is unclear what factors among the religiously active made the difference. Moreover, it is difficult to discern what impact is measurably and verifiably important within the notion of being "religiously active."

Few studies distinguish the differences between these terms or deconstruct abstract concepts of metaphysics (i.e., spirituality, faith and religion) related to specific health conditions (i.e., psychosomatic illness, mental health disorders, quantum healing, resiliency). The complementary and alternative medicine (CAM) domain of mind-body medicine provides a method and language to assess the metaphysical constructs of faith, spirituality and religion and their influence on health and healthcare practices.

In Christendom, the experience of faith is founded on spiritual and religious beliefs based upon the concept of soul. The Apostle Paul, in a Christological context, defines faith in Hebrews 11:1 as "the substance of things hoped for; the evidence of things not seen." Though faith and spirituality are closely linked, an important factor in spirituality is the need for the discovery of something unknown.[15] Faith for many means trust, vertical with a higher metaphysical source and horizontal with other human beings. Vertical faith is one's relationship with God; whereas horizontal faith is a

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[14] Harold G. Koenig, "Religion and Medicine IV: Religion, Physical Health, and Clinical Implications." *International Journal of Psychiatry in Medicine" (3)(2001):* 321-336, esp. p. 321 n. 31.

[15] Rueben C. Warren, Harold C. Lockett, & A. A. Zulfiqar, "The Social Context for Faith and Health" in *The Health Behavioral Change Imperative: Theory, Education, and Practice in Diverse Populations* (ed. J. C. Chunn: New York: Kluwer Academic/Plenum Publishers, 2002), 127-151., esp. p. 131.

trust in others[16] with the necessary aptitude and skill sets that promote health; prevent, treat, and cure disease. Spirituality is "the ability of every human being to believe in the Divine Intelligence, our personal spark of the Creator; that resides within each of us as our life source."[17] The difference between spirituality and religion is that the former consists of the belief in something far greater than itself and the latter, defines the practices, polity and faith connection or affiliation of an individual or group.

The impact of horizontal and vertical faith on health and healthcare begins with operational definitions of faith. Faith is a way of living; it is life-transforming and has a dramatic, lasting impact on the believer.[18] This way of living can either be positive or negative faith and can affect an individual's or groups' health by giving meaning(s) that later is/are carried out in praxis or the lack thereof. Faith for many black people is equated to either a spiritual, religious or philosophical understanding of life and is oftentimes communicated theologically. Failure in understanding the context of faith either horizontally or vertically is problematic. The impact of faith on health and healthcare is critical because it influences behavior. Horizontal faith can provide hope in the expertise and intergrity of the health professional and vertical faith empowers the belief that God is present and protectively guiding healthcare decision-making.

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[16] Rueben C. Warren, "The Impact of Horizontal and Vertical Dimensions of Faith on Health and Healthcare." *The Journal of the Interdenominational Theological Center (2007):* 71-85, esp. p. 73.

[17] John T. Chissell, *Pyramids of Power!: An Ancient African Centered Approach to Optimal Health* (Maryland: Positive Perceptions Publications, 2000), 43.

[18] Warren, "The Impact of Horizontal and Vertical Dimensions of Faith on Health and Healthcare," (2007), 73.

Spiritual wellbeing is seldom described when health is considered. "Spiritual health" is associated with "salvation," (*salus*) which in Latin means health. For Christians, God's desire for human wholeness includes physical, social, psychological and spiritual concerns.[19] The Christian theologian, Paul Tillich, explored the concept of faith as being described as "ultimate concern." Ideally, to be ultimately concerned, the physical, social, psychological, and spiritual dimensions of the human experience must be explored. These dimensions are the components of a person's life, therefore "being ultimately concerned involves a centered act of the whole person directed toward something or someone transcendent."[20]

Faith affects physical, social, psychological and spiritual wellbeing, as well as the intellect, emotions, and will of the individual. In fact, "faith covers all of reality, secular and sacred."[21] Faith is holistic; as previously indicated, it is vertical and horizontal. Vertical faith as relational to God and horizontal is the relationships persons have with other human beings, including spiritual and social dynamics.[22] However, faith must be interpreted beyond its mere religious context.[23] Faith for black people is ultimately public theological talk about God; and the human struggle that seeks a holistic salvation, liberation, and the practice of

