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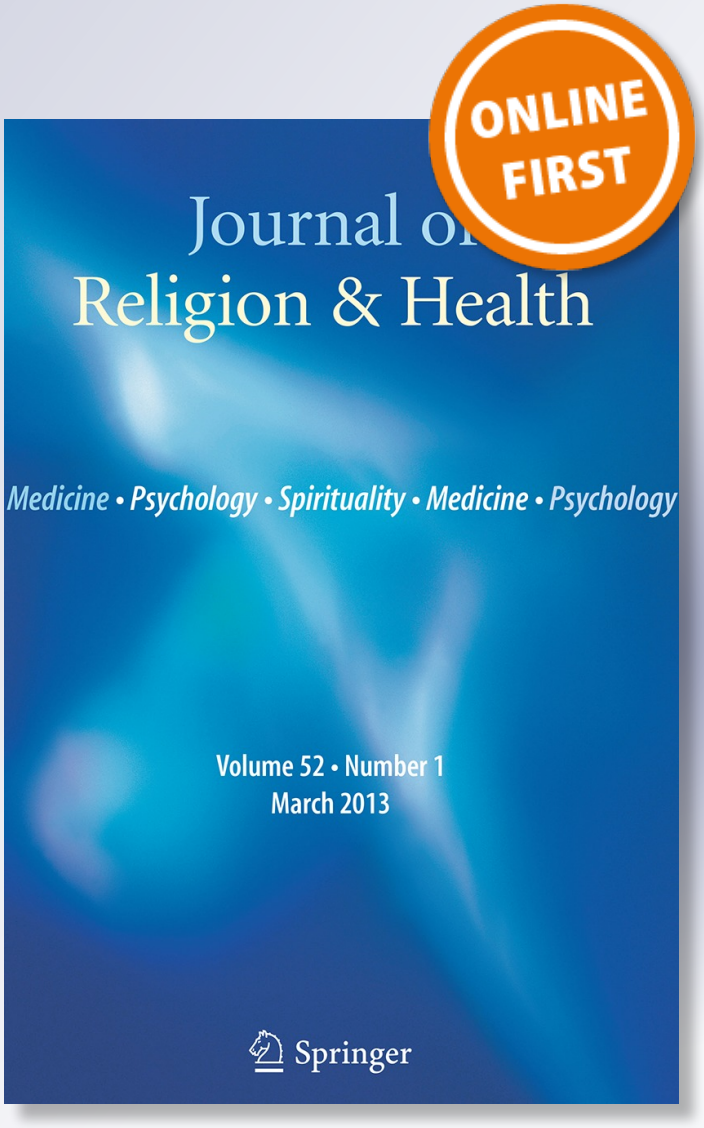

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ORIGINAL PAPER

As I See It: A Study of African American Pastors' Views on Health and Health Education in the Black Church

Michael L. Rowland · E. Paulette Isaac-Savage

Abstract The Black Church is the only institution that has consistently served the interest of African Americans, and there is no other institution in the African American community that rivals its influence (Camara, 2004). The spiritual well-fare, social support, health, and well-being of its people have been one of its main goals. With health disparities of African Americans still at an alarming rate, the Black Church has used informal education as a means to impart knowledge on health, as well as other non-religious and religious topics. One of the avenues least researched within the Black Church is the pastor's perception of its educational role in health and wellness and its efforts to reduce health discrimination and health disparities between African American and European Americans in the U.S. Since social justice appears as a theme and concern in the traditions of many churches, it is only appropriate that, among other things, the Black Church should address the issue of health education and interventions. The purpose of this study was to explore African American pastors' perceptions of the role of the Black Church in providing health care, health education, and wellness opportunities to African Americans. Many pastors reported their church provided some form of health education and/or health screenings. Their perceptions about the important issues facing their congregants versus African Americans in general were quite similar.

