

THE NATIONAL BLACK CHURCH INITIATIVE HEALTH EMERGENCY DECLARATION

A National Health Prevention Program



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THE NATIONAL BLACK CHURCH
INITIATIVE HEALTH
EMERGENCY DECLARATION:
A PREVENTIVE HEALTH
STRATEGY

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EXECUTIVE SUMMARY

President Barack Obama has made the issue of health reform one of his cornerstone topics. This in itself is a courageous and incredible act on behalf of the President. The President is approaching health reform largely on the issue of economics, and he realizes the political benefits of doing so. He also understands that a healthy America is a more productive America and a more competitive America. This is a noble and worthy reason to attack the uncontrollable growth and spending of healthcare while saving the fabric of our democracy. The President's efforts represent the second time since the "1985 Report of the Secretary's Taskforce on Black and Minority Health" that a President has put the full force of the White House behind the issue of healthcare reform in a serious manner. President Obama should be congratulated and commended for this extraordinary step towards health equality for all Americans. Equally interesting, the secondary goals of the President's efforts are to open up access to healthcare for the uninsured. This in itself is the foundational issue of why many Americans suffer from such debilitating disease states.

The National Black Church Initiative (NBCI) understands that healthcare reform means institutional transfer. That is to say that there have to be changes in institutional behavior to realize the enormous benefits in both in cost savings and in proven health techniques and strategies. Change takes time and this is one of the benefits of living longer. This is a principle that is as old as time, but a necessary point to understand before any significant change can take place.

The Black community however, because of its historic disadvantage of not being a part of the originally founded American democracy - some would say the American experiment - and because of its challenged health composition and status, can ill afford to wait for health reform that would not truly take hold for another ten years. The National Black Church Initiative, having grown morally frustrated on the pace of achieving equality in health in any area, is moving with immense speed to reveal its Health Emergency Declaration (HED). NBCI, through HED, will institute throughout its 34,000 churches proven health prevention strategies and models that will begin to alter, transform and eliminate the negative health statistics between whites and blacks in this country.

The health statistics in the Black community are so negative that the Black Church cannot even afford to wait a day longer before it declares a national health emergency. The most compelling reason in doing so is because every major effort by the federal government, state governments, county governments, health foundations and private health organizations has had little to no impact in sustaining good health practices in the Black community. This clearly shows that the efforts by these institutions have been half-baked, strategically flawed, and vastly underfunded. This means that having a sustaining impact on the incidence of chronic diseases is nearly impossible and the amount of change in behavior of the individuals that the programs are targeted for is nil.

The Black Church over the past two years has studied every major health disparity report issued by the federal government or the private sector, as cited in the body of this paper, where recommendations were made but never acted upon. As a consequence of this inaction, people of every age and gender in the Black community have a greater potential to suffer from a debilitating, life threatening diseases that will vastly undercut their length of life. As a result of prayer and sheer moral religious boldness, the Black Church plans to incorporate the largest faith-based health prevention program that any ethnic group in the history of this country has ever attempted in order to begin the healing process and to help eliminate health disparities by instituting science-based health prevention models in all of NBCI's member and sister churches throughout the country. NBCI plans to deal directly with the causal relationships of chronic health conditions affecting African Americans: Heart Disease, Cancer, Obesity, AIDS, Hypertension, Diabetes, Liver Disease, Smoking, Alcoholism, Drug Abuse, Violence, Depression, Mental Illness, Suicide, Bipolar Disorders, Respiratory Diseases, Arthritis, Disabilities, Alzheimer's, H1N1 Flu.

NBCI will accomplish the HED's goals by strategically redefining its relationship with every segment of the healthcare industry, including government. It will also engage up to 68 percent of African American congregations, touching some 14 million congregants and galvanizing more than 75,000 volunteers. The cost savings of this initiative over the next seven years is still being evaluated by a health economist. The guiding principle for HED is that our program will not participate in any program that does not seek as its primary goal to eliminate the health issues in the Black community, does not reduce the number of chronic disease cases in the Black community, or does not strengthen the existing health models to do so.

The Black Church will reemphasize the power of its theological and biblical tradition to reinforce the ten characteristics of HED.

- 35 focused health communities
- Faith based marketing health strategy
- Certification of African American Churches as Health Prevention Centers
- 2.5 hours of health education weekly
- Use of proven scientific health prevention modeling
- Use of modern media, including web and video tools as educational and reinforcement aids
- Enhanced health literature – NBCI Health Note
- NBCI Communication and Distribution Network
- NBCI Patient Education Assistance: Congregational Based Health Personnel Corps (CBHPC)

- Access to and participation in clinical trials

The Black Church is prepared to work with any health entity throughout the country or the world that has redefined health modeling in order to tackle and eliminate the chronic disease states that affect the Black community. NBCI plans to utilize existing literature and information to shape this initiative to maximize the best results of its objectives and goals. NBCI will work with teaching universities, hospitals, clinics, local and county governments to make sure that they are working toward helping to eliminate the frequency of these diseases in the African American community or subsets of the African American community.

NBCI hopes to utilize all existing federal and state capacities to make sure that African Americans are exploiting any avenue to improve their access to care so they can deal forthrightly in the areas of prevention and management with any disease states. NBCI will not hesitate to utilize its historic role as an advocate to expand as well as to offer alternatives that were not implicit when a program was first created to include these pressing areas that challenge our community. The first step is to work in conjunction with the proper government health authority, but the overarching goal is to fight for the right to have these healthcare needs addressed now and not later.

HED is designed as an innovative health prevention strategy that has the capacity to accommodate and provide integrative support of existing program systems. It is not designed as a stand-alone system, but will realize the full strength of its unique structure when fully or partially integrated into existing health systems that have proven effective in dealing with health disparities. The program's structure is designed with flexibility in order to accommodate forthcoming health reform models. The elasticity of HED will lie in the hands of the 35 Health Panels who will be able to amend their strategic plans and structure to accommodate any significant healthcare system change without compromising on the original intents of HED.

HED has five unique characteristics. These characteristics, if implemented correctly with full funding, staff, and volunteer support, will have an amazing impact on improving the health composition of African Americans. First among its chief characteristics is to help existing programs build sufficient capacity to reach their goals in recruiting the targeted African American population that they are designed to reach. For instance, if an existing government or university sponsored program or research project needs 10,000 African American women between the ages of 35 and 60 for a breast cancer, diabetes, heart disease, obesity or other chronic disease study, HED will have the capacity to assist and support that particular program in order for it to reach its capacity.

Secondly, HED will be able to help maximize participation of African Americans in all existing government sponsored health initiatives in order to achieve maximum participation in relationship to funding levels given to local, state and federal entities. This is to combat the inability of local or state government's health departments, who often lack sufficient levels of

cultural competency and organizational skills, to recruit and sustain targeted African American populations that federal grants often state they are to target. Thirdly, HED - with its unique structure to build capacity and recruit targeted populations - will also be able to work with private sector health initiatives in the areas of clinical trials or research surveys. Fourthly HED, because of its geographical positioning in 35 separate communities specifically identified as communities in need, will have the unique ability to participate in national health efforts as effective and far reaching educational health centers. One of the ways that HED can add urgency and substantive community-based advocacy on a policy level will be critical and successful programming like the Robert Wood Johnson Foundation's Leadership for Health Communities: Advancing Policies to Support Healthy Eating and Active Living.

This simply means that HED's structure could be incorporated and integrated into city, state and federal emergency platforms for the specific purpose of helping vulnerable populations and providing them with critical health education information. For the purpose of programmatic enhancement and the ability to pin-point any ZIP code within HED's structure, we plan to link NBCI's Communications and Distribution Network to cover not only NBCI's 34,000 member churches, but to include the existing 55,000 African American churches in the United States.

In conclusion, NBCI has set forth what it believes is a strong argument for the basis of declaring this health emergency in the Black Church. NBCI does this out of its tradition, its love for humanity and for the concept of fair and equal treatment under the law. NBCI explored the scholarly literature from 1985 forward on the subject of health disparities, and has followed the health literature trail to only 14 significant government sponsored health reports. This demonstrates an extraordinary lack of activity since former Secretary Margaret Heckler's "1985 Report of the Secretary's Taskforce on Black and Minority Health." NBCI has also looked closely at the perspective of African American physicians concerning health disparities and the reasons why they believe that this type of tragedy continues. These concerns were laid out in *The Handbook of Black American Health* by Ivor Livingston in 1993.

Furthermore, NBCI has focused on correcting the health behavior of the Black community through proven scientific health models. NBCI tackles all the major chronic diseases. This is why this is a seven year initiative. NBCI also embraces clinical trials, data collection, and other helpful and necessary health measuring tools that would help mitigate these health risk factors and measure HED's success. The issue of research material is that it normally does not end up in the public realm and sits in a journal for other health professionals to review. HED health panels and administrative staff will constantly review and integrate this type of research to enhance its preventive programming initiatives in faith-based settings. This is a way to make real the actionable research that has already been done accessible, and will be a tool for HED.

The philosophical underpinning of HED can be contributed to the distinguished Morehouse College president the Right Rev. Robert Franklin, and his groundbreaking work "Crisis in the

Village: Restoring the African American Community.” One can surmise that the village is the African American community, but particularly the Black Church. We have also employed the noted journalist Tavis Smiley’s work “Accountable: Making America as Good as its Promise.”

In addition to this paper, NBCI will produce an implementation guide so that faith-based communities can easily implement this health disparity prevention program. Entitled “The National Black Church Initiative Health Emergency Declaration Implementation Guide” , the implementation guide will be utilized by the 35 health panels that will be created for the sole purpose of implementing these health models in local faith based communities throughout the country that serve African American communities. Each local participating church – 34,000 that NBCI hopes will grow to 80,000 – will receive an “NBCI Church Health Ministry Guide.” This will allow local participating faith based communities to shape their calendars so that they can fully incorporate HED’s seven year schedule of health activities into their communities to have the most impact upon the health of the congregation.

INTRODUCTION

“Today, we are spending over \$2 trillion a year on health care – almost 50% more per person than the next most costly nation. And yet, for all this spending, more of our citizens are uninsured; the quality of our care is often lower; and we aren't any healthier. In fact, citizens in some countries that spend less than we do are actually living longer than we do.

Make no mistake: the cost of our health care is a threat to our economy. It is an escalating burden on our families and businesses. It is a ticking time-bomb for the federal budget. And it is unsustainable for the United States of America.

Our federal government also has to step up its efforts to advance the cause of healthy living. Five of the costliest illnesses and conditions – cancer, cardiovascular disease, diabetes, lung disease, and strokes – can be prevented. And yet only a fraction of every health care dollar goes to prevention or public health. That is starting to change with an investment we are making in prevention and wellness programs that can help us avoid diseases that harm our health and the health of our economy.”

– President Barack Obama addressing the American Medical Association, June 15
(Obama 2009)

More than two decades have passed since the “1985 Report of the Secretary’s Taskforce on Black and Minority Health” was released by then Secretary of Health and Human Services Margaret Heckler. The report contained many startling facts about the significant disparities in health experienced by African Americans and other minority groups in the United States. The report’s release was accompanied by much discussion about the best strategies that might be implemented to address the issue, with the report itself offering many possible solutions to the issues presented. The Taskforce readily admitted “despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics and other minorities still suffer disproportionately to whites.” (Heckler 1985)

Of all the recommendations cited by the Taskforce the only one that has been partly fulfilled in terms of African Americans is an improved methodology in the collection of health data. However, when it comes down to a comprehensive health strategy to close the health disparity gap, there has still been no groundbreaking action in the areas of health information, education, health services, health professional development, health cooperative efforts, cultural competency or research agendas. This lack of significant progress is evidenced by the statistical data that is cited in our research. As an example of the issue of research agendas, we note that there has not been a government wide, fully funded, comprehensive study on the effects of African American physiology concerning nutrition and physical exercise. There have been a plethora of studies in this area

concerning these factors on the general population, but the government has failed to zero in on the basic understanding of these two critical factors – nutrition and physical exercise – for the African American and minority communities.

Unfortunately, little concrete government action has been taken since the Heckler report in 1985. The result is that African American men today can expect to die sooner than a Palestinian living in the Occupied Territories. (Journey to Wellness n.d.) Likewise, African American children are more than twice as likely to die before the age of one as white American children. (See Appendix A, Slide 9/Slide 10, *Black Infant Mortality Rate (per 1,000 live births), 1995 & 2005/Black Infant Mortality (per 1,000 live births) by State, 1995 & 2005*) African American women are also more likely to die from cancer and cardiovascular disease, among other ailments, than their white counterparts. The situation has reached emergency proportions and we must take immediate action to solve the problem.

In an address at the Tenth Annual Colloquium on African American Health, Dr. Caroline Barley Britton, President of the National Medical Association at the time, presented a statistical composition on the status of Black health entitled “The Status of Black Health: A Decade in Review, 1995-2005.” Looking at physical activity, overweight/obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization and access to healthcare, her presentation clearly demonstrated the drastic racial health disparities in America today. This paper uses her presentation as reference throughout, with the full presentation available in Appendix A. (See Appendix A, Slide 3/Slide 4/Slide 5, *U.S. Population Distribution by Race/Ethnicity 1996-1997/Population Estimates in the U.S., 2006-2007/Distribution of Black Population, 2007*)

The National Black Church Initiative (NBCI) has been in existence for 15 years and has witnessed this lack of action on the issue of health disparities first hand. On occasion it has participated in the routine aspects of addressing Black health through conferences, seminars and small targeted programming. About two years ago, NBCI decided to take a hard look at health disparities and the reasons why they continue to go unabated. In the proceeding paper, NBCI will spell out the causes of these health disparities and discuss why it has chosen to move forward with declaring a national health emergency within the Black Church with the National Black Church Initiative’s Health Emergency Declaration (HED). HED is an initiative to prepare the African American community in instituting the most progressive comprehensive prevention programming to date based upon proven scientific findings. This action is being taken by the Black Church following the findings of a two-year study conducted by NBCI.

This paper is divided into two sections, the first discussing the reasons for declaring a national health emergency and the second discussing how HED will work within our present structure and the strategic techniques and models it will employ to achieve the most comprehensive preventive health initiative for any ethnic community the country has ever seen.

MAJOR RESEARCH REPORTS ON HEALTH DISPARITIES

There have been 14 major studies on health disparities to date since 1985 that have given great insight into the United States' persistent health inequalities. The value of these studies cannot be undermined, but they mean nothing if action cannot be taken. Most of the findings, recommendations and conclusions of these studies are still echoing that of the 1985 Heckler Report, which suggest that the issue of health disparities has not been taken seriously. One of the leading reasons that the US has such a costly and fragmented healthcare system is that the country fails to act upon sound recommendations once they are made, not only in addressing the subject matter of the report, but also to cut the cost of services needed to revamp the system. It seems that if we were to have instituted half of the Heckler Report suggestions at the time of its writing, the country's monetary outlay would have been reduced by a third and health disparities would have been on their way to being eradicated.