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[19] Donald D. McKim, *Westminister Dictionary of Theological Terms* (Louisville: John Knox Press, 1996), 125.
[20] Jeff Levin, *God, Faith, and Health: Exploring the Spirituality-Healing Connection* (New York: John Wiley & Sons, Inc., 2001), 211.
[21] Dwight N. Hopkins, "Introduction: Black Faith and Public Talk" in *Black Faith and Public Talk: Critical Essays on James H. Cone's Black Theology & Black Power.* ed. D. N. Hopkins: Maryknoll: Orbis Books, (1999), 1-7.
[22] Rueben C. Warren, Harold C. Lockett, & A. A. Zulfiqar, "The Social Context for Faith and Health," 143.
[23] Ibid., (2002), 131.

freedom.[24] It is in this effort that faith-health research is explored in order to introduce a renewed paradigm, an ancient African centered approach called *Optimal Health.*

METHODOLOGY

Study Design

On January 24-28, 2005 in Nashville, Tennessee, the Joint National Baptist Convention gathered for a forum. Historically, this was the first time the four largest black Baptist conventions had gathered as one convention. A survey on faith, health, and healthcare was administered to conventioneers. The eligibility criteria for participation included self-identifying as being Black/African American, 18 years of age or older and a Joint National Baptist Conference attendee. The study received *Institutional Review Board* (IRB) approval by Meharry Medical College before it was administered.

A random sample of 2,500 black men and women from among the 10,000 conventioneers responded to the survey. Exactly 1,827 of those surveys returned were completed and 1,327 were used in this analysis. Five hundred persons completed surveys by personal interviews conducted by one of the graduate students using the same questionnaire. The information was stored in a hand-held personal digital assistant (PDA) device. However, due to a computer data storage error, none of the information from the PDAs was retrievable. All survey respondents were volunteers and no incentives were offered for their

[24] Dwight N. Hopkins, "Introduction: Black Faith and Public Talk," 2.

participation. The assessment tool was a 14-page, 80-question survey consisting of three major sections: health and safety, healthcare and faith and religion. Demographic information was also collected to include: 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 wellbeing, social involvement, seatbelt usage, and the environment. Many of the Health and Safety, and Healthcare 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.

Section 2 of the survey consisted of 19 items that measured knowledge, attitudes and behaviors about healthcare 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. Additionally, survey questions found in the Faith, Religion, and Health section were developed by the research team and consultants to the Institute for Faith-Health Leadership at the Interdenominational Theological Center.

SURVEY RESULTS

Survey results included information from the following areas: demographic, health/safety, healthcare, and faith/religion/health.

Demographic results included: sex, marital status, number of persons living in the household, educational level, employment status, and yearly household income. Over half of the respondents who participated in the survey were black Baptist women (58.6%). Most of the respondents were married (61%). Those who responded were between the ages of 55-64 (30%), 65-74 (25.2%), and ages 45-54 (21.5%). A large number of the respondents (66.4%) reported having less than 3 people living in their household, compared to 3% reporting having more than 5 people. Almost a third (31.3%) of the black Baptist respondents had acquired a graduate or professional school educational degree; however combined over 50% had either an associate degree (26%) or undergraduate degree (24.6%).

Table 1
DEMOGRAPHIC PROFILE OF BLACK BAPTIST RESPONDENTS

Congregant Characteristics	**N**	**(%)**
Total	1327	100.0
Sex (n=1297)		
Female	760	58.6
Age (n=1292)		
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 >	10	0.8
# of persons living in household (n=1290)		
< 3 people	859	66.4
3-5 people	399	30.9
>5 people	35	2.7
Education (n=1274)		
Some grade school	12	0.9
Some high school	35	2.7
High school grad/GED	133	10.4
Vocational or Technical	56	4.4
Some college/associates	325	25.5
College	313	24.6
Graduate/Professional	399	31.3
Other (i.e., RN, LPN)	1	0.1
Employment Status (n=1325)		

Table 1 (con't)
DEMOGRAPHIC PROFILE OF BLACK BAPTIST RESPONDENTS

Congregant Characteristics	**N**	**(%)**
Work from home/homemaker	50	3.8
Full time	567	42.9
Part time	85	6.4
Student	29	2.2
Disabled	52	3.9
Retired	528	39.9
Seeking employment/Unemployed	14	1.1
Other	-	-
Household income before taxes (n=1248)		
<$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 >	37	2.8

Many of the respondents (42.9%) have full time employment and 39.9% currently are retired. Household income before taxes for this group of respondents reported that most (30%) individuals fell between the income range of $25,000 and slightly below $50,000.