Keywords African Americans · Black Church · Health disparities · Health education · Pastors · Perceptions

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Introduction

Discrimination in health care and health disparities among ethnic and racial groups continue to plague our country (Rowland and Chappel-Aiken 2012). African Americans continue to experience higher incidence rates of disease than most other groups. Some describe these incidents as injustices against African Americans. Unfortunately, these injustices have a long history in the African American community. To combat social justice issues, including health, African American have often turned to the Black Church. In many instances, religion and spirituality are intertwined in many people's lives. As such, many adults turn to their church for religious and spiritual growth and development. However, in addition to growth and development the Black church is viewed as a safe haven and a context for learning on a variety of topics. Fitzgerald and Spohn (2005) point out "[c]hurches, congregations and other religious organizations provide an array of sectarian and secular goods to participants. Through these organizations individuals can receive spiritual guidance, fellowship and sanctuary while building friendships and social networks" (p. 1015). The needs of African Americans have often been met through educational programming of the church (Woodson and Braxton-Calhoun 2006). Decades ago, Byrd (1986) appropriately noted that "inadequate attention has been focused on the role of the Church in the education of black people" (p. 83). More attention is given today, yet we know little of pastors' perceptions of the church's educational role. In this article, we discuss the findings from an exploratory study in which we examined African American health care issues from the perspective of pastors. Specifically, we report how the Black Church has served as an educational conduit to reduce health disparities and improve health outcomes for African Americans through its use of health education programming.

African Americans: Health Disparities and Discrimination

In spite of medical advances, many ethnic and racial groups have not shared equally in the advances in health outcomes and health status (Agency for Healthcare Research 2003; Rowland and Chappel-Aiken 2012). The US racial disparities in health outcomes are both clear and disturbing (Weisfeld and Perlman 2005). As a result of this apparent discrimination and mounting data of racial disparities, there is continuing need for "vigilance in the area of health care and civil rights" (Brach and Fraser 2000, p. 236).

The disparities in health care research regarding racial and ethnic minority groups (Agency for Healthcare Research and Quality 2011; Flores and Lin 2013; Fiscella et al. 2002; Hargraves 2002; Skarupski et al. 2007) have warranted attention from the media and others; yet, a clarion call to African Americans to change their health behaviors is still necessary. An examination of American adults' health literacy supports the need. The Institute of Medicine (IOM) (2004) defines health literacy as the "degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (p. 32). Using this definition, the National Center for Education Statistics (NCES) (2006) reported that on a scale of 0–500, with 500 as the desired score, African Americans' health literacy score was 216. As can be discerned from the comparative scores among African Americans and other ethnic groups in Table 1, African Americans have the second lowest health literacy score. Although the score demonstrates African Americans possess some level of health literacy, there is room for improvement and cause for concern.

In response to the undeniable evidence of racial disparities and discrimination in health care access, diagnosis, and treatment, the concept of providing and delivering culturally

Table 1 Health literacy scores

Ethnic group	Health literacy score
Caucasian	256
Asian/Pacific Islander	255
American Indian/Alaska Native	227
African American	216
Hispanic	197

Adapted from NCES (2006)

competent care has been instituted as a strategy to reduce racial health care disparities in the United States. Cultural competence involves "understanding the importance of social and cultural influences on patients' health beliefs and behaviors" (Betancourt et al. 2003, p. 297). This includes understanding how patients' spiritual beliefs may influence their health behaviors. The point is to know that health care must be tailored to the unique social and cultural lifestyles of targeted groups.

There are numerous incidents and reports of African Americans not receiving proper medical treatment. For example, research findings indicate that women and racial and ethnic minorities receive substandard medical care; in addition, African Americans routinely wait longer for organ transplants (Goodwin 2006) and are less likely to get adequate treatment for pain (Blackhall 2009). Relying solely on individuals to initiate visits with their primary care physician, if they are fortunate to have one, or to their local emergency health care facility will not resolve health care disparities for African Americans. Nor will it help if health care institutions work independently of one another. Collaborative efforts between institutions can be more beneficial in addressing issues in the African American community (Rowland and Chappel-Aiken 2012). Hence, the White House Office of Faith-Based and Community Initiatives by the Bush Administration was established in 2001. "FBOs (Faith-Based Organizations) were one of the primary recipients of the $30 million allocated through the Department of Health and Human Services to expand services to vulnerable populations" (Barnes and Curtis 2009, p. 253). It was believed, and rightly so, that groups in local communities and could better serve their residents. In the African American community, this gave religious institutions the opportunity to provide additional support to local residents.