All of the data from the 14 major reports is largely a result of the recommendations of Secretary Margaret Heckler's 1985 inaugural report. More recently, a non-governmental report from the Kaiser Family Foundation (2009) entitled "Putting Women's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level" took an in depth look at racial disparities on a state-to-state basis. The study looked at a wide variety of health disparity issues, and discovered an especially disturbing trend in minority women's health. The study discovered that minority women are far worse off than men across the country. What is even more distressing is that when broken down by state the national statistics mask incredibly disturbing disparities on the state level. States like Arkansas, Indiana and Louisiana have large gaps in their healthcare coverage while other states like Maryland, Virginia and Georgia are faring better. (James, et al. 2009) This inequity from state to state shows a true lack of a universal and effective method to lessen the gaps in healthcare.

Even more unfortunate was the fact that where state disparity levels were closer together it meant a lack of overall healthcare, not an increase in the quality of healthcare for minority women. Even in the states where healthcare disparities were significantly less drastic across the three areas studied, few states seemed to succeed across all three areas with any regular success. Furthermore, there seemed to be little reason as to why some states had healthcare disparities, when other states with disparities in healthcare access did not always have the greatest gaps in health status or social determinants. (James, et al. 2009) This shows that it is not just the availability of healthcare resources, but also the ability of minority groups to motivate their members to work with doctors and other healthcare officials that needs to be revamped.

There have been some significant but isolated programs launched on a state and regional basis, as well as significant research developed by major academic institutions around the country that deal with the issue of health disparities. Unfortunately, there are three significant problems with these programs and studies: One, they have a negligible impact on the overall statistical numbers of the population since they are isolated in nature, short term, address only smaller populations,

and have a limited financial commitment. Two, most of these isolated studies are located at predominately white universities and performed by white researchers, with results never to find their way into the homes of African Americans after submission into a health journal. Finally, because of a lack of cultural competency and the inability to recruit African American participants in these programs only a lucky few benefit from these new practices or therapies. The benefit of these studies, however, is that in some cases they have created durable, cost saving best practices that can be quickly implemented, but are largely ignored because of the minute scale on which they are performed.

Because of these studies and previous initiatives, there remains sufficient data to create effective public policy around this national issue and comprehensive health education and wellness programming. The National Black Church Initiative believes strongly that action must be taken now on this available data; however, more defined studies are needed as well and will be implemented as the result of the HED.

BARRIERS TO A HEALTHY MINORITY POPULATION

Today, even after numerous studies, we find ourselves in the same position of figuring out what the strategic approach in dealing with racial health disparities should be. The fundamental question here is whether we can actually afford the luxury of spending another 24 years coming up with a strategic approach to solving the healthcare death trap for African Americans and their dependents. NBCI commends President Obama for proposing sweeping changes to the health care system that will cover some 40 million Americans who find themselves without health insurance and adequate access to the healthcare industry. However, even if all African Americans had access to healthcare, it would take another 10-12 years to see any changes. This is largely because of the historical race barriers that are still in place today and confront even those African Americans with health insurance. The issues of institutional transfer and the lack of know how to actively and effectively access the healthcare system will always be a fundamental problem for African Americans given the extraordinarily high rate of illiteracy. Therefore we must create two systems of care in the African American community; one with a heavy and permanent interest on prevention and the other educating on how to properly and effectively access the healthcare system to maximize the level of care, thus preventing the historic barriers leading to health disparities.

It is time to develop and implement effective, preventive, innovative strategies to quickly reverse the current trends. NBCI's argument is basic: unless we develop a comprehensive health and wellness program to aid and teach African Americans how to effectively access the healthcare system the statistical health data will remain the same. In the remaining course of this paper's narrative NBCI will layout a comprehensive strategy based largely upon the first comprehensive report by Secretary Heckler, then subsequently assessing the 14 additional reports and the strategy laid out by the Office of Minority Health.

First it is important to address why NBCI believes that a health emergency must be declared, and also why previous attempts and current programs are not doing enough to truly change the situation the country finds itself in today. NBCI believes there are many profound and obvious reasons that a health emergency must be declared in the Black community. As noted in the introduction, these reasons all stem from the fact that the Black community in America has consistently received inferior healthcare opportunities and healthcare education in comparison to other communities. The yearly studies addressing disparities in healthcare have already shown that these disparities exist, but nothing significant has been done to address them. Thus we find the Black community in a perpetually poor state of health even when there exists appropriate data that indicates it can be turned around. These issues are not just seen every day by the Black community, but have been documented in studies and are backed by statistical data as well.

The reason why the government has been unable to implement any effective health programming in the African American community is because it has failed in several different areas: 1) the lack of authentic and sincere moral leadership from the White House, 2) an inability to effectively access the African American community and utilize all of its community vendors (i.e. churches, business, political), 3) a failure to listen to the direction and call of the Congressional Black Caucus Brain Trust, 4) lack of a comprehensive game plan, 5) sporadic and non-existent funding for any significant length of time (5-10 years), 6) stakeholders who are outside of the African American community pushing their separate health disparity agendas based on government funding, and 7) African American researchers who fail to obtain sufficient funding to implement comprehensive programming as well as African American researchers who do not possess cultural integrity nor the support of critical African American segments.

Since Margaret Heckler's report, there has been little dynamic leadership coming from the White House to promote this cause. NBCI is not claiming that there hasn't been any action at all, like a speech or a conference, but there has been a lack of leadership on disparity issues since the Clinton administration. Unless there is daring Presidential leadership, and health disparities become a presidential priority, nothing substantial will be done. President Obama has not made a decisive statement on health disparities in particular, but he has strongly addressed the health reform issue in general. There can be no gains or substantial improvements on health disparity unless the President of the United States makes it a priority on a policy level and backs it up with budgetary authority. Any action without these two major factors will make sure that health disparities become just another passing thought for yet another administration. Health disparities must be made a priority by the President within the context of health reform this time around. The central purpose of HED is to force health disparities into the public eye and make sure that it is a policy priority with a budgetary commitment.

The Congressional Black Caucus (CBC) has done a tremendous job in helping to bring this issue to the forefront on a policy level. Without the CBC Health Brain Trust's insistence every year since its creation under the leadership of its founding chairman, Rep. Louis Stokes of Ohio (D), the Heckler Report would have never come to light. The Caucus should be praised for giving

significant weight to creating the dynamics that govern the complexity around the issues of health disparities. However, members of the Caucus can also be credited with helping to create the healthcare environment that has literally ignored the Black community. Individual members voted for this unequal structure because of political consideration, both concerning their congressional position and their constituents, helping to create a system that is non-responsive to its own people. HED can ill afford to be a mouthpiece for the Caucus when in essence some members vote to ignore the deepening costs of money and lives by voting to support the current healthcare industry model for their personal political benefit. However, the Caucus should not be singled out as it is the entire congressional leadership and the executive branch who have been responsible for the failure to address the issues caused by healthcare disparity.

President Obama's recent efforts to reform the healthcare system are a remarkable feat for such a young president. Even though times have changed and there seems to be a willingness in the country to reform, the fundamental question for African Americans and Latinos still remains a question of whether or not they can afford to wait until the system is reformed before significant actions are taken to improve minority health status. As mentioned before, many experts say it will take another 10 years if Congress continues on the path of healthcare reform to adequately cover and serve everyone. If we wait another 10 years to tackle these issues the chronic disease states that ravage African Americans will go unabated, and we can ill afford for that to happen. The present system for delivering care to the African American community is not only inadequate, but criminal too. The institutional transfer that would need to take place in the context of health reform advocated by President Obama cannot adequately deal with the fundamental issues that are presently destroying the state of African American health. What we need right now is a comprehensive, preventive strategy that has the ability to impact a large segment – over 50 percent of the African American population – in helping to stabilize the tragic health statistics that now confront African American communities.

It is even more evident that we cannot wait for healthcare reform to take effect when it is considered that that is all that the African American community has been doing for decades - waiting. When we look at professional works that have been published after the Heckler Report, it is clear that medical professionals have been waiting for the government to take action for years now. David Satcher's foreword to the "Handbook of Black American Health" includes a description of the healthcare system and where it is going that is eerily familiar to the exact situation that the country is in today, despite the work being written in 1993.

“...1993 is a most opportune time to examine in depth the health status of Blacks because significant changes in health care and health professions education are on the horizon. A majority of Americans of all races and social classes are demanding such changes. Major national councils, commissions and organizations are documenting the need for such changes. Further, we have recently elected a new administration to Washington that is clearly committed to such change. In the near future,

the administration will present to Congress a proposal for major health care reform in this nation. Congress will carefully examine and debate the proposal, but when deliberations are concluded, we will be moving toward major health care reform.” (Satcher, 1994)

It is not simply the foreword to the book, but most of the entries in the book that sadly are just as appropriate for the current time as they were when they were written. Comparison of the numbers referenced in the “Handbook of Black American Health” to the numbers of today show that while change has come in some areas, others have barely been effected. The government even had a *Healthy People 2000* initiative aimed at reducing health disparities greatly by the year 2000, but we are now over a decade beyond that and still seeing the exact same issues. The early critics of that initiative claimed it did not plant the needed “seeds” in order to be successful. Now looking back it is clear that it didn’t, and it was severely lacking in the community support that organizations like the church could have given it. (Livingston, Introduction 1994) It was the hope of the “Handbook” that its articles would be taken and used to plant those seeds, but it is clear from the fact that we are still looking at the exact same problems that the government and other organizations do not seem to be listening.

In other words, there is no guarantee that healthcare reform will truly come. Even if every African American was given healthcare tomorrow, because of their lack of knowledge on how to effectively access the healthcare system the statistical data in the areas of AIDS, diabetes, heart diseases and stroke probably would not change significantly. The African American community needs a comprehensive health education plan to not only learn how to adequately access this new system, but also a plan that will help them understand the diseases that they face, how to maintain these chronic health states so that they don’t worsen and ultimately how to prevent these chronic states from occurring in the first place.

THE HECKLER REPORT: THEN AND NOW

“Health is something that touches everything and is influenced by everything: level of education, health insurance, behavior of individuals, their diets. This also means that health is something that is influenced by national policy ... but also by state and local governments as well. What it really means is that to improve the health of our citizens overall it will require a number of actions from a number of fronts. The federal government and local governments have a role, but also the private sector as well. What this means is that everyone should be vested in working to improve the health of our citizens and access to healthcare because everyone benefits.”

– Louis Sullivan, former Secretary of Health and Human Services (Louis 2009)

The Heckler Report cited many of the above issues extensively, but their recommendations were either not listened to or ineffective. The report showed that each year there were more than

18,000 “excess deaths” among African Americans because of heart disease and stroke, compared with the number of deaths that would have occurred if their healthcare was on a par with non-Hispanic whites. It also estimated that among African Americans there were 11,000 excess deaths from homicide and accidents, 8,100 excess deaths from cancer, 6,100 from infant mortality, 2,150 from cirrhosis and 1,850 from diabetes. (Heckler 1985)

Despite the apparent gravity of the study’s evidence, the Department of Health and Human Services’ (HHS) response was lackluster at best and negligent at worst. HHS received much criticism, and many considered the few proposed actions to be sorely inadequate. The government allocated no additional spending to address problems of disparity. In fact, the administration at the time cut back spending for public health programs including Medicaid, community health centers, and family planning. During 1985, spending for health care actually rose at the lowest rate in the prior two decades. (Pear 1986)

The report also discussed the best way to approach the health crisis. According to the initial and subsequent reports, health information and education is the key to creating a healthier African American community. The Heckler Report states “the ability to make informed decisions plays a significant role in influencing the overall health of Americans.” (Heckler 1985) The taskforce looked into how health information was delivered to minorities and found that it was either not delivered within cultural context or not delivered in a proper venue - or simply not delivered at all. Despite multiple recommendations on how to fix the issue we still find ourselves with these problems today, especially in the area of cultural competency, as the information below shows.

It is not just those who are well who have failed to be educated. The Heckler Report also shows that those who are sick must be educated in order for the comparatively high death rate for minorities compared to whites to decrease. The report notes that in most cases “patient education is often linked to the delivery of medical care of a specific health problem and frequently takes place in special settings, such as hospitals, schools, communities, homes, or the worksite.” (Heckler 1985) This means that minorities received their medical information straight from doctors and only when they were already sick. This trend continues, as the data below shows that minorities are still less likely to receive medical care until a disease state has become very advanced.

Despite the forward thinking recommendations, Secretary Heckler insisted that existing programs, with existing funds, would be best used to provide more education in targeted communities to meet needs and solve problems. The report stressed self-help over government influence and as such ignored the fact that the health issues faced by African Americans were caused by more than just a lack of motivation to get healthy. As the quote from former HHS Secretary Louis Sullivan at the beginning of this section suggest, health is something that is affected by all aspects of the world, not just personal or outside influences, and one of the major reasons for there being so little headway in the area of health disparities is the fact that most plans for attacking the issue do not come at it from all of the necessary directions. The Heckler Report notes that it is not just the individual who should be involved in health, but “family,

churches, employers and community organizations” should all be used as “a support system (or teaching vehicles) to facilitate and sustain behavior change to a more healthful lifestyle.” (Heckler 1985)

African Americans have suffered from lower life expectancy rates than whites for as long as statistics on the matter have been kept. Trends show that in the two decades since the Heckler report was released, the gap between the life expectancy of whites when compared to African Americans has closed by fewer than 10 months. Whites still live an average of 4.6 years longer than African Americans. (See Appendix A, Slide 7, *Life Expectancy (in Years) at Birth by Race and Sex, 1995-2006*) Below are the US life expectancy rates from 1985-2005.

| Year | All Races | | | Whites | | | Blacks | | |
|------|-----------|------|--------|--------|------|--------|--------|------|--------|
| | Both | Male | Female | Both | Male | Female | Both | Male | Female |
| 2005 | 77.8 | 75.2 | 80.4 | 78.3 | 75.7 | 80.8 | 73.2 | 69.5 | 76.5 |
| 2004 | 77.8 | 75.2 | 80.4 | 78.3 | 80.8 | 80.8 | 73.1 | 69.5 | 76.3 |
| 2003 | 77.4 | 74.7 | 80 | 77.9 | 75.3 | 80.4 | 72.6 | 68.9 | 75.9 |
| 2002 | 77.3 | 74.5 | 79.9 | 77.7 | 75.1 | 80.3 | 72.3 | 68.8 | 75.6 |
| 2001 | 77.2 | 74.4 | 79.8 | 77.7 | 75 | 80.2 | 72.2 | 68.6 | 74.7 |
| 2000 | 77 | 74.3 | 79.7 | 77.6 | 74.9 | 80.1 | 71.9 | 68.3 | 75.2 |
| 1999 | 76.7 | 73.9 | 79.4 | 77.2 | 74.3 | 79.9 | 71.4 | 67.8 | 74.7 |
| 1998 | 76.7 | 73.8 | 79.5 | 77.3 | 74.5 | 80 | 71.3 | 67.6 | 74.8 |
| 1997 | 76.5 | 73.6 | 79.4 | 77.2 | 74.3 | 79.9 | 71.1 | 67.2 | 74.7 |
| 1996 | 76.1 | 73.1 | 79.1 | 76.8 | 73.9 | 79.7 | 70.2 | 66.1 | 74.2 |
| 1995 | 75.8 | 72.5 | 78.9 | 76.5 | 73.4 | 79.6 | 69.6 | 65.2 | 73.9 |
| 1994 | 75.7 | 72.4 | 79 | 76.5 | 73.4 | 79.6 | 69.5 | 64.9 | 73.9 |
| 1993 | 75.5 | 72.2 | 78.8 | 76.3 | 73.1 | 79.5 | 69.2 | 64.6 | 73.7 |
| 1992 | 75.8 | 72.3 | 79.1 | 76.5 | 73.2 | 79.8 | 69.6 | 65 | 73.9 |
| 1991 | 75.5 | 72 | 78.9 | 76.3 | 72.9 | 70.6 | 69.3 | 64.6 | 72.8 |
| 1990 | 75.4 | 71.8 | 78.8 | 76.1 | 72.7 | 79.4 | 69.1 | 64.5 | 73.6 |
| 1989 | 75.1 | 71.7 | 78.5 | 75.9 | 72.5 | 79.2 | 68.8 | 64.3 | 73.3 |
| 1988 | 74.9 | 71.4 | 78.3 | 75.6 | 72.2 | 78.9 | 68.9 | 64.4 | 73.2 |
| 1987 | 74.9 | 71.4 | 78.3 | 75.6 | 72.1 | 78.9 | 69.1 | 64.7 | 73.4 |
| 1986 | 74.7 | 71.2 | 78.2 | 75.4 | 71.9 | 78.8 | 69.1 | 64.8 | 73.4 |
| 1985 | 74.7 | 71.1 | 78.2 | 75.3 | 71.8 | 78.7 | 69.3 | 65 | 73.4 |

U.S. Centers for Disease Control, National Vital Statistics Reports, Vol. 56, 12/28/2007

NINE MAJOR REASONS FOR DECLARING A HEALTH EMERGENCY

The above shorter life expectancy rates stem from a variety of causes, most of which are also the reasons NBCI believes that a national health emergency must be declared within the Black community. NBCI has identified ten major reasons as to why the African American community finds itself in such a dire situation. Each reason has many factors contributing to it, but all of them work together to create a strong argument for why action must be taken and why NBCI

is the proper organization to take that action. The following are the ten major reasons NBCI will be declaring a health emergency.