Health and Safety results were used to determine the knowledge, attitudes and behaviors of issues such as; general health status, exercise, eating and drinking habits, smoking, sleep behavior, emotional and/or psychological wellbeing, social involvement, seatbelt usage, and the environment. A large number of black Baptist respondents (66.2%) reported their health as good when asked to rate their general health, and 65.4% of the respondents reported that they currently do exercise. Many of the respondents (73.2%) reported that they eat healthy; however, over half

(52.4%) do not eat breakfast, lunch, or dinner every day. Over half (55.3%) eat fruit daily and of those who responded "yes" to eating fruit daily, (89.8%) have 1-3 servings daily. When asked do they eat vegetables (79.5%) responded yes; and of those who eat vegetables daily (89.4%) eat between 1-3 servings a day. Half of the respondents (55.8%) never add salt to their meals at the table compared to (39.5%) reportedly do when food is not salty enough, and (4%) almost always add salt before tasting.

Over half (57.5%) of those who responded reported that they have never smoked. However 37.3% indicate that they have smoked but only in the past. When asked the amount of hours they sleep at night, 61.1% of respondents said between 6-8 hours. A large numbers of respondents reported that they get along well with others (98.7%), largely (83.5%) enjoy going to work every day, many (93.6%) are satisfied with their lives, the majority (92.8%) feel good about themselves, and (97.6%) are in good spirits most of the time. When asked whether they preferred staying at home rather than going out and doing new things (49.4%) rather go out, (32.7%) prefer to stay at home, and (17.9%) responded sometimes.

Almost two-thirds (65.3%) of the respondents reported getting bored often, 66.8% are stressed sometimes, and of those who responded yes and asked how often, 65.1% said some of the time. Almost one-half (46.1%) reported being stressed at work. When asked if they ever felt lonely, 65.1% of the respondents reported "no." A large number of respondents (79.2%) indicated that they belong to a community or social organization; of those who responded yes (45.1%) belong to a civic organizations, (40.6%) social (i.e., LINKS, sororities, fraternities), and (40.1%) professional (i.e., educational, medical).

The respondents were also asked whether they have ever smoked and 57.5% have never smoked, 37.3% have smoked, but only in the past, and 5.2% currently smoke. Of those who responded "yes" to smoking, they were also asked how many packs per day do they currently or did they smoke. Two-thirds (66.8%) of the respondents reported that they smoked less than one pack per day, 25.3% one pack per day, 5.6% two packs per day, and 2.2% smoked more than two packs daily. Respondents were also asked whether they have or if they currently drank alcohol and half (50.0%) have never drank alcohol, 34.8% have but only in the past, and 15.2% currently do. Those who responded "yes" to currently drinking alcoholic beverages were also asked of their weekly consumption and 46.6% report having less than one drink per week, 30.9% reported that they do not drink, 18.1% have between 1-5 drinks per week, 2.0% consume 6-10 drinks per week, and 2.4% have more than 10 drinks per week.

Most individuals (88.1%) when in a vehicle are more likely to drive than ride. 76.7% of the respondents reported using seatbelts all of the time. When asked "why" 61.3% responded that it is the law and 51.7% utilized seatbelts for safety. When respondents were asked why they do ***not*** use seatbelts; of those who responded, 8.3% stated they forgot to put them on. The majority of black Baptist respondents when asked how often they made sure that children who rode with them used seatbelts or car seats, 89.7% responded "all of the time" and 76.3% encourage other adults who ride with them to use seatbelts all of the time. Almost all of the respondents (91.9%) think there is a need to tell people about the importance of using seatbelts; and when asked whether they think stronger seatbelt laws were needed in their states of residence, 46.4% did not think they were needed, while 39.6% thought they were, and 14.0%

were not sure of the need for stronger seatbelt laws. Over a third (39.1%) of respondents did not think stronger seatbelt laws led to issues of harassment of particular individuals or group(s). A large number of respondents (93.7%) believed seatbelts save lives. Almost all (90.9%) of respondents reported that they lived in a healthy/safe environment.