In 2009, President Obama established the new White House Office of Faith-Based and Neighborhood Partnerships. Also with a focus on communities, the office works "on behalf of Americans committed to improving their communities, no matter their religious or political beliefs" (The White House 2009, para. 1). The new sociopsychological paradigm of disease and health encourages further mergers of medicine and religion to combat illness effectively. Over a decade ago, Chatters et al. (1998) deemed religious congregations as "headquarters for health promotion and disease prevention activities" (p. 695). Since social justice appears as a theme and concern in the traditions of many churches (Barnes 2005; Lincoln and Mamiya 1990; Marty et al. 1990), it is only appropriate that, among other things, the Black Church should address the issue of health disparities. "The Black Church has strong roots in African traditions that naturally link religion and medicine in a holistic manner" (Isaac et al. 2007, p. 262).

Health Education and the Black Church

As an anchoring institution in the African American community (Pattillo-McCoy 1998), the Black Church has served as a major agent of cultural transmission and a powerful agent

of healing (Isaac et al. 2007). To that end, the Black Church has assumed multiple roles. In addition to serving as the epicenter for religious, social, and political (Byrd 1986) activities, the Church had an important educational role (Isaac 2010).

While many associate the Church's religious education programs with the study of the Bible and Sunday school, religious education may include topics found in formal settings such as history of denomination, theology, and the arts. It was not unusual for the "pulpit and Sunday school programs to address the religious and intellectual needs of African people" (Byrd 1986, p. 87). Consequently, the Church was concerned with African Americans' "whole being." Several types of educational programs for adults were to be found in the historical Black Church including leadership and job training, community study groups, and child and prenatal care (Gandy 1945). Lectures were held on a variety of topics other than religion including politics and social action.

Social Services in the Church

The Church's reputation is that of a social welfare agency providing different types of assistance to individuals in need. Blake and Darling (2000) explain that some churches have "even served as mutual aid societies that have helped their members survive crises associated with illnesses or death" (p. 412). This is further espoused by Ford et al. (1996), who note that among other things, churches have historically provided for the nourishment of African Americans. In fact, "[f]aith-based initiatives have long been a part of the African American community, in which churches and congregations have met the physical… needs of the large community" (Kotecki 2002, p. 13). At times, the Church has partnered with other agencies in an effort to address health, economic, and social disparities. Lincoln and Mamiya (1990) described this seeming relationship between the Black Church and black secular organizations as symbiotic and cooperative. Recovering a sense of an original bond with medicine and social service activities (Marty et al. 1990), many churches have employed a health care practitioner and/or established health ministries.

Using faith communities to address social, economic, and health issues is not new (Barnes 2004; Johnston and Benitez 2003). We have heard more about this practice in recent years with the enactment of the aforementioned White House initiatives. According to Johnson (2002), studies have revealed that faith-based organizations (FBOs) are more effective in providing social services than their secular or public counterparts. Advocates of FBOs often report successful programs that address drug addicts, youth, ex-convicts, teen mothers, and other populations. Johnson further explained that FBOs "enjoy a unique effectiveness in providing social services" (p. 3) and they "provide many diverse social services such as counseling for depression, offender rehabilitation programs for drug treatment and other programs" (p. 4).

Given the Black Church's historical and enduring role within the African American community, it is an ideal context for offering health promotion activities, particularly for African Americans (Markens et al. 2002). "Black churches have led the promotion of health care, disease prevention" (Center for Substance Abuse Treatment 2009, para. 37). Churches "can provide the social and emotional reinforcement needed for health promotion programs to be effective" (Wilson 2000, p. 40). They are an important conduit through which to "inform racial/ethnic minorities about preventive care" (Markens, Fox, Taub and Gilbert, p. 806).