It should be noted that these reasons are not new to the Black community. Most of these health issues have been affecting the Black community for as long as such records were kept, and even longer still before that. From the information above, it is clear that many of them were around when the Heckler Report was issued, and it is even more evident when recommendations from more than sixteen years ago echo almost exactly what this paper says, as they do in Livingston and Jacques Carter's "Improving the Health of the Black Community: Outlook for the Future." In fact, we are making many of the same recommendations they did, but the difference is that after pointing out these issues action will be taken. (Livingston and Carter, *Improving the Health of the Black Community: Outlook for the Future* 1994). HED will tackle all these problems aggressively, but will have the unique authority of the Black Church. These plans will be discussed further along in the paper after the reasons for creating them have been properly laid out.

1. Lack of proper programming

The first of the major reasons that NBCI is declaring a health emergency is the fact that there has been a lack of serious commitment to creating a science based, proven health and wellness program in the Black community that is designed for the express purpose of preventing chronic diseases. This fact is clearly shown by the data that was collected for the "2008 National Health Disparities Report" and "Health, United States, 2008". The former study comes to the conclusion that while some health disparities in African American communities are improving, many are falling by the wayside thanks to a lack of education and support in the Black community. (Agency for Healthcare Research and Quality 2009) While the findings do prompt action in a certain direction they do not organize or propel anyone to take steps to correct these inequalities nor have their suggestions been proven widely in the field.

"Health, United States, 2008" also shows a lack of health and wellness programs proven to work. The report shows that African Americans, and many other minorities, fail to utilize programs and health coverage because they are not aware of its availability thanks to a lack of properly organized education. (National Center for Health Statistics 2009) NBCI also believes that previously suggested programs and efforts to raise health awareness in the Black community have not been strong enough. Garth N. Graham's strategic framework, (Graham 2008) which has been adopted and used by the government, fails in many places. It is our belief that HED fixes many of the gaps and problems seen in that work.

2. Denial of latest clinical therapy

Despite advancements in the culture of the United States, racism is still heavily prevalent in the country and it does not avoid the medical profession. African Americans have been denied the latest clinical therapies pertaining to treatment for heart disease, cancer, diabetes and AIDS. This is

shown by the fact that price discrimination has always existed in the medical profession, (Kessel, Price Discrimination in Medicine 1958) and thus care is more costly for low income families (which are predominantly minority families). Disparities do not exist only based on income though; in fact even when status, health and income are equal minorities still receive inferior treatment for their serious ailments. (Nelson 2002)

The issues between white doctors and minority patients do not stop at simple racism either. A lack of ability to communicate between the normally middle-class, white doctor and the black patient presents a serious problem in African Americans receiving coverage. (Levy 1985) In 2008 the disparity had grown sizably in a patient centered measure of patient and provider communication. (Agency for Healthcare Research and Quality 2009)

Without a proper level of understanding between patient and doctor, the gap in healthcare cannot be fixed. Communication and knowledge are the best ways to fix these problems and HED has steps included in our programs to both provide knowledge for the Black community and open up dialogue between white doctors and black patients.

3. Lack of funding from specialized groups

The American Heart Association and the American Diabetes Association, along with other specialized healthcare organizations, have a lack of funding and comprehensive programming to support addressing the healthcare inadequacies in the country today. Both groups feature programs for the African American community, as do many others, but since the health disparities in the Black community do not seem to be decreasing it is hard to argue that they are truly having much of an effect. In fact, studies have shown that many of these specialized diseases have not increased or decreased over the years despite these programs and efforts.

The conditions that these organizations address are at crisis levels. From 2002-2005 there were almost no changes in differences between white diabetes patients getting proper care and African American diabetes patients getting proper care. (Agency for Healthcare Research and Quality 2009) The large gap stayed consistently the same throughout the time period despite targeted programs running at the same time. In 2008 one of the largest health disparities was Black diabetes patients having to suffer amputations due to their disease and lack of care for it. (Agency for Healthcare Research and Quality 2009) In the case of heart disease the results were much the same, with African American men being far more likely to die of heart disease than most other groups, despite the fact - or possibly because of it - that they are less likely to be diagnosed with it. (Office of Minority Health 2009)

NBCI Health Emergency Initiative looks to correct these numbers by creating programs that are not only well funded and organized, but also actually reach the Black community through the strength and voice of the Black Church. This is an outreach program that none of the specialized groups can truly create because they do not have the Black Church's authority or already installed base to leverage.

4. African Americans are lacking in health coverage

There is a large population of African Americans who do not have healthcare, do not use the healthcare provided to them or do not know about the healthcare available to them. In 2006, 18.1 million African Americans lacked health insurance. This places them more than 1.5 million behind the majority White population, meaning coverage overall is far smaller in the Black community than in the White. (National Center for Health Statistics 2009) 2008, the last year with complete data on the issue, saw the number of uninsured African Americans at an all time high. (Sherman, Greenstein and Parrott 2008) Under the regular model, that number is not predicted to drop in the coming years. Studies even show a gap in how well-insured African Americans are covered, with many not receiving the same treatment thanks to both a lack of education and a lack of trust in medical treatments and personnel. (Carlisle, Leake and Shapiro 1997)

With the challenges of the economic crisis, the problem becomes all the more traumatic as more and more minorities lose jobs and health coverage. Estimates show that 1 in 5 African Americans do not have health coverage at the moment and that that number is likely to worsen as the recession continues. (Radio News Source 2008) Action must be taken to better educate the African American community on how to get coverage and what options they have when it comes to obtaining medical coverage. NBCI's efforts tackle both of these fronts, by educating the community through classes and outreach and by providing members of our churches and communities with information on how to obtain insurance and coverage.

5. African Americans suffer disproportionately in most disease states

The African American population has continually suffered disproportionately in most disease states. Studies from 1985 to the present show a much larger portion of African Americans with major diseases such as cancer, AIDS, diabetes and heart disease in comparison to Whites. In the most recent collection of information disparities can be seen in all major categories:

- From 2000 to 2005, the gap between Blacks and Whites remained the same for colorectal cancer. In 2005, Blacks were more likely to be diagnosed at advanced stage with colorectal cancer than Whites (103.8 per 100,000 compared with 80.0 per 100,000). (Agency for Healthcare Research and Quality 2009)
- The gap between Blacks and Whites for those who had been diagnosed with diabetes and were keeping it under control increased. In 2003-2006, the rate was significantly lower for Blacks than Whites (43.0% compared with 60.5%). (Agency for Healthcare Research and Quality 2009)
- African Americans are 1.4 times as likely as non-Hispanic whites to have high blood pressure and are thus at a greater risk for heart disease. (The Office of Minority Health 2008)

The increased numbers have much to do with the African American community not seeking help when it is needed as a large percentage of most of these cases are diagnosed in the later stages of illnesses like Alzheimer's, cancer and AIDS. (American Society for Gastrointestinal Endoscopy n.d.) (Alzheimer's Association n.d.) (Office of Minority Health 2009) Because of the late diagnosis, the death rate from these diseases is far higher for African Americans than it is for Whites. (See Appendix A, Slide 15, *Age-Adjusted Incidence of Diagnosed Diabetes per 1,000 population Aged 18-79 Years, by Race, Ethnicity, United States, 1997-2006*) Many of the diagnosing issues stem from the previously discussed problems with African American patients not seeking healthcare in the first place, and when they do, not being able to communicate with the doctor. This leads to a distrust of doctors and a lack of motivation towards going to see them until it is too late. (Betancourt, et al. 2003) (See Appendix A, Slide 11/Slide 12, *Cancer Age-adjusted Mortality Rate for Blacks, 1995 & 2005/ Age-adjusted Cancer Deaths (per 100,000), Blacks by State 1995 & 2005*)

To change this the Black community must be brought together with doctors of every race, and the lines of communication must be opened. NCI has multiple initiatives in HED to do just this. Without the proper forms of communication and education the African American community will continue to suffer disproportionately to Whites as has been shown by the lack of decrease in most of the major health disparities over the past two decades. (See Appendix A, Slide 8/Slide 13-14 *Top 10 Leading Causes of Death, 1995 & 2005, Cerebrovascular Disease Age-adjusted Mortality for Blacks, 1995 & 2005*)

6. Government spending has not been sufficient

One of the major reasons that there has been little to no change in the health disparities of minorities is that government spending towards the issue has been lacking in a very major way. In 2009 the Office of Minority Health only had \$2 million to give out for grants, and in a very narrow section of the health field. While the Office of Minority Health spent \$11, 322,893 on minority AIDS/HIV health initiatives in 2007, that number is far too small and when broken down throughout the country can barely cover a few states. (The Henry J. Kaiser Family Foundation 2008) Overall the Office of Minority Health had an even smaller budget in 2009 than it did in 2008 with the department only receiving \$49 million in funding for 2009 as opposed to 2008's \$56 million. (Federal Government 2009)

It is no wonder that the OMH is rated at only 20 percent for its program results and accountability. (Federal Government 2009) Without the proper funding to support what needs to be done no organization could hope to close the disparity gaps, especially without an already established network and a strong moral authority. For an issue that is so prevalent throughout the country there must be more funding for programs and a way to make sure that minority healthcare programs are fully funded. HED not only works on a smaller budget thanks to the already established programs in our churches, but also has the groundwork to expand with a relatively small amount of cost in order to fully utilize the funding given to the program.

7. Obesity

One of the most disturbing trends in the African American community is the quickly growing obesity rate, especially in women and children. While 36.3 percent of African American males are obese (only a small increase over White males) an incredibly disturbing 54.3 percent of African American females are obese (more than 15 percent higher than all other racial groups). Obesity is a known health risk factor and contributor to heart disease. The percentage of Whites in both categories is lower, especially White females. (National Center for Health Statistics 2009) Obesity and a lack of physical fitness can lead to hundreds of health issues that will plague patients for the rest of their lives.

The disturbing obesity trend is not just in adults, as an increased number of children are considered obese every year. While this is an overall trend across all races and ethnic groups, Blacks once again suffer disproportionately. The group of children that has increased the most in obesity rates in both the past and present is Black male children, who have shot up 18.5 percent in obesity rate since 2006. Meanwhile, obesity rates in Black adolescent girls have skyrocketed by 14.5 percent, making more than a quarter of the African American girls in the country obese. (Centers for Disease Control and Prevention 2009) Clearly the connection between the growth in obesity in adults and children is visible. (See Appendix A, Slide 16, *Overweight and Obesity Rates for Adult Blacks, 2007*)

On top of offering physical education classes and a plethora of opportunities to become active for both children and adults, HED hopes to educate parents in the proper diet and activities for their children. These good health measures will hopefully teach children to act in the same way as adults, thereby resulting in a healthy living style throughout the Black community and reversing this rapidly growing trend of obese adults and children.

8. AIDS

From 1998-2006 the gap between Blacks and Whites with HIV/AIDS decreased. However, in 2006, the rate of new AIDS cases was still almost 10 times higher (60.3 per 100,000 compared with 6.4 per 100,000) for Blacks than for Whites. (Agency for Healthcare Research and Quality 2009) Among women the gap is even greater culminating at a number that is 11 times higher for Black women than White women. (James, et al. 2009) Blacks are actually more likely to be tested for AIDS, with 52 percent reporting they had done so in 2008 in comparison to 34 percent of Whites. However, because of the high rate of AIDS in the Black community the testing numbers for Blacks need to be far greater. The numbers for the amount of undiagnosed AIDS/HIV cases are huge with more than 100,000 African Americans in the U.S. living without the knowledge that they have HIV/ AIDS. (Isbell 2009) This lack of knowledge, testing and education must be brought to a stop.

The Black Church has been vilified concerning its conservative stance on AIDS. NBCI will not spend time trying to defend the church's position, but NBCI has found a creative way to incorporate the church's theological framework concerning human sexuality and still promote the use of education, testing, prophylactics and safe sex techniques. HED will incorporate these four aspects into a comprehensive program that deals with all aspects of human relations and marriage. HED will allow the church to utilize its authority to immediately begin to arrest this disease because it threatens the existence of the Black Church itself unlike any other health issue. (See Appendix A, Slide 17-18, *Proportion of AIDS Cases, by Race/Ethnicity, 1985-2007*)

9. Racism within the medical profession

It is now abundantly clear that the medical profession has been discriminating against Black doctors, students and patients for many years. The American Medical Association (AMA) has issued an apology for the egregious way it has treated African Americans. In 2005, the AMA invited a group to examine the roots of racism in the medical profession and found that they were a major part of the problem. Throughout the years the medical community had discriminated against Black doctors and studying medical areas which are relevant to the Black community, kept Black doctors out of the AMA, and prevented Black medical students from getting their degrees and furthering their education. In the apology the AMA admits to failing the Hippocratic oath, saying, "In this regard the AMA failed, across the span of a century, to live up to the high standards that define the noble profession of medicine."