Healthcare results measured knowledge, attitudes and behaviors about healthcare practices, including: access to health services, health utilization and finance, screening patterns, and prevalence of reported health conditions. Most of the Black Baptist respondents (91.9%) have a private physician and have regular medical exams (91.1%). Thirty-eight percent (38.1%) saw their physician last month and (90.0%) had their blood pressure checked within the last year. Also, 77.1% have private insurance to pay for their medical care. When asked to rate their weight, half of the respondents (56.2%) reported being overweight compared to 41% who reported normal weight. Of the respondents, 82.2% have a private dentist and 35.1% saw their dentists at least six months ago; 42.9% floss their teeth sometimes and 70.5% pay for dental care with private insurance.

Table 2.
SAMPLE HEALTHCARE RESULTS

Medical and dental care

Characteristics	N	(%)
Do you have a private medical doctor? (n=1282)		
Yes	1178	91.9
No	104	8.1
Do you have regular medical exams? (n=1280)		
Yes	1166	91.1
No	114	8.9
When did you last see your medical doctor? (n=1276)		
Last week	260	20.3
Last month	488	38.1
Six months ago	390	30.4
A year ago	104	8.1
3-5 years ago	29	2.3
More than 5 years ago	5	0.4
Do you have a private dentist? (n=1270)		
Yes	1042	82.0
No	228	18.0
When did you last see your dentist? (n=1259)		
Last week	99	7.9
Last month	214	17.0
Six months ago	442	35.1
A year ago	310	24.6
3-5 years ago	134	10.6
More than 5 years ago	60	4.8

Large percentages have never been told by their doctor that they have kidney disease (95%), liver disease (96.6%), diabetes (78.7%), asthma (85%), or cancer (92%). However, 54.8% of the respondents have been told by their doctors that they have hypertension. Of the 1,327 participants, approximately 31% have been tested for

HIV/AIDS. A few have been told by their doctors that they had emotional (4%) or mental disorders (2.7%).

Faith, Religion and Health results assessed the knowledge, attitudes, and behaviors relative to faith, religion, and health influences and decision-making. Almost all of the respondents (99.3%) were Christian – Protestant and 96.1% of the respondents felt that religion was very important in their life. When asked about their understanding of life, many of the respondents either had a religious (66.3%), spiritual (78.1%), and/or philosophical (28.2%) view. Only a small amount of the respondents (1.4%) reported having either none or they did not know of their understanding of life. Most of the respondents (94.7%) reported attending church or religious services three (3) or more times within the past 30 days. Almost all black Baptist (99%) believe that God and/or Jesus is a healer, and 91% think religion affects physical and/or mental health.

One third (31.1%) of the respondent reported that they never talk to their pastor about health problems, 28.0% only talk to their pastor some of the time when they are sick, and 42% never talk to their pastor about what their physician tells them. Over half (63.7%) never talk to their pastor about what the dentist tells them; 47.6% never seek advice from their pastor regarding major health decisions; and 42.7% never seek advice from other church members regarding major health decisions. Most of the respondents at the black Baptist convention reported always praying before (91.9%) and after (93.4%) making medical decisions.

Table 3
FAITH, RELIGION ANDHEALTHCARE RESULTS
REGARDING THE BELIEF AND AFFECTS ON HEALTH

Characteristics	N	(%)
Do you have a belief that God and/or Jesus is a healer? (n=1214)		
Yes	119	99.0
No	4	0.3
Don't know	13	1.0
Do you think religion affects physical and/or mental health? (n=1201)		
Yes	1087	91.0
No	86	7.0
Don't know	28	2.0
Do you pray before making medical decisions? (n=1224)		
Yes	1125	91.9
No	35	2.9
Sometimes	64	5.2
Do you pray after making medical decisions? (n=1124)		
Yes	1143	93.4
No	25	2.0
Sometimes	56	4.6

Almost all (89.1%) of the respondents believe that faith affects mental and physical health. Most of the respondents (95.7%) adhere to a belief that faith can change a person's health crisis status, 97.9% believe that faith helps in making medical decisions, and 97.1% of the respondents believe that faith can help sustain a person's health. Finally, respondents at the black Baptist convention reported doing the following when responding to family member(s) health problem: 81.8% keep doctor's appointment, 73.3% read

Scripture, 53.7% secure medication, 34.6% have a conversation with minister/faith leader, 30.0% attend a worship service, 29.7% converse with a friend, and 26.7% use a home remedy first. When responding to their own personal health problem, 84.9% keep doctor's appointment, 74.9% read scripture, 58.1% secure medication, 34.6% have a conversation with a friend, 33.0% converse with a minister/faith leader, 32.5% attend a worship service, and 29.5% use a home remedy first.

