2017

Culturally Competent Health Education in African-Americans' Faith-based Communities for Better Health Outcomes: A Literature Review

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Biography

Anne is a first-generation immigrant who came to the United States from Cameroon. She is a Nursing student at San José State University working toward her Bachelor of Science in Nursing. Anne became a McNair Scholar in 2016, and she plans to pursue a Ph. D in Nursing. Her current research interests include healthcare inequality, underserved populations, preventive care, and obesity-related chronic illnesses. She hopes to use her interest in scientific investigation to improve the health of the less privileged in our society. Under the mentorship of her academic mentor and guidance from the McNair Scholars program, she nurtures and strengthens her research and academic skills, which are critical for her future academic endeavors. She is grateful to all the McNair staff for their dedication and support for minority students like herself. In her free time, Anne loves spending time with her husband and son.

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Abstract

Obesity is a compelling health issue among African-Americans, who have the highest prevalence of excess weight among all ethnic and racial groups in the United States. This soaring obesity rate contributes to poor health outcomes and significantly inflates the risks for many chronic diseases, including cardiovascular diseases, diabetes, and certain forms of cancer. The literature provides evidence for the success of health programs aimed at promoting healthy behavior and lifestyles in African-American faith-based organizations, as the influential role of churches in African-American communities is well documented. However, few studies have investigated the criteria essential for improved efficiency of health interventions addressing the problem of obesity in the church-based environment.

This paper examines the sociocultural and environmental factors associated with enhanced efficiency of health-promotion programs to reduce obesity in African-American faith-based communities. The databases PubMed, CINAHL Complete, Cochrane Library, and PsycINFO were searched, and ten relevant articles published during the last five years were selected. The findings corroborate prior research about the instrumental role of churches to promote a healthy lifestyle and reduce obesity among African-Americans. We identify that a partnership between health educators and the community is crucial to achieve a high success rate in church settings. These results indicate that better success is achieved when the church leadership and churchgoers' input are integrated into the program's design. Furthermore, health educators need to have a good grasp of the participants' cultural perceptions, understanding, and expectations of obesity. We recommend that future researchers examine the cultural and spiritual strengths of these faith-based communities and the best strategies to use in order to achieve long-term weight loss.

Key words: African-Americans, obesity, faith-based, culturally appropriate interventions

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Introduction

Health-promotion programs in faith-based organizations offer several beneficial health outcomes. This non-traditional environment is increasingly used to deliver community health education because it provides the opportunity to reach a wide range of an underserved population, to deliver culturally appropriate interventions, and to promote sustainable behavior modification (Fallon, Bopp, & Webb, 2013). Within African-American faith-based communities, health education programs remain limited despite substantial evidence from the literature indicating that it has several advantages. Important barriers to these health programs include financial limitations, scheduling conflicts with church activities, and congregations' lack of interest. These barriers contribute to the low utilization of African-American faith-based communities to promote health (Fallon et al., 2013; Lancaster, Carter-Edwards, Grilo, Shen, & Schoenthaler, 2014). Nonetheless, Lancaster et al. (2014) argue that in African-American churches, health programs focused on weight management and weight-related behavior offer substantial benefits for addressing the obesity issues which disproportionately affect this population.

Health Education in African-American Faith-based Communities

Obesity rates remain on the rise around the world, affecting both underdeveloped and developed countries (Prentice, 2006). In the United States, the obesity rate has doubled in the adult population since the 1960s, increasing form 13.4% to 35.7% (U.S Department of Health and Human Services (HHS) 2012; Flegal, Carroll, Kit, & Ogden, 2012). Altogether, the overweight and obesity rate now exceeds 68% in the U.S. adult population. This trend remained slightly stable over the past decade and does not show any signs of substantial regression (U.S Department of Health and Human Services, 2012, Flegal et al., 2012; Mozaffarian et al., 2015). The incidence of obesity is significantly higher among African-Americans: 38% of men and 54% of women are obese, and 10% of African-Americans suffer from extreme obesity; that is, having a Body Mass Index (BMI) of 40 or more (U.S Department of Health and Human Services, 2012; Mozaffarian et al., 2015). In the African-American population, obesity is double that of White Americans, who average a 32.6% obesity rate (Mozaffarian et al., 2015).

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Furthermore, across all races and genders, Flegal et al. (2012) found that, among ethnic minorities, African-American women and Mexican-American women had a higher increase in obesity between 1999 and 2010. These alarming figures come along with staggering medical expenditures and health costs.