An apology does not change how things are as the AMA's apology readily admits when it states "In offering an apology, the AMA recognizes that contrition cannot remove the stain left by a legacy of discrimination." (Davis 2008) Despite admitting this, and promising more integration and less segregation, the plight of African Americans in the medical profession has not improved. In 2006, Blacks represented 12.3 percent of the country's total population but just 2.2 percent of physicians and medical students. That proportion is less than it was in 1910, when Blacks represented 2.5 percent of physicians and medical students. (The AMA's Apology 2008) These issues within the medical profession also pertain to the cultural competency issues that we have discussed. How can doctors hope to connect and communicate with patients that they have not been properly trained to treat? The years of ignoring the African American population by the medical profession have distanced the Black community from the medical community.

Despite now taking further actions to rectify past injustices, the AMA is still not doing enough, nor can it possibly hope to do enough to fix the issues created by 100 years of discrimination. The only option is for the Black community to grow stronger in the field of medicine and create more Black doctors who will go out and create better health awareness for their communities.

HED hopes to help in this by providing youths and adults with the chance to afford higher Education, and assistance with support for them throughout their studies.

10. Lack of potential Black Doctors in medical school

One of the outcomes of the medical profession's discrimination towards Blacks is a serious lack of Black doctors. This lack of representation within the Black community also leads to the issues of cultural competency facing African Americans. Over the past decade the number of Black medical students applying to, studying at, and graduating from medical school has actually dropped, though it has increased slowly over the past few years. In 2006 only 1,176 Black medical students enrolled in medical school and in that same year only 1,122 Black medical students graduated. (The Journal of Blacks in Higher Education 2007)

The numbers are growing - in 2007 9.2 percent more Black males applied to medical school - but with 28.8 percent of the population identifying as Black/African American and only 14.6 percent of medical doctors identified as Black/African American, it is easy to see that higher enrollment is needed. (Saha, et al. 2008) NBCI hopes to create an environment within the Black Community which encourages young Black people to consider the medical profession and if they decide to go into medicine support them along the way. (See Appendix A, Slide 6, *Distribution of Nonfederal Black Physicians, 2007*)

FITNESS IN AMERICA

Clearly African American health is still a serious issue; however we cannot hope to change it without changing the view of fitness in America as a whole. A recent study from the Medical University of South Carolina (MUSC) entitled "Adherence to Healthy Lifestyle Habits in US Adults, 1988-2006" shows that it is not simply Blacks in America who are unhealthy, but the country as a whole. The study found that the percentage of adults aged 40-74 years with a body mass index greater than 30 has increased from 28 percent to 36 percent; physical activity 12 times a month or more has decreased from 53 percent to 43 percent; eating 5 or more fruits and vegetables a day has decreased from 42 percent to 26 percent; moderate alcohol use has increased from 40 percent to 51 percent; and smoking rates have not changed (26.9 percent to 26.1 percent). (King, et al. 2009) Clearly health issues do not simply pertain to the Black community and this is all the more reason that change must be implemented now in order to move minorities out of the health crisis they find themselves in. If we do not begin to change the health styles of this large group of Americans then America will continue to become less and less healthy.

The study drew these conclusions:

“Generally, adherence to a healthy lifestyle pattern has decreased during the last 18 years; adherence to all 5 healthy habits as a group has gone from 15% to 8% ($P < .05$). Men overall and non-Hispanic whites (both men and women) have a pattern of declining adherence to a healthy lifestyle that exceeds their respective comparison groups. Of equal or greater concern is the finding that individuals with cardiovascular disease, hypertension, diabetes, or hyperlipidemia do not adhere to a healthy lifestyle any more frequently than people with no such conditions. Perhaps not surprisingly, the prevalence of diabetes, hypertension, obesity, and cardiovascular disease all have increased since 1988-1994. The decrease in healthy habits seen in this study is consistent with previous reports of increasing obesity and has broad implications for the future acceleration of risk of diabetes, hypertension, and cardiovascular disease in middle-aged and older adults.

“The incidence of many diseases, including diabetes, cardiovascular disease, and cancer, are related to lifestyle factors. Physical inactivity, inadequate intake of fruits and vegetables, smoking, and obesity contribute a large measure to the morbidity and mortality from cardiovascular disease, and are the underlying cause of premature death in cardiovascular and other diseases. Thus, decreasing adherence to healthy habits will undoubtedly have a negative impact on the future incidence of premature death and disease.

In addition, trends over a similar time period as the current study indicate a worsening of health-related quality of life and self-rated health. Physical inactivity, smoking, and obesity are closely linked to depression and lower quality of life. Conversely, increasing adherence to healthy habits is associated with improved quality of life in people with diabetes” (King, et al. 2009)

This study is the most compelling reason why NBCI is declaring a health emergency in the African American Church. What the study shows is that none of the traditional health advocates that society has available, like dietitians and health counselors, that the general population including African Americans are willing to listen to are making any headway in encouraging real change to a healthier lifestyle. The Black Church is and always will be the soul of the Black community. NBCI can utilize its unique capacity of moral authority to advocate a science based healthy lifestyle approach.

CONCLUSION

The study also indicates that the lack of living a healthy lifestyle has reached a crisis level and something needs to be done. Looking at this and all of the preceding factors together it clearly shows that while the government and other organization have been attempting to tackle the issues of heal disparity, they have clearly not been able to do so successfully. As we look back at the Heckler Report it is clear that the gap in healthcare between whites and blacks has changed very little and furthermore the black population, along with other minorities, is still in an emergency situation that can be easily characterized as “in critical condition”, as is shown by the myriad issues listed above. NBCI believes that it has the proper organization and plan to truly change the health status of the African American population Below we will outline this plan and develop further why we believe the Black Church is the perfect organizer and facilitator for such a major and drastic health movement.

The National Black Church Initiative Health Emergency Declaration (HED)

The National Black Church Initiative (NBCI), a coalition of 16,000 African-American and Latino member churches works to eradicate racial disparities in healthcare. In addition to our member churches, we have 18,000 sister churches. NBCI is a faith-based health organization dedicated to providing critical wellness information and preventive health screening to all of its members. The African-American community ranks first in eleven different health risk categories. NBCI's purpose is to partner with national health officials to provide health education, reduce racial health disparities, and increase access to quality healthcare.

NBCI plans to employ tens of thousands of volunteers to put together a structure never before seen in the Black community through its 34,000 faith based communities – that should expand to a total balance of African American churches of around 80,000 – to address the devastating health condition of the Black community discussed in the first part of this paper through an innovative health prevention program that challenges, confronts and starts to eliminate health disparities in the Black community through proven scientific prevention models. This will be the National Black Church Initiative Health Emergency Declaration (NBCI HED).

The critical point of this plan is that NBCI is not creating a new structure to tackle this issue, but will be working within the existing framework of the modern Black Church. The number one cause of health programs failing in the Black Church is the fact that the host organizations or the funder insist on creating a new structure in the Church, over and against the ecclesiastic framework of either the African American tradition or a denomination within the African American tradition.

Church organizations are not made to be bent or changed or altered to fit a particular cause. Simply put, the Church must remain the Church. The success of the National Black Church Initiative lies in the single fact that over 15 years ago, when NBCI came to this extraordinary understanding of incorporating health models into the Black Church, NBCI did so without changing or insisting on changing the Church as a living organism. NBCI created health programming that would fit strategically with the Church in order to achieve the best results. This is why NBCI's structure allows it to take this extraordinary next step.

Within the coming months, NBCI will declare a National Health Emergency within the Black Church. In declaring a National Health Emergency in the Black Church the one thing that NBCI is not seeking to do is to add a layer of bureaucracy on top of the normal functions of the Black Church. Government and other funders must model themselves to this structure if they plan to have the type of program success that the Health Emergency Declaration proposes to produce.

What does it mean to declare a National Health Emergency? This simply means that the Black Church realizes that it must bring to the problem its full moral authority in dealing with the extraordinary explosion of existing health and risk factors that contribute to chronic diseases (diabetes, heart disease, AIDS). Moreover, the Black Church must organize all of its resources to slow the mortality rate from chronic health diseases down, or it could well be a Church of historic perspective and not one with a future. The Church must totally reorder its resources and utilize them in such an effective manner that it will call to bare its very soul in creating healthy congregations. NBCI believes that the numbers set forth in the body of this paper are the most telling story of all. Since 1985 the country has seen nothing but a moderate decrease in health disparities adjusted for the increase in population, and an explosion of health risk factors among the African American population, in every age group and every health category.

What NBCI hopes to do is to change behaviors from ones of excess to ones that are proportional, healthy and produce healthy individuals, families and faith communities. NBCI will achieve this substantial change in lifestyle behavior because of how NBCI plans to institute these scientifically based programs. In addition, NBCI will have an impact because of its systemic approach to attacking the problem of chronic disease at the root of the causes, and utilizing the full moral authority and structure of the Black Church to reinforce healthy behavior in every stage of Black life. For instance, what NBCI teaches in the Black Church will be reinforced in Black social groups, fraternity groups, community organizations and most importantly, in the home.

The present structure of the American healthcare delivery system perpetuates these issues further and leads to greater morbidity and a higher death rate among African Americans. The leading factors that cause this bleak picture are racism and discrimination, the lack of access to care, the lack of access to new therapies, the lack of health insurance, and weak and poorly funded health prevention programs that tend to only reach less than one percent of those who truly need them. The health prevention models which are introduced in the Black Community are poorly staffed, lack a strategic initiative, lack cultural competency approaches both in program and curriculum, and receive funding only to cover the overhead of the program and not for its implementation or the duplication of modeling that program in other communities even if the program is successful (i.e. CDC VERB and other programs).

The Health Emergency Initiative will seek to arrest those chronic risk factors by employing proven, science-based health modeling, and insisting that every member of the African American Church should employ these helpful techniques that will hopefully cut the rate of morbidity and mortality to the normal rhythm of life.

THE GOALS AND OBJECTIVES OF NBCI HED

These are 16 elements of the National Black Church Initiative Health Emergency Initiative:

- Health education
- Prescreening and early detection
- An acute understanding of family medical history
- Increased visits to the doctor
- Improving nutrition and diet
- Screening for oral health diseases and the maintenance of good dentistry
- Increasing and improving physical exercise
- Drug therapy and compliance
- Age appropriate health screening
- Reduction and elimination of alcohol and tobacco consumption
- Reduction of stress
- A complete elimination of violence both in words and deeds
- Prescreening for mental health disease states
- Maintenance of good mental health practices
- Avoidance of accidents
- Building trust between health officials and the Black community and better communication

What makes this initiative different from any other initiative launched in the Black community are our four major emphases. NBCI plans to introduce to every participating African American church a mandatory weekly 2.5 hours of health education. In addition NBCI wants to begin to transform the nutritional intake of the Black Church via the utilization of new, healthier products, healthier ways of preparing food and emphasizing reduced meal portions. NBCI also hopes to encourage a 500 percent increase of physical exercise for every member of the family, especially children. Finally, we will make sure prescription drug compliance is the norm. Based upon current research and the opinion of medical experts, if the African American community performs these four basic actions the general health of the African American community will improve.

The National Black Church Initiative is launching one of the most progressive and comprehensive health prevention initiatives in the country. With its 34,000 church network it vows to employ science based health models for the explicit purpose of reducing health disparities. Previously this paper has dealt extensively with the reasons why health disparities are out of control. What we hope to do in this part of the paper is to discuss a plan of action to begin to drastically reduce the number of health disparities by the use of an aggressive health education and promotion program.

There are ten characteristics of the National Black Church Initiative Health Emergency Declaration.

1. 35 focused health communities
2. Faith based marketing health strategy
3. Certification of African American Churches as Health Prevention Centers
4. 2.5 hours of health education weekly
5. Use of proven scientific health prevention modeling
6. Use of modern media, including internet based tools and video as educational reinforcement aids
7. Enhanced health literature – NBCI Health Note
8. NBCI Communication and Distribution Network
9. NBCI Patient Education Assistance: Congregational-Based Health Personnel Corps (CBHPC)
10. Clinical trials

HOW DOES NBCI HED PLAN TO INTEGRATE WITH THE EXISTING HEALTH SYSTEM

NBCI plans to fully integrate HED into proven health systems that have demonstrated strong outcomes for African Americans both in public and private sectors. For instance, many experts have pointed out that African Americans have not used Federal Public Clinics effectively, largely because of their locations and other institutional transfer issues. NBCI knows that in many cases Federal Clinics are underutilized, but have tremendous resources. Through HED's transportation system we plan to dramatically increase the traffic to these federal health clinics around the country. In some cases NBCI will locate health panels in close proximity to these Federal Health Clinics. This is one of the reasons NBCI plans to work very closely with the Department of Human Services' Public Health Corps headed by the Surgeon General.

Likewise, NBCI will work with the Centers for Disease Control and Prevention with a strong emphasis on prevention and proven program methodologies. NBCI has identified areas in the CDC that have relevant resources, like the diabetes division and HIV/AIDS division to work closely with using a fully integrated, programmatic response to maximize the best outcomes in our 35 health communities discussed below.

NBCI will work with HHS, NIH, CDC and the Office of Minority Health to identify areas in which these health panels will have the maximum exposure to prevent diseases and promote wellness. For instance, if there is a underserved area - either in a urban or rural setting - HED will evaluate the health data and work to fulfill the needs of that underserved area in cooperation with these organizations.

NBCI will also work to ensure and help strengthen proven preventive modeling that is targeting the African American community by the private health development sector. NBCI will offer volunteers, program duplications, participants and other necessary elements to enhance, enrich and assist private healthcare developers that are working within the African American community.

This two-pronged integrative approach will prove to be the basic structure of HED's success. HED will evaluate the best proven methodologies and either attach its specific goals to them or assist the programs for the maximum positive outcome in improving the overall health picture of the targeted communities.

35 FOCUSED HEALTH COMMUNITIES

Each of these sections will be headed by a faith based community. There will be a lead church in each community, and NBCI will have key churches that will serve as organizing churches for the rest of the churches in their particular subdivisions. These will be called cluster churches. There will be one Master of Public Health (MPH) with a coalition of 50-100 volunteers in each geographic area that has the authority to implement programs in each of the subdivisions. For instance, subdivision A may be focusing on preventing cancer while subdivision B is focusing on heart disease. Eventually each of those subdivisions will receive each of the educational programs devoted to the study of various chronic diseases.

The selection of the 35 communities will depend on a number of factors. The factors that NBCI lists are cited within the texts of health literature and by most health experts. However, we strongly believe that there are hidden determining factors that also need to be considered in the selection of these communities. Because of the nature of the African American community and the worsening health conditions in them, these factors will be critical to determining where and how to apply these necessary preventive health tools to stabilize these communities and reduce the frequency of community disease states. It would be irresponsible for NBCI not to consider the government's perspective and utilize the current literature by them and other notable resources, so both will be consulted and considered extensively. NBCI is currently reviewing existing

literature by the government and other entities that have studied African American communities and therefore we will consult with multiple important health organizations across the country.

These are some of the factors that NBCI will consider, but consideration is not limited to them:

The social and economic conditions within the community;

The availability of access to healthcare for residents of the community;

The community's African American and Latino population;

The health statistics of the community and the healthcare system of the community;

The availability and quality of physicians and specialized care in the area;

State spending on healthcare and who in the community is covered by health insurance;

The availability of grocery stores who supply healthy eating alternatives, especially in minority communities;

These are a few of the factors of we will explore. We will also to look at racism as a factor. We will make sure to take into account the environment of the community (rural, suburban or urban) too. As cited above, the Kaiser Report set forth some of the criteria that NBCI will be looking at in terms of health disparity issues on a state to state basis. This is how each health community will be determined.