Table 4

FAITH, RELIGION AND HEALTHCARE RESULTS REGARDING THE ROLE THAT FAITH PLAYS IN A HEALTH OUTCOMES

Characteristics	N	(%)
Faith affects physical and/or mental health (n=1231)		
Yes	1097	89.1
No	90	7.3
Sometimes	44	3.6
Belief that faith can change a person's health crisis (n=1246)		
Yes	1192	95.7
No	13	1.0
Sometimes	41	3.3
Faith helps in making health decisions (n=1244)		
Yes	1218	97.9
No	7	0.6
Sometimes	19	1.5
Faith helps in sustaining health (n=1229)		
Yes	1193	97.1
No	9	0.7
Sometimes	27	2.2

DISCUSSION

The responses in this survey to faith, religion, and health descriptively affirm the interconnectedness between these constructs and health, and healthcare decision-making. The synergy is best explained in the responses of one's religious, philosophical, or spiritual understanding of life that is cultivated through knowledge gained through the lived experience, and therefore drives attitudes and behaviors, as it relates to health and healthcare, whether real or perceived. The respondents affirm their health as good; thus, it is important to recognize that affirmations are part of the African American religious culture. In that regard, affirmative hope is always rooted in faith for a desired outcome. Although it cannot be seen, a belief is cultivated through one's religious or spiritual perspective that it can and will affirmatively be so. And for people of color, faith is intimately tied to spirituality, particularly for people of African descent, and African spirituality is translated into daily practices.[25]

Black Baptists belief in God and their existence is driven by the belief in a spiritual resurrection and future existence in eternity (heaven) with God and Jesus, the Christ. Oftentimes, such a belief has resulted in the lack of proactive care for oneself in the here-and-now; because the ultimate concern or desire is in the future reign in eternity with God. Many perceive this as "escapism." However, under the systemic oppression of slavery and its post social conditions that have negatively impacted black life, escapism may be perceived as the only way out. It can best be understood as James Cone argues that Death was [is] a compelling and ever present reality for the slave "because of

[25] Warren, "The Impact of Horizontal and Vertical Dimensions of Faith on Health and Healthcare." 76.

the cheapness with which his [her] life was regarded.[26] For instance, in order to continue having hope, many enslaved Africans had to look forward to another reality beyond time and space.[27]

Religious instruction has cultivated thinking among respondents that God and/or Jesus is a healer. However, it may be possible that the respondents believe that despite any adverse behavior or social disparate condition that challenges their health or decision making, they can petition to God, through Jesus for healing without any pro-active measures on their part. This belief may lead to passive or minimal responses to health challenges. The impact of having faith in others in whom they trust (horizontal faith); or, respectively, in God or Jesus (vertical faith), is unclear; it needs further investigation. Despite the historical and structural sin (i.e. racism, sexism and classism) that the respondents undoubtedly continue to endure, it is their faith that sustains them, as suggested in many of their survey responses.

Structural sin refers to the systematic barriers that prevent health and wellbeing for specific groups of people (racial and ethnic minority populations, low income populations, etc). In this instance, structural sin is exemplified by institutional racism, sexual bigotry and the exploitation of low-income people. Structural sin has to be addressed at the individual and group physical and spiritual level, if sustained health improvements are to be expected.

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[26] James H. Cone, *Black Theology & Black Power* (New York: The Seabury Press, 1969), 92.
[27] Cone, *Black Theology & Black Power*, 93.

The vast majority of respondents had private medical and dental insurance. However, while the financial barrier to healthcare is removed, accessibility and acceptability of care remain.