Many Black Churches have demonstrated their ability to influence their parishioners as they make lifestyle changes through health education programming. In their examination

of faith communities, Johnston and Benitez (2002) found many had health education partnerships. Isaac (2002) reported numerous health-related activities and educational programs sponsored by the Black Church. Some researchers indicate successful attitudinal and lifestyle changes. For example, Holt et al. (2009) examined prostate cancer screening among African American men who attended church. They reported that spiritually based educational programs offered in two churches were well received. Other researchers have reported success in health and Black Church studies on mental health (Mynatt et al. 2008; Taylor et al. 2000), diabetes (Boltri et al. 2006), and mammography (Markens et al. 2002). Despite the achievement of some of these programs, we often fail to hear of the pastor's perceptions of health education in the church.

Current Study

To expand the knowledge base regarding the Black Church's role in health education, we conducted a study examining African American pastors' perceptions of the health education role of the Black Church. We sought to discover how the Black Church provided health education, health topics addressed, and the challenges and barriers to health education. Furthermore, we explored pastors' perceptions of the health issues that affect African Americans and, in particular, their congregational members.

Methodology and Findings

A questionnaire was developed by the authors based on a review of the literature. To establish validity, 10 pastors were asked to complete the instrument. The questionnaire, consisting of 32 questions, was mailed to 500 pastors in two Midwestern states. The pastors were randomly selected from a list of African American churches in each state.

Of the 500 pastors who received the questionnaire, 20 % (100) returned them, which were used for the final analyses. Most of the pastors were leaders of Baptist Churches; the second largest group of pastors were from the African Methodist Episcopal denomination. Other denominations represented included Church of God in Christ (6 %), Christian Methodist Episcopal (5 %), and others (5 %). The majority (38 %) of the pastors were between the ages of 50 and 59. Eighty percent of the pastors had a bachelor's degree or higher, with approximately 30 % possessing a terminal degree.

Over 80 % of the churches were small and urban (inner city) and varied in congregational size. Almost 30 % had 100 to 249 members. A little over 20 % had membership ranging from 250 to 299 people. The average age of church members were estimated between 40 and 59 years. An equal number of churches had been in existence for 10–29 and 30–49 years.

Many of the churches were actively engaged in some form of health-related activities. Sixty-two percent had health care materials available, which were specifically designed for African Americans. The pastors were asked about health ministries in the Church. For the purposes of this study, a health ministry was defined as an informal or formal structured program dedicated to improving the health of the congregation. Generally, programs are directed by a health professional or a member of the congregation who is not a health professional, but who serves as the coordinator of the program. Fifty-nine percent of the pastors reported having a health ministry/education program with the purpose of educating members, providing emotional support, empowering members to take better care of themselves, and/or serving as an extension of the Church's religious doctrine. Of those reporting health care ministries or programs, 26.9 % had 1–5 members who were health professionals (i.e., doctors, nurses, dentists, etc.) and 17.7 % had 6–12 members.

During a 12-month period, the churches offered health education programs in the form of screenings and/or workshops in several areas related to alcohol and drug abuse, breast and prostrate cancer, and chronic obstructive disease, just to name a few. However, most pastors reported offering workshops or seminars on diabetes and health screenings for high blood pressure (see Table 2).

Health education programming was often determined by one or more factors. It was developed based on a request by a church member(s) who may or may not be a health professional, a health professional outside of the Church, or an agency or by interest expressed through prayer concerns or personal consultation with the pastor. Some pastors reported using their own knowledge of health issues of African Americans, their personal assessment of community needs, or simply their felt need as determinants. However, the majority of programs (80 %) were determined as a result of involvement by a health professional associated in or outside the Church.