35 HEALTH PANELS

In each community we will create health panels. These health panels will consist of African American and Latino health professionals from that community who will help create a strategic plan to implement the 15 characteristics of the health emergency, along with the ten characteristics of HED. These panels will focus on providing education on all of the major health topics, the evaluation of literature to see whether or not it is relevant to the black community, the scheduling and implementation of the ten health models discussed below and making sure that each community in the designated area receives an equal amount of education.

The panels will also be responsible for certifying all healthcare speakers. The panel will work very closely with the Director of the HED and the deputy to make sure that the 35 Master of Public Health officers (MPH), who will be hired to carry out the programs, are properly deployed to effectively carry out the goals of the health emergency. Each panel will thus have a vested interest in the community in which it is empaneled to make sure that they reach the strategic goals that they have constructed.

Each panel also must decide what its relationship will be to state and local county health officials. The panel should avoid becoming just another government instrument, should be capable of

raising the critical questions that confront the minority communities, and be able to ask public officials why there are insufficient resources to take care of certain issues. The panel will be forbidden to share its health data with state, county and city health officials unless authorized. The panel should avoid helping to implement programs which have already proven themselves ineffective in the African American community and it also should resist the temptation of accepting monetary gifts to steer the panel away from the set criteria and strategic planning that the panel has already agreed upon. All strategic plans must be based upon real data. The panel should avoid being bogged down in setting priorities as well as creating the strategic plan. The panel would be given no more than three months to implement their plans, and all strategic plans would have to be approved by the director of the HED.

The panel may be engaged into many of the foundational core issues of HED, one of which is to work with like minded organizations to create policies within the government sector that would support HED's work. For example, The Robert Wood Johnson Foundation's Leadership for Health Communities: Advancing Policies to Support Healthy Eating and Active Living is one such initiative that HED can support. Given NBCI's vast community based structure that covers every major congressional district in the country and its history of activism it can work with the Foundation to help it in its goal of supporting "state and local government leaders nationwide in their efforts to advance public policies that support healthier communities and prevent childhood obesity."

The panel should find creative ways that enable it to position itself in participating in the collection of research data in order to shape its health priorities as well as complement its strategic planning.

THE ROLE OF THE MASTER OF PUBLIC HEALTH IN HED

The aforementioned MPH will act as the chief health liaison between the health panel and the churches. In this role they will help create and administer the evaluation of the program so that it may function better and be duplicated in other communities. In doing so the MPH will compile statistical data for the program that can be used by future organizers to better implement HED.

The MPH will also train the Congregational Based Health Personnel Volunteer Corps (CBHPVC) on the objectives and goals of HED. They will train the CBHPVC in the various areas of patient advocacy and on serving on the health panel and assisting in training. The MPH will also conduct the training sessions of the key church volunteers assisted by the CBHPVC.

Overall the MPH is poised help assist the running of HED and make sure that the program is administered properly by supporting the NBCI President in administering the program.

CONGREGATIONAL BASED HEALTH PERSONNEL VOLUNTEER CORPS

The HED will pay particular attention to individuals who have chronic health diseases within NBCI's faith based communities. NBCI will survey its congregations for individuals who are health care providers. NBCI plans to utilize them as part of the Congregational Based Health Personnel Volunteer Corps (CBHPVC). These volunteers will be trained by our Master of Public Health staff and with other local health entities.

There are two critical areas where the issues of health disparity loom large. One is the area of drug compliance and the other is the area of health management of the disease state. Both of these areas are critical to the well being of the patient. If a physician prescribes medication to an individual who is illiterate or otherwise challenged, they will need assistance from their families and their churches to comply with the instructions. We hope to provide that assistance through the CBHPVC.

- These individuals will work with patients who have chronic diseases, are educationally challenged or are physically challenged.
- They will serve as patient advocates.
- They will help patients navigate the healthcare system so that they can receive the adequate healthcare that is due to them.
- They will make sure that patients take their medications and treatments on time and correctly.

The CBHPVC will act as the glue for the entire HED. They will serve as an early warning system too, alerting pastors and families when an individual is out of compliance with his doctor's Recommendations, thus giving that individual's family and pastor a chance to intervene and to encourage the person to stick to their diet, be physically active, take their medications on time and visit their physician.

HEALTH PRIORITIES

The following are the health issues that will be the main focus of HED:

Heart disease

Cancer

Obesity

AIDS

Hypertension

Diabetes

Liver Disease

Smoking

Alcoholism

Drug Abuse

Violence

Depression

Organ Transplants (MOTTEP/Howard University, www.mottep.org)

Suicide

Bipolar Disorders

Respiratory diseases

Arthritis

Disabilities

Alzheimer

H1N1 Flu

The panels will decide the priorities of the above health conditions in each community. The panel will consult with state, federal and local health officials concerning their choices and the reasoning behind their choices. State and health officials will not have veto power over the panel's decision. The panel will evaluate their concerns like any other health professionals. The panel will listen to any authorized health entities on why they should address certain conditions before others.

HED AIDS INITIATIVE

As noted above, the Church will forcefully use its moral authority to deal with the AIDS epidemic forthrightly, clearly and comprehensively. No other disease has caused the Church more pain than the AIDS epidemic. Once the 35 panels have been selected AIDS will be one of the first diseases tackled. HIV/AIDS threatens the existence of the Black Church and it must be eliminated. This can only be done through extensive education, regular testing and the promotion of safe sex practices, like the use of condoms and abstinence. Because of the rapid growth of HIV/AIDS in the Black community, and especially its aggressive attack upon both heterosexuals and African American women, the church feels strongly that it must work closely

with public health experts in coming up with a strategic plan to eliminate AIDS in all segments of the African American community. Here are the cornerstones to the HED program:

The Black Church AIDS Epistle – We will issue a theological epistle on AIDS and cite it as an evil to the Church, thus allowing the Church to take unusual steps to eliminate AIDS from its community. The theological framework on this epistle will rest on three biblical principles. One, that Christ has come so that we can have life in heaven more abundantly. Two, to love our neighbors as ourselves. This principle denotes our responsibility to our partners, our Church, our community and our family. The only way to offer love is to be honest and forthright about one's AIDS status, thus protecting oneself, one's friends, one's sexual partners, one's neighbor and one's community. The third principle promoted is that we have all sinned and fallen short of the Glory of God and the Black Church will make no distinction between those who are HIV positive and those who are negative, those who are straight and those who are gay, and we will share the love of God through our savior Jesus Christ with everyone. The Church will promote its ordinance and ethics, and will not compromise. It will also continue to hold sacred the responsibility of marriage and the importance of faithfulness to one's self, one's sexual partner, and one's community.

Comprehensive Education – The Church will educate the Black community about HIV/AIDS through its 2.5 hours of health education every week in every Black Church.

Testing – Testing will be encouraged at every phase of the life of individuals who are sexually active. This includes those who are married and those who are not.

Safe Sex Practices – The Church will promote all forms of safe sex practices including the use of prophylactics and the principles that govern the holiness of abstinence.

FAITH BASED MARKETING HEALTH STRATEGY

One of the critical issues regarding African American health and why health education programs are not successful is that the organizations who are implementing the programs have very little experience with the African American community. In addition they lack the professional marketing skills to market to the African American community.

Ten years ago a large professional study was conducted by a well known European surveyor to determine whether or not marketing companies had to employ culturally relevant information to certain ethnic groups in order for them to respond enthusiastically to the product or message that was being advertised. The study concluded that companies marketing to minority communities did not have to employ relevant cultural information to receive the type of response that they were seeking. The study went on to say that the only thing that needed to change was that the racial composition of the individuals employed to announce the product or message. In other words, one can have the same message being aired and by only switching the race of the speakers the message will become more important to that race. Many African American

sociologists, anthropologists and Black public relations specialists angrily and vehemently objected to the study's conclusion and indicated that the vast majority of the people who responded to the survey were of European decent and were thus just airing their views over and against the cultural ways of minority communities. This shows the terrible state of both marketing towards the Black community and the lack of cultural competency used when doing so.

NBCI feels strongly that there needs to be cultural competency in every phase of HED so it can be successful. A marketing strategy is not only warranted but essential for its success, thus rejecting the findings of the European study conducted ten years ago. There is ample proof of the strong effect of cultural competency on any program for any ethnically based community and the Black community is no exception.

The chief failure of programs marketed in the African American community is that there is no culturally competent marketing strategy. Thus programs receive from African Americans the same low level of enthusiasm put forward by funders who just want to claim that the program was given to the Black community and the Black community ignored it. Thanks to the Black Church's already established role in the community, and the fact that it understands the community, NBCI is in a perfect position to effectively market and drive HED, making sure that the African American community takes notice and becomes involved.

CERTIFICATION OF AFRICAN AMERICAN CHURCHES AS HEALTH PREVENTION CENTERS

One of NBCI HED's chief goals is to strengthen the African American Church as a health center that can deliver effective health education to its congregants and the members of their immediate communities. HED will provide training as well as technical assistance for churches, giving them the ability to organize and strengthen their health ministries. It is important that every church understands what elements qualify it to become a good and technically viable health ministry that can deliver critical health education to its members and to its neighbors in the community in which it ministers. It should also recognize and be able to distinguish the difference in having a health ministry or simply offering a health fair once a year. NBCI HED will offer training and provide technical assistance on how to build a strong and viable health ministry so that good and preventive education can be offered to that congregation. NBCI will teach each church that the health fair is a product of the health ministry; it is not the health ministry itself.

These are the characteristics that NBCI will look at and eventually use to certify African American churches in the process of building a health ministry or strengthening an existing health ministry:

- A physician as a member of their congregation who is willing to offer some direction.
- Whether the ministry enjoys the support of the pastor and the pastor offers encouragement.

- Are there more than three qualified health professionals available who have four years of health education or more and are certified?
- Are there sufficient volunteers to support a program within the congregation?
- Does the church conduct annual health awareness weeks or an annual yearly health fair?
- Does the senior pastor offer a health sermon once or twice a year?
- Does the church distribute to the membership health information produced by their local health department or other health entities?
- Is there a qualified individual who can evaluate the cultural competency of the health literature being distributed?
- Is the church a member of a national health promotion organization (i.e. NBCI)?
- Does the person who heads the health ministry attend conferences or health seminars sponsored by qualified health organizations?
- Does the church's health ministry disseminate relevant health information which is timely and important in the current context?
- Can the health ministry provide volunteer training, and if there is training is it conducted by someone who has experience in the field?
- Is the health ministry recognized by the local health department?
- Is there a qualified list of individuals who are capable of giving accurate science based information to the congregation?
- Does the church have a defibrillator and qualified personnel to administer it?
- Does the church offer first aid and CPR training?
- Does the church offer cooking classes?
- Does the church encourage physical activity?
- Does the church teach life guard training?
- Is there anyone in the church capable of performing the Heimlich maneuver?

NBCI health panels, working along with the designated MPH personnel will provide the training to qualify and also certify churches on the above criteria.

USE OF PROVEN SCIENTIFIC HEALTH PREVENTION MODELING

NBCI will employ scientifically proven health models to radically change African American behavior when it comes to good health practices within their lives. NBCI plans to heavily market these models within the Black Church and hopes to also move outside the African American Church.

NBCI will not be introducing any models that have not been scientifically proven to be successful. NBCI will not be reinventing the wheel. NBCI believes that there are sufficient models available that have been proven successful, and the goal will be to implement and duplicate these models to reach a larger group of targeted populations who need them. In addition to the models below, we will also implement models by Dr. Yancy of UCLA, who believes that the black faith community is particularly "ripe" for addressing this area of health disparities because of the many opportunities to model healthy behaviors and to create experiential learning as a part of the organization's routine activities.

Yancy's work focuses on making environmental changes that not only effect individuals, but the entire African American Community. A few examples of these proven, scientific health models that we plan to implement under HED are listed in Appendix B of this paper.

Brown Bag Health Model dealing with drug therapy and compliance - NBCI will partner with the Black Pharmacist Association and individuals who have chronic health diseases. Participants can bring all of their medicines to a consultation in a brown paper bag. The Pharmacist will teach them the correct way of taking those medicines as well as share critical tips on how to take them. For instance, AIDS, heart disease, diabetes and lung cancer patients will all be able to learn more about their medications. This action will be taken to increase the knowledge of the individual and by increasing their knowledge increase compliance while protecting privacy. A frequent problem with patients in drug therapy is that after they start feeling better they stop taking medication.

Hyper Tension Health Model – Every Saturday at 9 a.m. in the 35 communities we will have a physician at the church talking about hypertension and the importance of making sure people understand how to take care of their blood pressure. The program will provide education on hypertension, discuss the side effects of hypertension, conduct blood pressure screenings and help the Hypertension Club in the church strengthen their outreach to every member who has this issue. We will work with local, state and health officials to adequately staff and fund this particular initiative, and we will create a protocol for helping individuals who have an above average blood pressure.

Jerusalem Walk Program - Every congregation will participate in this program a minimum of one time a month and a maximum of twice a month. The Black community can ill afford to wait for an annual walk in their community as walking is one of the best ways to stay healthy. The Jerusalem Walk Program is a program that incorporates the pastor's leadership and the entire congregation to walk a mile from their church and back. When they get back to the church they

will have a lecture on the value of walking and all it does to strengthen the heart. Prayer will be incorporated as a means of reducing stress and there will be a scheduled lecture on the value of eating fruits and vegetables from local farmers in the community. NBCI hopes to create over 50,000 walking clubs throughout the country. This would in itself transform the African American church with large amounts of increased physical exercise. This also may create issues for city planners in less walkable communities, which NBCI will help to address.

Fruits and Vegetables - Led by a qualified nutritionist and dietitian, the National Black Church Initiative will stress the value of fruits and vegetables in every diet. Once every two weeks local farmers will introduce a new vegetable to the community and explain its nutritional value. NBCI will see to it that African American farmers are the primary contacts for this program so as to involve the African American community as much as possible. This program will have a few different features. There will be a lecture on the value of fruits and vegetables and the particular fruit or vegetable of the week. The fruit will be cut up and eaten and the nutritionist and dietitian will explain the value of eating it. The vegetable of that week will be displayed and prepared properly in a healthy way to be shared with the class. This will give individuals an opportunity to share recipes with each other based on the proper way of preparing the vegetable for the maximum nutritional benefit. Parents will sign an agreement to incorporate this vegetable into their family diet within the next 30 days, making sure their children receive it regularly.

NBCI Women's Health and Wellness Initiative - NBCI will be taking a strong and forward approach to women's health as it is one of the most critical aspects of health in the African American community. We want to make sure that women know the proper ways to stay healthy and will do so through this initiative, which involves women's health education and preaching.

NBCI Child Obesity Program - Our focus here is to organize team sports through church leagues. This has proven to be an effective weight reduction measure in children because more than two hours of physical activity is provided for the children in this way on a daily basis. We will utilize those particular organized team sport initiatives as a means of teaching them how to take care of their bodies and how to eat well.