Many in the black Church rely strongly on the Bible, particularly the respondents of the black Baptist religious tradition. Reciting biblical faith narratives for black people brings forth positive self-affirmations and a contextual understanding on how to endure their social condition. It is through interpretations of biblical narratives and Scriptures such as, "For as he [she] thinketh in his [her] heart, so is he [she]" (Proverbs 23.7), that respondents are likely to find strength, hope, and healing through their strong reliance on the Bible. Therefore, the Bible may be a resource worth exploring as a health educational tool that exegetes the biblical text. Moreover, to "unpack" the contextual and authentic meaning and translate the biblical text ethically can have practical health implications.

According to the denominational covenants of the respondents, the believers must abstain from the selling and usage of intoxicating drinks. The data indicates that many of their health practices can be attributed to religious beliefs, as suggested in their affirming response to the question, "does religion affect physical and/or mental health"? Religious beliefs for the respondents play an important role in health decision making. For instance, over half of the respondents had reported that they had never smoked cigarettes or drank alcohol. It appears as though their beliefs have played an important role in this positive health behavior because neither smoking nor drinking behaviors are condoned among black Baptist communities. Therefore, refraining from cigarettes and alcohol use (or even overeating) are health

promoting and behaviors that may be positively influenced by religious affiliations.

In a study by H. Benson, faith in God had a health-promoting effect.[28] The respondents reported that they always pray before and after making medical decisions, and believe that faith can make a difference in a healthcare crisis. In a previous study by Eisenberg et al., a widely cited article on unconventional therapies, the authors noted that 25% of all respondents reported using prayer as medical therapy.[29] In addition, a study by D. King and B. Bushwick reported that 48% of hospital inpatients wanted their physicians to pray with them.[30] While prayer is positive and affirming, a question can be asked, "Are the prayers mostly made during a crisis about a health issue or are they made frequently regarding general health and wellbeing?"

Trusted relationships play a major role in communication and compliance[31] when addressing health issues in the black community. The data in this study indicates that 98.7% of the respondents reported that they got along well with others. This suggests that relationships may provide an excellent avenue to develop, not only a health promotion strategy, but also healthcare, as well. Relationships in the black community are the building blocks

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[28] H. Benson, *Timeless Healing* (New York: Fireside, 1996), 52.
[29] D. Eisenberg, R. Kessler, C. Foster, F. Norlock, D. Calkins, & T. Delbanco, "Unconventional medicine in the United States: prevalence, costs, and patterns of use," *New England Journal of Medicine* (1993): 246-252, esp. p. 248.
[30] D. King, & B. Bushwick, "Beliefs and attitudes of hospital impatients about faith healing and prayer," *Journal of Family Practice* (1994): 349-352, esp. p. 350.
[31] Rueben C. Warren, *Oral Health for All: Policy for Available, Accessible and Acceptable Care* (Washington: Center for Policy Alternatives, 1999), 28.

for trust and are group-oriented. These relationships are founded upon religion and spiritual beliefs. While these elements are important for all communities, they are particularly relevant for communities of color. For example, 79.2% of respondents in this study belong to a community or social organization. This provides an opportunity to develop group health promotion activities such as healthcare networks, faith-based health clinics, food cooperatives, walking clubs, cooking programs and various other ministries with measurable health outcomes.

Being affiliated with a community or organization allows one to build comradeship through philosophical, religious, or spiritual understandings that may have positive health implications. The data in this study indicates that when respondents were asked to select an answer regarding their philosophical understanding of life, 78.1% of respondents had a spiritual understanding of life, 66.3% indicated religious, 28.2% reported having a philosophical understanding, and 1.4% either had none or did not know. Healthcare providers should be aware of these various understandings of life in order to maximize the care and effectively communicate with their patients. Healthcare providers need to know how the group dynamic influences individual health behavior and health decision-making. Dismissing, ignoring, or deriding as unscientific, the spiritual, philosophical or religious understanding of their patients will surely compromise the care and/or compliance.[32]

The group dynamic is important because it is unlikely that any health delivery system will be effective if the individual is isolated from the group. Decisions, particularly about health, are seldom made in isolation, outside of their

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[32] Warren, Lockett, and Zulfiqar, "The Social Context for Faith and Health," 128.

immediate family, friends, and others in whom there is established trusted relationships. People often seek advice about cause and treatment from families and friends prior to seeking professional care. Many of the respondents, as previously indicated, belonged to either a community or social organization; however, the respondents also attended church or religious services regularly. The faith group has an underestimated influence on an individual's decision-making about health and healthcare issues.[33] It is within the group setting that individual and/or group beliefs are shaped and decisions are influenced.