The Cost of Obesity in the United States
Financial Impact of Obesity

Between 1987 and 2001, obesity was responsible for a 27% increase in inflation-adjusted medical spending. The treatment of diabetes, hyperlipidemia, and heart disease accounted for the majority of this health cost rise (Thorpe, Florence, Howard, & Joski, 2004). Furthermore, the medical cost for obese individuals is 37% higher than the healthcare cost of people with a normal body weight (Thorpe et al., 2004). The medical spending growth appears to mirror the surging trend of obesity over the past decades. Finkelstein, Trogdon, Cohen, and Dietz (2009) reported that the annual health spending attributable to obesity was estimated to be $147 billion in 2008, which contributed to a 9.1% increase in all medical expenditures. Several studies indicated that the current obesity epidemic is a major driver of the soaring cost of medical spending in the United States. For instance, Tsai, Williamson, and Glick (2011) found that, compared to individuals with a healthy weight, the yearly direct medical cost of overweight and obesity per-person are respectively $266 and $1723 higher. Elevated body weight has a substantial impact on inpatient and outpatient medical expenses; the most significant costs are attributed to obesity-related diseases that demand extended treatment (Atella et al., 2015; Li, Blume, Huang, Hammer & Ganz, 2015). Cawley and Meyerhoefer (2012) reported that in the United States, 209.7 billion dollars are spent annually to treat obesity-related diseases in the adult population. This figure, which represents one-fifth of the national healthcare expenditure, is projected to keep rising alongside the rate of obesity (Cawley & Meyerhoefer, 2012).

Health Impact of Obesity

Obesity remains a significant, yet modifiable, risk factor associated with many serious health issues. Obesity heightens the risk of several chronic diseases, including hypertension, cardiovascular diseases, type 2

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diabetes, and certain forms of cancer (Hammond & Levine, 2010). Obese individuals also experience a decreased quality of life and higher rate of mortality. These negative health consequences are pronounced among minority populations, who often have less access to health care along with a higher rate of obesity-related comorbidities (Liao et al., 2011). Consequently, it is no surprise that a report from the Center for Disease Control and Prevention (2011) states that the rate of hypertension among African-Americans is 38.6%, a value that surpasses the prevalence of hypertension in the overall U.S. adult population.

Not only are African-Americans disproportionately affected by the obesity epidemic, they equally register some of the lowest access to quality health care and the highest mortality and morbidity rate of preventable chronic diseases. As Liao et al. (2011) point out, ethnic and racial minority populations still lag behind in access to adequate health care, even though some progress has been achieved to eradicate healthcare inequality and to improve the nation's health. Until the healthcare system implements sound strategies to counteract the woes inflicted on marginalized communities by poor access to health care, obesity and correlated illnesses could continue to burden the most vulnerable portion of the population, including ethnic minorities such as African-Americans.

The Importance of Churches in the African-American Population
High Church Attendance Rate among African-Americans
Religious engagement and participation rates remain high in the United States and even more so among African-Americans who report a significantly higher level of church affiliation compared to other ethnic groups. A sharp contrast exists between African-American and Caucasian populations in regards to religious affiliation, with African-American people two-times more likely than Caucasians to be members of a religious group (Krause & Hayward, 2013). In addition, African-Americans report more consistency of church attendance and higher practice of religious activities–including prayer and worship services–than all other racial or ethnic groups in the country (Krause & Hayward, 2013). Therefore, it appears that religion and spirituality are solidly entrenched in black culture and remain a prominent element in the lives of African-Americans, which

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has been proven to enhance healthy behavior (Fitzgibbon et al., 2005; Dodor, 2012).

Common Role of Churches: Spiritual and Social Support System

According to Taylor, Lincoln, and Chatters (2005), African-American churches play a multifunctional role in the lives of their members. Churches are the cornerstones of African-American communities due to the social assistance they provide to their members. These religious institutions actively promote their members' welfare by investing in their education and health. They also provide for their socioemotional needs, such as advocacy for family cohesiveness and stability. Another way churches are pivotal in African-American communities is that they constitute major support networks on which its members rely to meet essential social needs, including encouragement and companionship (Taylor, Lincoln, & Chatter, 2005). Researchers argue that such a safe and trustworthy environment where the individual has a sense of belonging is a vehicle for the promotion of positive behavior change. Churchgoers can also find a variety of spiritual resources that strengthen their belief system and have a positive impact on their personal and social wellbeing.