Smoking, Alcohol and Drug Cessation Program - We will work with industry and tobacco experts across the country to implement an additional 1,500 smoking cessation programs to get African Americans off tobacco. In addition we will also increase Alcoholics Anonymous and Narcotic Anonymous presence in the Black community by tens of thousands of groups. All of these programs, except the tobacco program, are already in Black Churches across the country so executing them is something that is already structurally available across America. The HED initiative would increase the awareness of what we call the three deadliest sins model (alcohol, tobacco and drugs) in African American churches.

The Health Clubs - The health clubs would be church based clubs focused around a certain health issue. The Diabetes Management Club, The Heart Club, and so on. Groups of individuals

who suffer from the same diseases will come together for support and to offer tips on how to cope with their disease.

Corn Syrup Initiative - Corn syrup is the major ingredient in many foods that causes an escalation in diabetes and heart diseases. This particular initiative will be used to reduce the amount of corn syrup consumed in the African American community's diet. We will employ a number of strategies to educate people on what has high amounts of corn syrup and how to avoid the ingredient.

NBCI WEB-BASED HEALTH TELEVISION

NBCI plans to launch an internet based health television outreach using the latest technologies to discuss health issues that primarily affect African Americans. Many African Americans learn by sight, and NBCI plans to use African American culture as a vehicle to discuss complicated disease states. For instance, Health Television will videotape African American consumers shopping in a grocery store and show items in a grocery cart, visually exemplifying items that are healthy and those that are not. NBCI Health Television will also feature videos of African Americans preparing food in the most nutritious way possible through cooking shows.

In addition it will have 60-80 segments on every disease state that affect African Americans. NBCI Health Television will discuss what the symptoms are not just verbally, but graphically via the video. The videos will cover the disease itself, its symptoms, how the disease affects those with it, the stages of the disease, possible treatments and how to receive help to manage the condition.

NBCI WEB-BASED FAITH HEALTH RADIO

NBCI will record up to 12 hours of programming a week and create a site especially for the downloading of current radio programs that deal with preventive health. NBCI will compile certain important podcasts on health, covering every major health outlet in the country, like NPR, CBS, NBC, ABC, FOX, CNN and others. NBCI will download critical health conversations after they are reviewed by NBCI in terms of the importance of its content to promote HED. In other words, if a doctor is discussing suicide prevention and this is a qualified expert, NBCI will download that conversation and put in the form of a MP3 based podcast as well as streaming on NBCI's radio website, so that individuals can partake of these conversations to further their knowledge and empower them to take action about their health. This will be marketed in a way so that we may integrate the music of the Black Church with a health sermon. In short, the individual targeted will hear the health conversation, some music of the Black Church, and health sermons encouraging them to take the next step to wellness.

NBCI SOCIAL HEALTH NETWORKS

NBCI plans to fully utilize popular social networking systems, like MySpace, Facebook, LinkedIn, Plaxo, Twitter, Google, Yahoo and others, to not only interlink congregations around the corner or across the country, but also use them as another tool to get out health tips. This content, which will be created by NBCI staff, will promote the health priorities, disperse health calendars and release the latest NBCI Health Note edition (as discussed below). NBCI will send out tens of millions of emails and tweets as reminders to encourage its congregants to always think upon the area of improving their health. NBCI is working on a computer program that will remind an individual by phone call, email, Twitter or other web based communication tools of their doctors appointment, exercise time, healthy recipes, proper diets, healthy products, when and how to take their medications and other health tips that illustrate the importance of HED.

ENHANCED HEALTH LITERATURE – NBCI HEALTH NOTE

The National Black Church Initiative Health Note is an innovative, 2-8 page, 11x17 brochure that highlights a particular health topic. It is an attempt to create an easy to read brochure that shares critical information as to the nature of a disease, its symptoms, locations to access free to moderately priced healthcare services (in an individual's city or state), top websites concerning the disease, and key contact phone numbers.

The Health Note demonstrates how faith based communities can utilize their theology to promote good health practices. It also creates an environment that promotes a healthy working relationship between the patients and the healthcare professionals to achieve a specific health outcome - compliance.

The NBCI/DCBCI Health Note was created to deal with complex health issues in a simplified but substantive manner.

NBCI COMMUNICATION AND DISTRIBUTION NETWORK

NBCI has 16,000 African American churches and 18,000 sister churches as members. Because of its enormous size, it is able to conduct targeted distribution of health literature and other materials. This makes NBCI one of the largest distribution networks in the country. NBCI can easily target its distribution network to NBCI churches, NBCI sister churches, or other churches outside our distribution network.

With this enormous distribution network, it is possible to touch every metropolitan and rural area in the country where African Americans and Latinos reside. NBCI also has the capacity to create literature both in Spanish and in English. Having this reach gives NBCI the unique ability to reach into metropolitan areas and deliver literature to particular ZIP codes, wards of cities (city election boundaries), and certain targeted neighborhoods. Over the years, NBCI has been able to perfect

this particular distribution network. This is one of NBCI's strong suits, and it is developing new techniques and strategies to improve the accuracy and speed of delivery of critical health information and other materials that will strategically affect the African American and Latino communities.

In the future, NBCI is looking to incorporate their technology information initiative by connecting key churches through wireless communication. NBCI will accomplish this task by sending the literature to key churches that in turn distribute that literature through their cluster churches. With this type of accuracy NBCI will be able to target certain churches, individuals, genders or races as needed. More specifically, NBCI has the capacity to distribute large volumes of health information to target populations for specific health concerns.

NBCI can deliver gender specific health literature to women concerning breast cancer, heart disease and other diseases like osteoporosis. NBCI is one of the few national organizations that have the capacity to distribute a large volume of health information to women who are a part of our congregations. The targeting of those women for this literature is usually done by the Center for Disease Control (CDC). If the CDC concludes that a particular age group is vulnerable to this disease state and should be tested, NBCI can survey its congregations and can map out strategies to Efficiently deliver targeted information to those specific groups of women in its congregations.

NBCI also has the ability to identify or target health information for men. If the literature is for men who are fifty-five and over concerning a disease like prostate cancer or other male diseases, NBCI will provide the same manner of information distribution within its congregations for them. NBCI is able to accomplish this task through the NBCI /DCBCI Health Note.

CLINICAL TRIALS

NBCI understands the importance of clinical trials for African-Americans. It is important that African-Americans are proportionately represented in clinical trials for common diseases such as diabetes, AIDS, cancer and heart disease that affect African Americans disproportionately. For the past four years NBCI has conducted seminars in its faith communities to encourage more African Americans to participate in clinical trials. NBCI believes it has finally reached a point where it can begin to encourage African Americans to participate in clinical trials in larger numbers. NBCI feels that all clinical trials should be conducted with the highest of ethical standards and adhere to current federal laws, rules, and regulations that govern these trials. It is critical that these protocols are in place before NBCI or NBCI member congregates endorse or participate in any clinical trial regimen. Our objective is to avoid the ghost Tuskegee.

The following issues should be settled before any participation occurs:

- There must be a signed consent form.
- There must be an education session explaining the purpose and value of the clinical trial, and its possible outcomes in terms of data and the management of a particular disease.
- There must be education on the effects of drug therapy or therapy in general.
- There must be adequate coverage for all unforeseen possibilities.
- All government protocol in reference to safeguards must be adhered to.
- The individuals who agree to participate should follow the clinical trial's instructions in order to achieve the best results.
- All possible side effects of the clinical trial must be explained fully and in writing.
- All clinical trials must be reviewed by NBCI's medical consultant.

There are three critical reasons why NBCI is supportive of clinical trials. The first is that they are a way in which people can receive cutting-edge drug therapy and medical coverage when the individual does not have health insurance, or has a limited form of health insurance. Secondly, it is critical for African Americans to be represented in these trials so that researchers can understand the differences in physiological effects of drugs concerning the racial minority as opposed to the majority. The third is that these trials may help society create a cure or an effective drug management technique that will reduce the suffering and mortality of those groups of people who suffer from a chronic or fatal disease.

This is an exciting and important step for HED, and will thus be given the greatest care and consideration before action is taken. NBCI will work closely with its partners to ensure the highest possible level of integrity in its clinical trials. Great care will be given to the implementation of the protocols of the clinical trials. There will be a panel of experts to guide us in this important endeavor. NBCI will use scholarly texts on clinical trials and current and relevant books and articles that will help us shape our understanding of the global benefits and downsides in the experimental world of clinical trials. Alex O'Meara's "Chasing Medical Miracles" will be one of the texts that NBCI will utilize in order to better understand the way in which clinical trials can benefit the African American community and world health in general.

RESEARCH DATA AND EVALUATIONS

One of the most exciting possibilities of National Black Church Initiative's Health Emergency Declaration is the enormous opportunity for the collection of critical research data within the African American population. This data along with existing data would help NBCI create more effective preventive tools, and also strengthen the HED program to create the maximum beneficial results in our efforts for health parity the African American community.

NBCI plans to consult extensively with evaluation teams as to the correct approach to both the structure of HED and to its proposed programming. NBCI has been speaking with Johns Hopkins University for some time to this end, and is exploring the possibility of working with them to devise a plan that will help to construct an effective evaluation tool. For HED's in house program evaluations of the effectiveness of the ten proven prevention models, the Master of Public Health staff member will be responsible for creating the appropriate evaluation tools to assess their effectiveness. Again, it will be prudent to consult federal entities in these areas because NBCI may be able to partner with them in such a way that benefits both organizations.

WHY HED WILL WORK

Because of NBCI's already established roots in both the Black community and the world of health, implementing HED will not face the same roadblocks that other initiatives have. By utilizing already proven and effective methods and techniques HED will be able to educate and enlighten the Black community on health issues. The size of NBCI's network, along with the organizational structure of the HED, will allow for easy and effective dissemination of information throughout the country. With the proper funding, HED can become a true force to change the health status of the African American community, and NBCI is ready to organize and execute the entire program.

The unique part of HED, and what will separate it from other programs that have not succeeded, is that NBCI vows to:

- Inform – NBCI will provide needed education about the disease states affecting African Americans.
- Encourage – NCBI will encourage patients to follow through with suggested doctor's recommendations and implement pro-healthy lifestyle behaviors for an increased lifespan. NBCI will explain the consequences of not living a healthy lifestyle and ignoring doctor's recommendations. NBCI will provide the tools that patients need to be successful in implementing health quality improvements in their lives.
- Help – NCBI will provide the means so that participants can receive the tools to succeed at implementing health quality improvement actions in their lives (childcare, transportation, meeting places, resources, etc.)
- Support – NBCI, through its affiliate churches will offer spiritual support, counseling, food, clothing and other basic needs and cooking classes. All of this is critical in moving to a state of healthy living.

- Monitor – NBCI will stay abreast of participants’ enrollment and make sure they maintain their status so that they will stay with their program for achieving a better health state.

It is these unique features, as well as the plans that are described above, that make HED different from the health programs that have come before it targeting African American communities.

Along with the above key points, NBCI will also utilize its structure to bring about a successful program. HED avoids the issues of poorly staffed projects by creating a system that is based upon four layers of effectiveness. One, a strong administrative health staff; two, health panels consisting of African Americans and Latino health professionals; three, a corps of highly trained and highly motivated Master of Public Health clinicians; four, a Congregational-Based Health Personnel Volunteer Corps. This is all backed by thousands of educated volunteers who have the necessary background to assist.

HED's geographically located health panel’s primary objective is to create a seven year strategic plan for their particular area. This is one of the reasons why the duplication of these successful, science based health models will not be a problem. The level of staffing training and commitment from the Black Church will allow for the program to be easily documented and reproduced in other communities.

HED will provide training on a bi-annual basis around the issue of cultural competency for the entire HED staff, as to not have problems concerning cultural competency in both its personnel and its curriculum structure. NBCI will also offer ‘Grand Rounds’ to its healthcare providers who are a part of its congregations to keep them abreast and able to pass on this information to members.

The HED will utilize the full power of the Black Church to demand African Americans be included in new therapies so that African Americans can receive the latest medicines and be promptly treated. NBCI will do this by encouraging its congregates to participate in clinical trials in order to inform them of who is developing these therapies, what the nature of these therapies are, and how one can participate in these therapies (only if their attending physician approves that the benefit outweighs the risk).

HED will solicit and educate key members of Congress about the insufficient funding for African American health, which needs to be quadrupled in order to properly deal with health disparities. There must be more funding for programmatic response solutions instead of research further documenting the existence and causes of disparities. NBCI does understand the value of actionable research, but when research is done simply for individual acknowledgment without future application to better the world then research does not maintain the value that it promises in dealing with health disparities. HED will create a diversified structure of funding, consisting of, but not limited to, federal government, HHS, CDC, NIH, state and local health entities, health

foundations, corporations and an extensive capital campaign among its 34,000 churches to endow the initiative over the next ten years.

Because of NBCI's already established roots in both the Black community and the world of health, implementing HED will not face the same roadblocks that other initiatives have. By utilizing already proven and effective methods and techniques HED will be able to easily educate and enlighten the Black Community on health issues. Because of the size of NBCI's network information will be easily disseminated throughout the country, and because of the organizational structure that HED will use that information will get where it needs to go quickly and effectively. With the proper funding, HED can become a true force to change the health status of the African American community, and NBCI is set to organize and execute the entire program.

NBCI believes that it can do little to nothing to truly affect the racial structure that exists in America's society, even though race issues have continued to improve. A small sign of this is the AMA's apology to African American physicians and their commitment to work to solve health disparities.

The President is proposing an ambitious and costly healthcare reform in the United States. NBCI strongly supports the goals of the President. However, we believe that even if healthcare reform is maintained by Congress, the problem of institutional transfer in developing cultural competency among healthcare workers will take years and even decades to achieve. We will not argue that access to that care in any form would improve health disparities, but we are not trying to simply improve health disparities, we want to eliminate them. Thus, we approve of the forward thinking of President Obama, but unless there is also a major emphasis on scientific based, well funded prevention programming in the Black community that impacts behavior, The Black community's disease and health crisis statistics will not change significantly.

FURTHER WORK

The following entities are critical structural components that HED is still considering how to form its relationship with in order to achieve its goals:

- State and local health officials
- Specialized organizations
- Pharmaceutical companies
- Foundations

NBCI remains committed to working within its present structure, but is also open to building new associations in order to foster awareness. At the same time it is critical to get a number of things done. To this effect, what NBCI has done is to create a task force consisting of five parts: One is a master of public health graduate, one is a physician, one is a university researcher, one is a clergyman, and one is a local citizen. These individuals have all agreed to work with NBCI to create an approach to the entities listed above that will not compromise HED's mission when enlisting the support and provisions of the above entities. NBCI also believes that it will be imperative to consult extensively with federal health entities concerning possible joint ventures that could be developed. NBCI will talk with the HHS Office of Minority Health, NIH Office of Minority Health and faith based entities, The Centers for Disease Control and others in order to accomplish this. NBCI programming staff along with the task force is rigorously working to set up guidelines that establish functional, beneficial, and correct relationships to create the most effective working standards with the maximum results in working with these other important health entities.