Although many pastors reported health educational activities, it is important to note that some pastors did not (40 % of respondents). Of those churches reporting no health education programming during the 12-month period, 59 % cited a lack of financial resources as the main reason for not doing so. Other reasons included lack of interest among members, lack of space and time, as well as lack of qualified health care professionals in the congregation or a willing participant to serve as coordinator.

The pastors' perceptions of health issues plaguing the African American community and their respective church were somewhat similar. They reported high blood pressure (30 %), diabetes (21.2 %), and HIV/AIDS (20 %) as the top three health concerns facing African Americans. Ironically, although they reported HIV/AIDS as the third greatest health concern in the African American community, only 3 % saw it as a great concern in their own congregation. And, when asked about the causes of deaths among their congregants, none of the pastors identified HIV/AIDS as a cause. This might explain why less than half (39 %) reported providing HIV/AIDS education within a 12-month period.

In relation to their own congregation, pastors reported high blood pressure, diabetes, and heart disease as major health concerns (see Table 3). Although concern for breast cancer was not rated high among the pastors as a concern in the community, 35 % reported cancer as the leading cause of death in their congregation during the 12-month period. High blood pressure was a close second, at 31 %.

Discussion

Despite apparent gains for African Americans in some areas, they continue to experience disparities in health care and treatment options. HIV/AIDS, heart disease, cancer, and other

Table 2 Health education programs in the Black Church

Health issue	Number Reporting Screenings and/or programs
High blood pressure	47
Diabetes	43
Breast cancer	38
HIV/AIDS	34
Hypertension	33
Prostate cancer	35
Heart disease	31

Table 3 Greatest health concerns

Health issue	African American community (%)	Congregation (%)
High blood pressure	30	30
Diabetes	21	29
HIV/AIDS	20	3
Heart disease	14	15
Breast cancer	5	11

illnesses continue to heavily plague the African American community. Realizing the importance of reaching this population, health care providers and other professionals have taken a parsimonious approach and partnered with organizations in the African American community. In addition, the federal government has stepped in with financial assistance as it has realized that community organizations can play an important role in addressing health issues.

Partnerships with the Black Church can prove invaluable. However, these partnerships cannot be entered into haphazardly. To be successful, Rowland and Chappel-Aiken (2012) state these "delicate partnerships require people who possess strong strategic planning skills and sensitive facilitation and negotiation skills" (p. 23). As stated earlier, many pastors reported having members who were health professionals, which accounted for how many determined which health programs to offer. However, some did report that health professionals outside the Church were another reason for offering programs. This may indicate that churches likely had partnered with health organizations, thus supporting the importance of partnerships.

This exploration of African American pastors' perceptions of health care and the Black Church supports the Church's continued need to play a health educational role. The pastors in this study reported diabetes and high blood pressure were major diseases afflicting the African American community and their own congregants. Most of the pastors in this study were knowledgeable about this fact, and their church responded accordingly with health-related workshops/seminars or screenings. Wilson (2000) suggests that "[h]ealth fairs with screenings are used by many organizations" as a means to promote healthy living and to promote "disease prevention intervention strategies" (p. 39). Thus, it appears some churches are utilizing prescribed methods in their efforts to eliminate health inadequacies.

Many have argued that the Black Church's response to some health issues has been slow. Some see the Church heavy on the spiritual or emotional and lacking on the practical application. Nonetheless, "even with its shortcomings, [the Church]—provides an environment where extraordinary change can happen" (Davis-Carroll 2011, p. 225). It appears that when it comes to diseases or other health issues that affect members of their own congregation, the churches, with support of the pastors, in the current study were more astute and responsive. However, when extending health education to the broader community, some churches must provide more relevant topics.

Most of the Churches in the study provided some form of health-related information/materials, which was for the most part, specifically targeted toward African Americans. Providing culturally relevant health-related materials is an informal means of communicating the importance of a healthy lifestyle with African Americans. According to Hill (2004), health education materials are an important source of communication about medical and health behaviors. However, "their value depends on their accessibility" (p. 5), since "[i]nformation can play an important role in fostering… self-care behavior" (p. 5). In several instances, literature can be found in the Church vestibule lying either on a table or in a more conspicuous place such as a wall

file. While the Church is to be commended for having health materials readily available, there is no guarantee that members will peruse and implement the advice provided.