Of the respondents, 91.9% have a private medical doctor and 82% have a private dentist, and 91.1% have regular medical exams. It was not until the late 2000s that the American Medical Association (A.M.A.) acknowledged over a century of wrongs towards black physicians. In the context of the A.M.A.'s acknowledgment that an ethical problematic arises, if the A.M.A failed to treat black physicians fairly, how could they provide quality care to black people, as a service population? This question does not negate that many white physicians undoubtedly provided quality care to all people regardless of race/ethnicity, education, or ability to pay. Historical challenge of institutional racism has and continues to operate in the health delivery system and other areas of social support. If a health and human services organization or association acknowledges unfair treatment to its colleagues, it is reasonable to suspect plausible unfair and/or unequal treatment to vulnerable patients as well. The black Baptist respondents in this study used their healthcare providers; however it is reasonable to ask the question "Why do

[33] Warren, Lockett, and Zulfiqar, "The Social Context for Faith and Health," 130.

healthcare disparities continue when barriers of income, access, and frequency of visits to their primary physicians and dentists are removed?"

Almost all respondents reported that they lived in a healthy/safe environment; however, they may not be aware of the environmental hazards that disproportionately plague many black communities. Environmental justice research has documented communities with high concentrations of racial and ethnic minorities and/or low-income communities are disproportionately exposed to a variety of environmental burdens and hazards.[34] These toxic exposures place the black population at risk for many environmental related diseases and conditions. The characterization of exposure in the community requires an understanding of all of the potential pathways by which pollutant releases may result in exposure and adverse health conditions.[35]

ETHICAL IMPERATIVES

Should health outcomes be based upon social stratification in an environment where public intervention could significantly decrease such health disparities? This is the fundamental ethical question intersecting the political, social, economic, and spiritual spheres within all modern societies. Two of the favored ethical approaches to answering the question have been raised in terms of utilitarianism and pragmatism, respectively.

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[34] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Washingtion: National Academy of Science, 2003), 25.

[35] Institute of Medicine. *Unequal Treatment*, 14.

On utilitarian grounds, the ethical course is to seek the greatest good for the greatest number.[36] In terms of health, the greatest good would be for the maximum number of people in a given society to be in optimal health.[37] It could further be seen as a violation of utilitarianism if large sectors of a given society experience suboptimal health due to surmountable deterrents such as the affordability of and access to healthcare.

Additionally, much of the work done in the Public Health arena is premised upon the American contribution to philosophical tradition of pragmatism.[38] For the pragmatist, functional, empirically-based solutions count as ethically right; always being open to revision and correction with a deep humility which recognizes that better information may demand a different course of action. It is precisely this presupposition that Thomas R. Frieden uses to construct his health impact pyramid to proffer a framework for public health action that improves societal health.[39] Frieden argues that at the base of the pyramid, which indicates interventions with the greatest potential impact are efforts to address socioeconomic determinants of health; among which are poverty reduction and improved education.[40]

In the black Church tradition, morally what things

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[36] R. Audi, *The Cambridge Dictionary of Philosophy* (Cambridge: Cambridge University Press, 1998), 824-825.
[37] Chissell, *Pyramids of Power!, xxii.*
[38] L. Harris, *The Critical Pragmatism of Alain Locke: A Reader on Value Theory, Aesthetics, Community, Culture, Race, and Education* (Lanham: Rowman & Littlefield Publishers, Inc., 1999), xi.
[39] T. R. Frieden, "A Framework for Public Health Action: The Health Impact Pyramid," *American Journal of Public Health*, (2010): 590-595, esp. p. 590.
[40] Frieden, "A Framework for Public Health Action: The Health Impact Pyramid," 591.

ought to be done and how those actions are determined lie largely within the clerical domain. Issues of liberty, acceptable life choices, end of life decisions, pregnancy terminations, contraception, and who should have access to social goods, are some of the questions that arise in this context. Of real concern is the way the ethical and medical often overlap in faith communities; making these environments highly susceptible to bioethical and biomedical infractions. Medically, many black faith leaders enjoy the privilege of articulating what they understand to be God's desires concerning how congregants should eat, whether or not they should seek medical attention, and if they should follow the directions of medical professionals *as a matter of faith*. In some faith traditions, avoiding physicians is seen as an act of devotion to God and a demonstration that one trusts God to heal sickness and disease. Likewise, there are other religious communities that do not believe in blood transfusions or invasive surgery, even to save the life of a child or family member. The extent to which congregants hold these views is often related to the perspective, teachings, and interpretation of sacred texts emanating from their faith leaders.[41]