CRITICAL DOCUMENTATION AND IMPLEMENTATION GUIDE FOR HED

The National Black Church Initiative is producing three critical documents in order to implement this program. The first document is the **NBCI HED paper**, which you have a part of now. The second document is the **NBCI HED Implementation Guide**. This document will spell out step by step how we plan to implement the ten characteristics of HED. The third document is the **NBCI Church Health Ministry Guide**. This guide will lead the church step-by-step on how to create an effective health ministry that corresponds with HED and that can be certified by the National Black Church Initiative.

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APPENDIX A - (Britton 2009)

The Status of Black Health A Decade in Review, 1995-2005

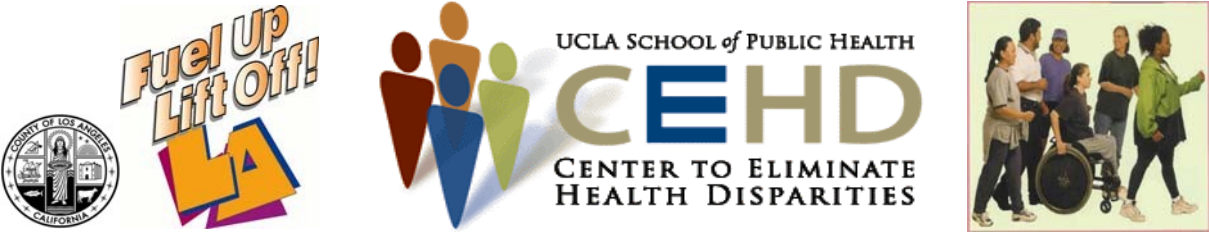
**Carolyn Barley Britton, M.D., M.S.
President**

National Medical Association

March 21 , 2009

**THE TENTH ANNUAL
NATIONAL COLLOQUIUM ON AFRICAN
AMERICAN HEALTH**

APPENDIX B - THE WORK OF DR. ANTRONETTE YANCEY



Healthy/Fit Organizational Practices & Policies

Physical Activity Promotion and Obesity Prevention & Control Collaborative
Center to Eliminate Health Disparities and **CO**mmunity **R**esearch in **CA**ncer Network
UCLA School of Public Health

Premise

The societal costs of the obesity epidemic to the public and private sectors are escalating, in dollars, disease and lives. Changing social norms by influencing organizational culture is necessary to engage staff, clients, patients, constituents, residents, members, or congregants in healthy eating and active living. Americans are at high risk for obesity-related morbidity, mortality and disability because the U.S. postmodern environment has become increasingly “obesogenic” (obesity-producing). Obesogenic environments are characterized by: pervasive and culturally tailored commercial advertising, marketing and promotion of highly-processed foods and sedentary entertainment and transportation; a smorgasbord of relatively inexpensive, readily available, highly palatable, energy-dense, but nutrient-poor foods; and a proliferation of motorized vehicles, elevators, escalators, moving sidewalks, riding lawnmowers, blenders, mixers, robots, and other labor-saving devices, combining with an underinvestment in public mass transit to engineer most of the obligatory physical activity out of our lives.

Immediate investment is needed, in terms of personal/familial responsibility ~~and~~ organizational practice and policy change, to reduce this toll on our society. All societal sectors and industries (government agencies, community-based organizations, corporate workplaces, schools) must share, with individuals and families, in the costs and benefits of adopting and maintaining a healthy/fit lifestyle in this obesogenic environment. Organizations have considerable latitude and opportunity to use their physical and social infrastructure to make engaging in healthy eating and active living the *easier* choices, and sedentariness and poor nutrition the *harder* choices. Physical activity and healthy food choices may readily be incorporated into the normal conduct of business, a relatively minimal investment of resources with great potential for improving morale, productivity and mental/physical health status.

Proposed Policies/Practices

Core

1. Include a 10-minute exercise or movement break in any meeting, event or other gathering lasting one hour or longer, and at a certain time of each workday. While work or organizational demands (travel, imminent deadlines) preclude participation on some days, aim to engage at least two-thirds of those present in the workplace.
2. Include healthy food choices at meetings, events, or other gatherings at which refreshments are served, e.g., fresh fruit, fresh vegetables, water, whole grain products, lean protein sources (low-fat or non-fat dairy products, soy products, fish, skinless poultry).
3. Establish healthy food procurement policies consistent with #2, for caterers, conference hotels, and other venues.
4. Post stair prompts (signage, riser banners) and utilize other means of encouraging stair usage (e.g. slowed hydraulic or skip-stop elevators, improved lighting, wall artwork, organizational leaders' modeling of the behavior, especially in groups of colleagues/co-workers moving between organizational activities in buildings); if applicable, address building maintenance practices that discourage or prevent stair usage.
5. Host walking meetings at least weekly.
6. Include at least 50% healthy and competitively priced food choices in vending machines (e.g., fruit, water, low-fat and non-fat milk of any flavor, soy milk, <2 oz. packages of nuts or dried fruit/nut mixes, whole grain crackers), cafeteria offerings, and on-site food vendor selections.

Elective

1. Encourage more casual attire compatible with lifestyle integration of physical activity (taking the stairs or a walking break), i.e. discouraging neckties and high-heeled shoes.
2. Provide a bowl of fresh fruit (encouraging purchase from local farmers' markets) in the reception or central congregating area.
3. Install water fountains or dispensers in every work unit.
4. Change organizational culture to promote and reward lifestyle integration of physical activity, e.g., fidgeting in meetings (standing up at intervals, doing "airline exercises in one's chair), taking short walking breaks during the day, or exercising at lunch, rather than the typical culture of rewards for "being chained to one's desk" working without interruption.
5. Include language in sub-contracts mandating or providing incentives for sub-contractor / supplier organizations' adoption of these healthy/fit organizational practices and policies.

6. Provide incentives for parking in more distant lots or facilities, or relying more on mass transit or carpooling; work to ensure that a safe physical environment, conducive to walking, i.e. presence of well-maintained sidewalks, appropriate traffic control, availability of escorts during low light or traffic periods. Restrict nearby parking to disabled employees and visitors.
7. Wherever possible, move employee or student “drop-off” locations sufficiently far from workplace or school entrances, e.g., behind disabled parking lots or playing fields, to require that adults or youth walk for at least 10 minutes to work or class.
8. Require equal placement of physical gaming machines (those requiring the user to be physically active to score points, e.g., Dance, Dance, Revolution) with sedentary games in video arcades, shopping malls, movie theaters, restaurants and other gaming locations.

The Health-e-AME Faith-Based Physical Activity Initiative:

Description and Baseline Findings

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Abstract

BACKGROUND: This paper provides an overview of the development, implementation, and baseline findings from a statewide faith-based physical activity (PA) initiative.

METHODS: The 3-year program is training AME volunteers across South Carolina to implement action-oriented and educational programs to increase PA in their congregations. Formative research and meetings with the AME Planning Committee informed the development of the program. The evaluation uses a randomized design with a delayed intervention comparison group. Annual telephone surveys are conducted with a randomly selected cohort.

RESULTS: To date, 98 churches have been trained. Interviews done with a random sample ($n=39$) indicated that 54% are implementing at least one PA program, and 72% of those who are not have specific plans to start. The baseline telephone survey ($N=571$) estimates that 27.8% of the population is regularly active, 54.9% underactive, and 17.3% sedentary. Baseline rates of regular PA were higher in those who were younger, healthier, and nonsmokers. There were no baseline differences in PA by randomization group, gender, marital status, overweight, or chronic disease.

CONCLUSIONS: Challenges to date have included obtaining rosters and implementing a large-scale program with limited resources. AME members' interest in the program has been strong and supported by church leaders. Current efforts are on training additional churches and working with those already trained to support sustainability.

KEYWORDS: Exercise, African American health, health disparities, faith-based initiatives, health promotion

Acknowledgments

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The health benefits of regular physical activity (PA) are well established for adults of all ages (USDHHS, 1996). However, rates of participation in PA are lower in African American than Caucasian adults (Schoenborn & Barnes, 2002). Corresponding to the lower prevalence of regular PA, rates of cardiovascular disease, hypertension, and diabetes, are substantially higher among African Americans than Caucasians (American Heart Association, 2002). Eliminating ethnic disparities in disease morbidity and mortality is a national public health goal outlined in *Healthy People 2010* (USDHHS, 2000).

Faith-based organizations are promising settings for delivering health promotion messages to African Americans. The church is an important source of support for African Americans (Levin, 1984), and can provide health promotion programs that are socially, culturally, and spiritually acceptable to members of the congregation (Wimberly, 2001). In addition, a community-based participatory research approach (CPBR), in which academic institutions partner with community organizations so that decision-making and resources are shared in an atmosphere of mutual respect and benefit, can assist in addressing the underrepresentation of people of color in prevention research. In recent years, a number of large-scale health promotion projects have been found to be effective in Black churches (Campbell et al., 1999; Kumanyika & Charleston, 1992; Resnicow et al., 2002; Resnicow et al., 2001; Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001). With the exception of Healthy Body/Healthy Spirit (Resnicow et al., 2002), these projects have emphasized nutrition to a far greater extent than PA, and as a result, changes in PA have often been smaller in magnitude than dietary changes (Kumanyika & Charleston, 1992; Yanek et al., 2001). There is a need to focus specifically on faith-based promotion of PA with African Americans.

This article reports the development, feasibility, implementation, and baseline findings of a faith-based PA initiative designed to increase PA in adult members of the 7th Episcopal District of the African Methodist Episcopal (AME) Church. It is a partnership between the AME church, the Medical University

of South Carolina (MUSC), and the University of South Carolina (USC). We also describe the demographic and PA characteristics of the evaluation cohort at baseline.

Methods

Overview of the Structure of the 7th Episcopal District of the AME Church

The 7th Episcopal District of the AME Church includes approximately 500 churches and 275,000 members in South Carolina. It is divided into six regional conferences, with conferences further divided into two to three districts. Conference and District Health Directors oversee the health ministry activities in the churches within their conference and district, respectively. There is also a Director of Health for the entire 7th Episcopal District (RS). The Bishop oversees all activities within the 7th Episcopal District. Seventeen Presiding Elders report directly to the Bishop, and approximately 500 Pastors report directly to the Presiding Elders.

Design

The Health-e-AME Faith-Based PA Initiative is a three-year project funded through a U.S. Centers for Disease Control and Prevention (CDC) CBPR grant. Because a traditional randomized controlled design was not acceptable to AME church leaders, a randomized design with a delayed intervention control group was chosen instead. Randomization occurred at the conference level in order to reduce contamination effects and maximize training efficiency. Three conferences and corresponding churches were randomly assigned to receive training in year one, and the remaining in year two. The immediate intervention conferences will receive up to three years of intervention, and the delayed intervention conferences will receive up to two years of intervention. The program is open to all churches within the conferences.

MUSC and the AME church had worked together on several health-related projects prior to this initiative. A needs assessment completed in 2002 with a sample of AME members revealed that PA participation was low. The AME Planning Committee, a group comprised of AME members, Pastors, and

Presiding Elders, and members of academic institutions, identified PA as an important target for reducing health disparities. MUSC, USC, and the AME Planning Committee then collaborated on the CDC application. All three organizations participated equally in the project, although the Church opted to have the universities handle the grant funds.

Intervention Development

From the outset, the Planning Committee and University partners wanted to develop a sustainable program and to reach the majority of AME churches in the state. For these reasons, we designed a program in which Health-e-AME project staff trains church Health Directors or PA Coordinators to organize and deliver the program within the context of their existing health ministry. Focus group ($N=8$) were conducted across the state to receive input on desired programs. Spiritual and religious components were integrated into all PA promotion messages.

Conceptual framework. Two theoretical models offered the best fit for the program goals. Social ecological models best captured the process by which members of faith communities minister to each other (Heaney & Israel, 2002). Social networks within the church provide emotional support, feedback, and affirmation related to the importance of PA. The framework also reflects multiple levels of influence, including the individual, social environment, physical environment, and policy and the hierarchy of the church.

There is also growing evidence that interventions must be tailored to an individual's readiness for change. According to the transtheoretical model (Prochaska & Marcus, 1994), cognitions should be targeted for persons who are ambivalent about change, whereas behavior should be targeted for persons who are cognitively ready to make changes. Interventions should also be tailored to ethnic and cultural perceptions of the behavior and common reported barriers.

Specific Program Components. Based on formative research and literature reviews, we developed PA programs that were structured and action oriented, designed to reach those in the

preparation, action, and maintenance stages of change, as well as programs and activities that were educational/motivational in nature, designed to reach those in earlier stages.

The three action-oriented programs were praise aerobics, chair exercises, and walking programs. Praise aerobics uses PAs of varying intensities that are set to familiar gospel music. Chair exercises, also set to gospel music, were selected to reach adults who have medical restrictions or conditions that make moderate-intensity forms of PA difficult or inappropriate. Finally, walking tends to be a preferred activity for many adults; thus we incorporated walking programs and contests into the program.

To reach church members in earlier stages of change, we designed an eight-week program titled “8 Steps to Fitness” to teach behavior change skills (e.g., self-regulation, problem solving, and stimulus control). This program was modeled after successful behavior change interventions (Dunn et al., 1999; Kumanyika & Charleston, 1992; Yanek et al., 2001), and was adapted to the needs and interests of the churches. It incorporated scripture related to each week’s topic and included a 20 to 30 minute group exercise portion. An in-depth facilitator’s guide was developed, complete with participant handouts, to simplify program delivery.

To reach individuals who might not seek out PA programs, and to build PA into existing church activities, churches were trained in how to incorporate PA messages in Pastor’s sermons, church bulletin boards, bulletin inserts, health fairs, and announcements. We also worked with a UCLA researcher (AY) to adapt strategies from worksites and community organizations to a faith community setting (Yancey, Kumanyika et al., 2004; Yancey, Lewis et al., 2004). These strategies were designed to change the sociocultural environments within organizations to incorporate PA and healthy food choices into routine activities. For example, Yancey and colleagues developed a 10-minute exercise CD and videotape used for breaks in worksite settings (Yancey, McCarthy et al., 2004), and we adapted it using gospel music and spiritual references (titled “Exercise Your Faith for Ten”). Churches were encouraged to use the

CD/audiotape during church activities that tend to be sedentary. We also encouraged churches to provide healthy food options and include PA at church events.

Overview of the Training. Many of the AME churches have existing health ministries. We identified either the Health Director or another person within the church to coordinate the PA programs. These individuals and an assistant attended a half-day training in how to deliver the PA program. The training included didactic and hands-on experiences. For example, participants engaged in praise aerobics, learned basics in counting and developing routines, and then broke into small groups to practice developing routines. Participants received copies of all program materials, facilitators' guides, participant incentives and handouts, CD/audiotape and videotape, and information on how to receive assistance after the training.

During the first year of the project, we conducted three large group trainings in each of the conferences randomized to the immediate intervention group and trained 130 individuals from 75 churches. We also conducted five mini-trainings, in which a host church and several nearby churches participate, and trained an additional 75 individuals from 23 churches. During the next two years, we will train churches in the delayed intervention conferences and will continue to train churches in the immediate intervention conferences. Our goal is to train 80% (400/500) of all AME churches.