Several factors impact education programming in the Black Church, including financial and human resources, leadership, and internal and external influences (Isaac 2002, p. 13). The Church's "available resources… speak to the variety and type of programs" (Isaac 2002, p. 13) it provides. One of the most important factors, however, is church leadership (i.e., pastor), which can impact how the church responds to internal and external influences. In addition, from a sociological viewpoint, a "congregation's liberal-conservative ideological orientation" (Fulton 2011, p. 618) may influence its priorities, hence educational offerings. Fulton states that "ideological orientation may operate differently in Black churches" (p. 618). The majority of the churches in this study were small in size, <250 members. Smaller Churches may not possess the financial and human resources of larger churches. This is supported by pastors in the study who indicated a lack of financial resources was a reason for not offering health education programming. Health education professionals must understand how factors can impact the provision of health education in the church.

Summary

As the United States continues to face tough economic times ahead coupled with possible budget cuts in health and social services along with a possible reorganization of health care, the Black Church can continue to play an educational, informational, and advocacy role for the promotion of healthy lifestyles for African Americans.

The research presented here can serve as a catalyst for other researchers, health care professionals, and health educators to work with Black Churches to eliminate health care disparities and improve the health and physical well-being of African Americans and others who suffer similar injustices. Health care professionals and educators in partnership with churches can develop additional educational programming that will provide African Americans and other ethnic/minority groups with specific medical information that encourages healthy lifestyle behaviors. Holt et al. (2009) suggest that health professionals in concert with community organizations, like the Church, can have significant impact on the health education of African Americans. The importance of "working closely with the community through all stages of intervention planning, development, and implementation" (Holt et al. 2009, p. 255) as well as evaluation cannot be overstated. This is espoused by Rowland and Chappel-Aiken (2012)

> Educators can greatly assist in the establishment of partnerships and collaborations between FBOs [churches] and health care institutions. From the needs assessment phase, to program implementation and evaluation, adult educators can ensure that programs are firmly rooted in adult learning principles and strategies that promote lifelong learning and healthy lifestyles of congregations and the surrounding community. (p. 23)

In addition to the aforementioned, health educators and professionals can introduce interventions to help reduce the heavy impact of disease and disparities plaguing the African American community. One example that could greatly assist in this area is the development of a mini-medical school program in the Black Church. It could not only alert more people to the unique needs and challenges facing the health outcomes of African Americans, but also make them aware of the disparities, so that they could be armed with

knowledge and skills in working with the medical establishment and navigating the health care system. By offering a program such as the mini-medical school, the medical community, health care professionals, and educators could do much to influence and change the attitudes of medical mistrust many African Americans experience in working with the health care system. Providing a mini-medical school program in the Black Church could change the practice of poor health and furthermore, it could inspire countless numbers of young people to consider medicine and other health-related fields as a career option. Increasing the number of African American health care providers is another opportunity to decrease health disparities.

The success of any church-related program often depends on the pastor. Thus, it is important to understand pastors' perceptions, motivations and barriers to promoting health education issues in the church. There are many health programs that have reported success. Yet, little is known how pastors feel about their health initiatives and interventions. Furthermore, "no studies have assessed the correspondence between church leader and church member perceptions of the church health promotion environment" (Williams et al. 2012, p. 49). Hence, more studies regarding the perceptions of pastors surrounding health initiatives and interventions in the church are needed.

Further research is needed to determine the "success" of health programs in the Black Church. For example, to what extent are African Americans changing their health behaviors as a result of their participation in health programming? What motivates or deters African Americans' participation in health education? The Black Church's educational programming is expansive. Although it has garnered more attention among health professionals and practitioners, there is still much we can learn from the Black Church's commitment to its members' well-being in both body and spirit.

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