To achieve long-term weight-loss results, it is essential to design culturally competent programs with interventions that are sensitive to the needs and realities of the African-American community (Cowart et al., 2010; McClelland et al., 2016). The powerful role church and faith play in the lives of African-Americans is well understood by healthcare workers. Nonetheless, the healthcare system underestimates and underexploits this asset in its endeavor to promote health equity. Increasingly, researchers corroborate the finding that faith-based institutions are crucial avenues that the health system needs to mobilize to improve the health of African-American individuals (Giger, Appel, Davidhizar, & Davis, 2008; Condrasky, Baruth, Wilcox, Carter, & Jordan, 2013; Fallon et al., 2013; Lancaster et al., 2014). In this perspective, Condrasky et al. (2013) argue that the social structure of African-American churches constitutes an excellent milieu to deliver health-promotion education due to their structure and function. Researchers can capitalize on the health aspect of the mission statement of these churches to gain access to the population and to easily recruit and track participants for health-promotion programs (Condrasky et

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al., 2013). According to Fallon et al. (2013), faith leaders are essential partners "who strongly influence intervention reach, adoption, implementation and sustainability" (p 134, para. 19), and their collaboration is a potent force that health educators should utilize.

Conceptual Framework

Bridging the profound health disparity in underserved communities remains a major challenge to the nation's healthcare system. In an effort to increase minorities' access to quality healthcare and to mitigate the conditions that disproportionately affect them, the National Institute on Minority Health and Health Disparities (NIMHD, n.d) recommends using Community- Based Participatory Research (CBPR). The NIMHD posits that "the CBPR Initiative seeks to incorporate a synergistic blend of research and outreach" through an inclusive approach set forth to gain the total involvement of the members of minority groups and abate their distrust of the scientific community (National Institute on Minority Health and Health Disparity, n.d.). Contrasting the limitations of the traditional research models that hinder the success of health interventions, Wallerstein and Duran, (2006) assert that CBPR is an "alternative research paradigm" (p 312, para. 1) that holds promising potential to reduce health inequality.

In the CBPR research framework, the research community or participants are integral and active partners of the study from start to finish. This research model allows the research participants or the community involved to contribute from the design and conception phase through the interpretation and dissemination of results. The process actively engages the community members, as they are no longer mere participants or subjects of the research, but more importantly, crucial allies in finding durable solutions to their health issues. The CBPR research model sets a platform for the community and the researchers to collaborate as equal partners. The community can thereby mobilize its unique strengths to address the complex health challenges facing them with the help of healthcare experts. (Berge et al., 2016). Moreover, Berge et al. (2016) argue that the investigators learn just as much as the community members and the participants of the research project. Because the stakeholders own the full process of the research, the results generally translate more efficiently into

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practice. From its commitment to the partnership, the community easily adopts and readily implements the findings of the study to achieve better health outcomes.

Discussion
Training Grounds for Health Promotion

Gaining access to the population is a significant factor in the strategy to address the needs of specific communities and to combat public health threats. The studies of Condrasky, et al. (2013), Fallon, et al. (2013), and Lancaster et al. (2014) corroborate literature and prior research about the essentiality of faith-based communities in carrying out health education and to promote healthy behavior. Churches, especially for African-American communities, are viable settings to reach people with limited or no access to healthcare. Besides affording ample access to the underprivileged population, churches possess strong structural, organizational, and spiritual power, which health professionals must recognize and capitalize on in order to improve the health of this population. Condrasky et al. (2013) acknowledged that health is an integral part of the mission of churches, while Fallon et.al (2013) noted that most church leaders deliver health promotion interventions mainly through counseling.

Even though these previous two investigations took advantage of different strengths or unique features of the churches, their results ascertain that healthcare intervention in faith-based communities produces a positive impact and promotes healthier outcomes. Furthermore, the authors of all three studies argued that gaining the collaboration of the clergy is essential to the success of the health program in churches. Faith-leaders hold a special place in the lives of churchgoers who seek their advice and support concerning not only their spiritual needs, but also their emotional and physiological well-being. This privileged position gives pastors and priests the ability to positively influence their congregations because they are both highly trusted and a role model. Consequently, these researchers recommended that community health educators partner with the clergy, gain their support, and engage their leadership role when designing and implementing health-promotion programs in faith-based organizations. Condrasky et al. (2013) found that these strategic partnerships were pivotal in the study they conducted in African-American faith-based organizations.