Given the strength of this reliance on the black Church by the black community, the need for data to reflect the health, perceptions, and habits of black congregants is of primary concern; particularly when the presence of vulnerable and underserved populations contained within the totality of the black Church experience is considered. The tendency of congregants to trust spiritual leaders on so many previously discussed and varied levels raises the ethical imperative for black faith leaders to have this health information so that the advice they provide to congregants

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[41] A. Scandrett, Jr., *Influence of Religious Beliefs on Behaviors of Attenders of the Black Baptist Church* (University of Oregon: Eugene (Dissertation), 1993), 97.

can be accurate, current, and grounded in factual reality in addition to spiritual authority. This further safeguards congregants against the kind of medical abuses that African Americans have been exposed to in the history of the American Health Movement.[42]

While spiritual in its application, the ethical is a human endeavor that is predicated upon consistently doing what one understands is the most rational and fair choice based upon what one knows to be true and what promotes social justice. Before gathering these data, black faith leaders may have been able to shoulder shrug when asked what exactly ails their congregants. But the mere collection of this information itself created an instantiation of the ethical in that it brought into fruition statistics that were necessary to have if the health status of black people is to be improved. Doing that which has to be done is to do the ethical. Thus, the aims of the Institute for Faith-Health Leadership to act upon the collected data and infuse them into the operational life of the black Church is an ethical imperative that flows from the very existence of the gathered information. The suffering of black people demands that black faith leaders respond accordingly to this data with all the power, love, and sound mindedness that can be mustered as both a spiritual and an ethical endeavor.

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[42] Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Doubleday, 2007), 101.

CONCLUSION

There is a growing body of evidence linking spirituality, religion and religious practices to health and healthy behavior.[43] These discoveries suggest that there are increased opportunities for faith communities, particularly black Church leadership, to partner with the health community to improve individual and group wellbeing.[44] Health behaviors encouraged or proscribed by a particular religion may be one explanatory mechanism to determine how religion can affect health. Improvements in health and increased outcomes through healthier practices have been associated with religious involvement in the African American community.[45] Studies of Mormons and Seventh-day Adventists in the U.S. and Australia[46] document lower risk of cancer and other diseases in these groups compared to the general population,[47] which provides insight into the central role religion can have in health outcomes.

The black Church can and should play a meaningful role in health promotion and protection, disease prevention, and cure. However, some of these roles may be inappropriate and conflicting with present beliefs of religious organizations. Nevertheless, black leaders must examine

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[43] B. Epperly, *Spirituality and Health, Health and Spirituality: A New Journey of Spirit and Body* (Mystic: Twenty-Third Publications, 1997), 29.
[44] Warren, "The Impact of Horizontal and Vertical Dimensions of Faith on Health and Healthcare," 72.
[45]K.F. Aaron, D. Levine & H. R. Burstin, African American church participation and healthcare practices. *Journal of General Eternal Medicine (2003):* 908-913, esp. p. 909.
[46] I. Rouse, B. Armstrong, & L. Leilin,"Vegetarian diet, lifestyle and blood pressure in two religious populations." *Clinical and Experimental Pharmacologyand Physiology (1982):* 327-330, esp. p. 328.
[47] G. Kune, S. Kune, & L. Watson, "Perceived religiousness is protective for colorectal cancer: data from Melbourne Colorectal Cancer Study." *Journal of the Royal Society of Medicine (2005):* 645-647, esp. p. 646.

themselves and wrestle theologically and ethically as to their beliefs that impact the health of the community. Although faith-leaders need to address the health concerns that are impacting the black community, government officials should not always expect enthusiastic responses from the lay community just because the faith community is involved (e.g., flu vaccination campaigns, HIV prevention and testing, and Medicare prescription rallies.[48] These roles can only be effectively actualized when *faith* is translated into *trust* and the resulting *trustworthy relationships* are actualized.

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[48] Warren, "The Impact of Horizontal and Vertical Dimensions of Faith on Health and Healthcare", 72.

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