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Partnership between Church and Healthcare Professionals

According to Condrasky et al. (2013), the success of their intervention—training the cooks of more than 50 African Methodist Episcopal churches to prepare healthy and nutritious food—depended upon a close collaboration between the trainers and trainees as well as the involvement of the church leaders. These results suggest that it was crucial that the participants in the health intervention did not feel alienated from the program. Rather, the program's layout must incorporate the communities' full and active participation and the intervention designed such that it meets the specific needs of the community. The likelihood that a population adopts a desired behavior change increases with their cooperation with program developers along with their active involvement in the health program. Condrasky et al. (2013) claimed that the support the pastors provided, to both the program and the cooks, was essential to gain the trust and interest of the communities. Along the same line, Fallon et al. (2013) argued that training faith leaders to deliver faith-based health counseling to their congregation increases the success of health intervention in churches. It appears, therefore, that health educators must exercise their best judgment and develop appropriate strategies to gain the trust and participation of the population at different levels so they are not mere recipients, but active partners.

Successful Strategies for African-Americans
Cultural Considerations

In contrast to the previous studies that value the participation of both the communities and faith leaders, McClelland et al. (2016) demonstrated that the success of health-promotion programs depends upon the cultural group's perceptions of health. In effect, they found that Arab-Americans and African-Americans hold opposite cultural expectations and norms regarding obesity. To the former, obesity is unacceptable and the members of this ethnicity are expected to have a healthy lifestyle and keep a healthy weight. To the latter, obesity or being overweight is normal in their culture and bears no stigma in their community. If being overweight or obese is expected and not a source of concern within a cultural group, how can weight-reduction programs designed for the general population be effective

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in this group? McClelland et al. (2015) suggested that public health educators bridge the cultural barriers hindering their success in ethnic minorities. These authors indicated that health promotion within these communities must integrate cultural sensitivities to succeed in improving healthy behavior. African-Americans can benefit from health interventions in their communities provided that their cultural beliefs are factored into the program design.

Nutrition Education and Belief System

Interestingly, Lancaster et al. (2014) based their review on studies that focus on African-American faith-based organizations with more than 90% of participants belonging to this ethnic group. They concluded that health intervention in these settings positively impacted members of these communities. The congregation reported a significant decrease in their weight, an increased level of physical activity and consumption of fruits and vegetables, and a decreased caloric and fat intake. These results fall in line with our expectation that a health intervention in African-American churches that stresses nutrition education can successfully improve knowledge about healthy eating. African-Americans can ultimately improve their overall health if they practice healthy food habits and increase their intake of fruits and vegetables. Lancaster et al. (2014) also reported that the presence of a support system, either through group sessions or in one-on-one health counseling, was proven equally important to achieving positive weight-related behavior. Lancaster et al. (2014) highlighted that, in contrast to their hypothesis, both support systems produce similar success rates. They insist that public health practitioners identify and use the tenets of the communities' faith to enhance the success of health programs in this environment. The individual belief system is a source of spiritual strength that empowers people to engage in and to maintain healthy behavior. Paired together, improved nutrition literacy and the tenets of their faith can motivate and challenge members of African-American churches to embrace sustainable health change.

Conclusion

Obesity trends run alarmingly high among African-Americans and place them at high risk for too many preventable chronic diseases, a crisis

compounded by their limited access to healthcare. Health promotion programs in African-Americans' faith-based communities offer promising success to reduce obesity in this population and to improve health. The advantages of churches are two-fold: they allow easy access to this ethnic minority, and they have excellent organization and resources. Health educators should capitalize on these advantages to improve congregations' health status. Successful health intervention in these communities calls for a partnership with faith leaders in addition to the active participation of the members of the congregations. Success also mandates that health educators understand and integrate communities' cultural beliefs and expectations about obesity. African-American churchgoers are more likely to engage in healthier eating behavior if their knowledge and skills about a healthy diet increase. Since sustaining a behavior modification can be a daunting endeavor, it is essential to identify and incorporate the principles of the individuals' faith in health-intervention plans. Health-promotion programs appropriate to the cultural and even spiritual realities of African-American faith-based communities better serve their needs and increase the success rate of health intervention in these institutions.

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