Other Program-Related Activities. The project expanded an existing AME health website by adding PA content, including information about PA, resource links, a list of participating churches, photographs of training events, and training materials. Project staff also created a quarterly newsletter that keeps participating churches and church leaders informed about the project. Special events were designed to increase the visibility of the project within the churches. For example, 11 of the Presiding Elders participated in a two-week pedometer challenge that was widely publicized at a statewide meeting, on the website, and in the newsletter. To increase visibility within the broader community, the project

worked with media outlets and conducted widely publicized events, such as a project kick-off that included the president of MUSC introducing the project and participating in praise aerobics.

Evaluation

Telephone Surveys. The sampling frame for the telephone survey consisted of all AME churches in SC stratified by conference. Churches were the primary sampling unit, and church members within selected churches were the secondary sampling unit. The number of church members needed was estimated as 248 per randomization group at baseline. Participants will be re-interviewed in years two and three. This sample size was based on having 80% power to detect a 15% difference in change in PA after one year of intervention at the $\alpha=0.05$ level of significance; an anticipated 10% design effect (cluster inflation factor); and an anticipated 30% loss to follow up rate. Since the primary sampling unit was the church, the actual number of church members to be sampled was expected to vary. A combination of small (< 100 members), medium (100-400 members), and large churches (> 400 members) was desired for each randomization group to yield at least 248 church members.

The only inclusion criterion for the churches was that the Pastors were willing to submit a complete roster of adult church members to the research staff (after making an announcement that allowed members to remove their name from the list, if desired). The church rosters were transferred to the Institute for Public Service and Policy Research Survey Research Laboratory at USC. Interviewers received four hours of training on the survey. All surveys were conducted using CIB-CATI (Computer-Aided Telephone Interviewing) software. Telephone interviews were conducted Monday (9:00 am to 9:30 pm) through Saturday (10:00 am to 4:00 pm). Each number was attempted at least once on different days during different time slots. The field period for the baseline survey was May to September 2003. To be eligible for the survey, participants had to be at least 18 years of age and report that they attended church services at least twice per month. Because the survey was completed by telephone, only verbal informed consent was provided. The project was reviewed and approved by the Institutional Review Boards at MUSC and USC.

Telephone Survey Measures. We collected information from the following major categories: sociodemographics, health, internet use, PA behavior, PA correlates, weight perceptions, diet, and process indicators.

Sociodemographic and health-related variables. Age, education, marital status, income, and gender were assessed. Respondents rated their health on a scale of 1 (poor) to 5 (excellent). They reported whether a health professional has ever told them they had high blood pressure, diabetes, high cholesterol, cardiovascular disease, or cancer. Respondents also reported height, weight, and smoking status.

Physical activity behavior. The BRFSS PA module, developed for telephone administration, assesses occupational activity, moderate and vigorous PA and walking. The proportion of participants who met the CDC-ACSM moderate or vigorous recommendations was calculated using BRFSS scoring algorithms. A recent study that compared an objective PA measure with the BRFSS PA module reported 80% agreement between the two methods of classifying individuals who met these recommendations (Strath, Bassett, Ham, & Swartz, 2003).

Interviews to Assess Program Implementation. Project staff interviewed the Health Director/PA Coordinator in a random sample ($n = 39$) of churches to assess the extent to which they had begun to implement the program, plans for future implementation, barriers to implementation, additional assistance required, and feedback regarding incentives and training. They were also asked about changes in their own PA or dietary habits as a result of the training.

Analysis of Telephone Surveys

SUDAAN version 8.0.2 (Research Triangle Institute, 2003) was used to account for the multi-stage, clustered sampling design of the telephone assessment of church members. Chi-square statistics were used to test the null hypothesis of no association among key survey measures and randomization group. PA levels, overall and by key survey measures, were estimated for the target population. Given the large sampling fractions of church members within a church, the without replacement study design along

with the Taylor linearization variance estimator were selected as the SUDAAN design options. Simple descriptive statistics for the simple random sample of program implementation and other general sample characterizations were performed using the SAS System version 9.0 (SAS Institute Inc., Cary NC, 2002).

Results

Baseline Characteristics (Survey)

Figure 1 represents the participant flow for the telephone survey. In total, we received 20 complete rosters that were used for the evaluation: 11 from immediate intervention churches (4 small, 4 medium, 3 large) and 9 from delayed intervention churches (3 small, 3 medium, 3 large). A total of 571 telephone surveys were completed.

Of the total sample, 72 (13%) respondents were from small, 179 (31%) from medium, and 320 (56%) from large churches. Sociodemographic and health-related characteristics of the sample are shown in **Table 1**. Although more women than men were surveyed, the sample was diverse along sociodemographic and health characteristics. The only statistical significant difference between respondents in the delayed versus immediate intervention groups was age.

Overall, 27.8% (± 2.0) of the population was estimated to meet recommendations for moderate or vigorous PA, 54.9% (± 2.0) were underactive, and 17.3% (± 1.2) were sedentary. As shown in **Table 2**, there were no differences in these rates by randomization group, gender, marital status, overweight status, education, income level, or by the presence of various chronic diseases. Younger people were more likely to be physically active ($p = .027$). Current smokers had the lowest rates of regular activity, and both current smokers and former smokers were more likely to be sedentary than never smokers ($p = .019$). Healthier (self-reported) people were also more likely to be physically active ($p = .020$).

Interviews = Program Implementation

Of the 39 completed interviews, 30 people (77%) reported that they had increased their own PA and 27 (69%) reported that they had improved their diet as a result of the training. Examples included taking more walks throughout the day, reducing portion sizes, reducing high fat foods, increasing fruit and vegetable consumption, and reducing soda consumption.

Twenty one people (54%) reported that they had implemented at least one PA program in their church. All of these had implemented an action-oriented program (38% praise aerobics, 36% chair exercises, 31% walking clubs, 23% “8 Steps to Fitness”) and half (49%) had also implemented educational activities. Thirty eight percent reported no problems implementing the program. The most common barriers reported by the remaining churches were lack of responsiveness or attendance of the congregation (33%) and lack of time (14%).

Of the 18 churches that had not implemented, 13 (72%) had specific plans to start. Many of the mini-trainings were held in October through December, and participants often commented on their plans to start the program after the holidays. Barriers related to lack of time and multiple responsibilities were cited most often (83%). One third of churches stated that a booster training session would help them begin to implement.

Additional trainings, seminars, workshops, and information about PA and nutrition were most desired for the upcoming year. A sizeable number of the churches stated that it would be useful to have project staff come to their church to talk about the program or provide some assistance with leading exercise classes.

Discussion

The Health-e-AME Faith-Based PA Initiative is a three-year project designed to increase PA participation among adult members of the 7th Episcopal District of the AME Church. The project employs a CBPR approach in which all decisions are made based on active input and approval from the AME church.

This initiative is unique in several ways. First, to our knowledge, it is the only faith-based project with a research component that focuses almost exclusively on PA. Second, it is perhaps one of the largest faith-based health promotion programs in existence. Third, the project represents a partnership between the AME churches of South Carolina and two academic institutions. The program is strongly supported by leaders within the AME church and the two universities and allows these three groups to come together to address a shared goal of eliminating ethnic disparities in morbidity and mortality.

The first year of the project has been successful and valuable lessons have been learned. First and perhaps most important, it has been critical to have leaders within the church support the program and to have a shared mission and agenda. The Bishop of the 7th Episcopal District embraced the program and is a role model of living a physically active lifestyle. He emphasized the importance of a health ministry as a way to promote health and eliminate health disparities. He has given project staff valuable time on annual meeting agendas and has encouraged exercise breaks during large meetings. As in any organization, leadership changes, creating times of uncertainty. This project is no exception. The Bishop who partnered with us during the first two years of the project retired in June 2004, and we are in the process of forming a relationship and partnership with the new Bishop.

We have faced a number of challenges in implementing and evaluating the program. Perhaps the greatest has been obtaining rosters from Pastors. Many of the Pastors wanted to submit a list of interested members rather than an entire roster, and some refused participation for this reason. Once rosters were received, there were some problems with wrong numbers and incomplete listings. Despite these

challenges, which have also been noted by others (Carter-Edwards, Fisher, Vaughn, & Svetkey, 2002), we believe that rosters provide the most comprehensive sampling frame for faith-based organizations. Institutions working with faith-based organizations should be prepared to explain research design issues in lay terms, allow extra time to receive the rosters, and offer assistance in compiling these lists.

Another challenge has been using a randomized design in a faith-based organization. Some Pastors expressed frustration at not being able to have their church trained in the program. Several Pastors from delayed intervention conferences wanted us to make an exception and include their church in the training during the first year or offer some components of the program to their church.

Project staff continues to struggle with the length of the training sessions. Although many of the individuals trained have some type of health background (e.g., nursing), a substantial percentage do not have such training and most have no formal training in PA. Most attended a four-hour session on a Saturday, which was viewed as too long by many trainees and many of the project staff. The trainees are volunteers, and often have many responsibilities to their families, churches, and communities. However, it is difficult to adequately cover the material in a shorter period of time. We have begun to implement shorter mini-trainings, which appear to be more feasible for both staff and trainees, although the impact on quality of implementation is unknown.

While the size of our project is a clear strength and creates the opportunity to reach thousands of African American adults across the state, it has also posed challenges related to cost and availability of resources. For example, we purchased 900 pedometers in the first year, which amounted each church receiving 8 pedometers. Another challenge has been limited staff resources. Trainings have been conducted on weekends and during the evenings, and staff has traveled relatively long distances to do these trainings. Health Directors/PA Coordinators in the churches have indicated that they would like our staff to visit their individual churches, which is not possible given the number of churches across the

state. These financial and logistical challenges have caused us to think about how to best implement training and technical assistance in a more cost-effective manner.

Assessing program fidelity has also been challenging. Approximately half of the trained churches had begun to implement the program. With a program of this size, we are not able to capture many of the details of program implementation. In addition, our evaluation is a community evaluation approach. Individuals were randomly selected to be a part of the evaluation cohort, and selected individuals may not ever be exposed to the program. This approach will allow a stringent, albeit somewhat conservative, test of the impact of the program on the entire AME community in SC. This “diffusion of innovations” is an oft-neglected but critical element of successful health promotion, particularly in underserved communities (Rogers, 1983).

Conclusions

Despite these challenges, it has been rewarding to hear “success stories” of churches implementing PA programs and partnering with other churches and community groups to share resources and responsibilities. The training has positively influenced the health behaviors of those trained. Finally, individuals associated with the program, from the project staff, to the Pastors, to the Health Directors/PA Coordinators trained to implement the program, have enjoyed participating in the program exercises and have experienced how PA and exercise can be fun and enhance spirituality. We believe that over the course of this three-year project, we will continue to learn a great deal about the challenges and rewards to faith community-academic partnerships for PA promotion.

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Table 1. *Baseline Sociodemographic and Health-Related Characteristics by Intervention Group*

| Factor Level | Delayed Intervention | | Immediate Intervention | | Entire Sample | | p-value |
|-----------------------|----------------------|-------|------------------------|-------|---------------|-------|---------|
| | n | % | n | % | N | % | |
| Age (in years) | | | | | | | 0.017 |
| 18 - 34 | 17 | 6.25 | 40 | 14.67 | 57 | 11.27 | |
| 35 - 49 | 93 | 37.54 | 88 | 27.80 | 181 | 31.73 | |
| 50 - 64 | 85 | 35.26 | 87 | 31.01 | 172 | 32.73 | |
| 65 + 53 | | 20.95 | 81 | 26.51 | 134 | 24.27 | |
| Gender | | | | | | | 0.793 |
| Women 186 | | 68.77 | 220 | 67.69 | 406 | 68.12 | |
| Men 74 | | 31.23 | 91 | 32.31 | 165 | 31.88 | |
| Years of Education | | | | | | | 0.241 |
| Less than high school | 38 | 14.50 | 45 | 15.64 | 83 | 15.18 | |
| High school or GED | 71 | 28.91 | 113 | 41.44 | 184 | 36.38 | |
| Some college 61 | | 27.40 | 66 | 21.40 | 127 | 23.82 | |
| College graduate 74 | | 29.19 | 63 | 21.53 | 137 | 24.62 | |
| Income | | | | | | | 0.631 |
| < \$25,000 87 | | 38.70 | 101 | 33.50 | 188 | 35.63 | |
| \$25,000 - \$49,999 | 81 | 36.70 | 101 | 43.75 | 182 | 40.86 | |
| \$50,000 + 62 | | 24.61 | 60 | 22.75 | 122 | 23.51 | |

| | | | | | | | |
|-----------------------------------|-----|-------|-----|-------|-----|-------|-------|
| Marital status | | | | | | | 0.400 |
| Married / marriage like | 125 | 45.28 | 143 | 51.84 | 268 | 49.16 | |
| Divorced or separated | 39 | 14.59 | 53 | 17.12 | 92 | 16.09 | |
| Widowed | 33 | 17.47 | 47 | 14.90 | 80 | 15.95 | |
| Single (never married) | 51 | 22.66 | 43 | 16.15 | 94 | 18.81 | |
| Overweight status | | | | | | | 0.210 |
| Normal weight | 54 | 20.00 | 75 | 26.17 | 129 | 23.63 | |
| Overweight | 87 | 34.73 | 97 | 33.80 | 184 | 34.18 | |
| Obese | 100 | 45.26 | 103 | 40.03 | 203 | 42.18 | |
| Smoking status | | | | | | | 0.792 |
| Current smokers | 31 | 10.35 | 27 | 9.19 | 58 | 9.66 | |
| Former smokers | 52 | 21.93 | 66 | 22.10 | 118 | 22.03 | |
| Non-smokers | 165 | 67.73 | 194 | 68.71 | 359 | 68.31 | |
| Health conditions (self reported) | | | | | | | |
| Diabetes | 67 | 25.41 | 72 | 24.95 | 139 | 25.13 | 0.912 |
| Hypertension | 128 | 51.80 | 167 | 54.54 | 295 | 53.44 | 0.635 |
| High cholesterol | 89 | 33.66 | 98 | 31.59 | 187 | 32.42 | 0.549 |
| Cardiovascular disease | 21 | 7.36 | 31 | 10.77 | 52 | 9.40 | 0.175 |
| Cancer | 10 | 3.70 | 20 | 5.91 | 30 | 5.02 | 0.312 |
| Self-rated health | | | | | | | 0.790 |
| Excellent | 36 | 12.65 | 41 | 13.64 | 77 | 13.25 | |
| Very good | 67 | 26.69 | 84 | 28.56 | 151 | 27.81 | |

| | | | | | | |
|-------------------|-----------|-------|-----|-------|-----|-------|
| Good | 101 | 40.83 | 115 | 36.06 | 216 | 37.98 |
| Fair | 47 | 15.99 | 55 | 17.51 | 102 | 16.90 |
| Poor | 8 | 3.83 | 16 | 4.23 | 24 | 4.07 |
| Physical activity | | | | | | 0.892 |
| Regularly | active 71 | 27.90 | 90 | 27.76 | 161 | 27.82 |
| Underactive | 135 | 54.08 | 165 | 55.41 | 300 | 54.88 |
| Sedentary | 47 | 18.01 | 52 | 16.83 | 99 | 17.30 |

Table 2. *Physical Activity Behavior Overall and by Sociodemographic Characteristics*

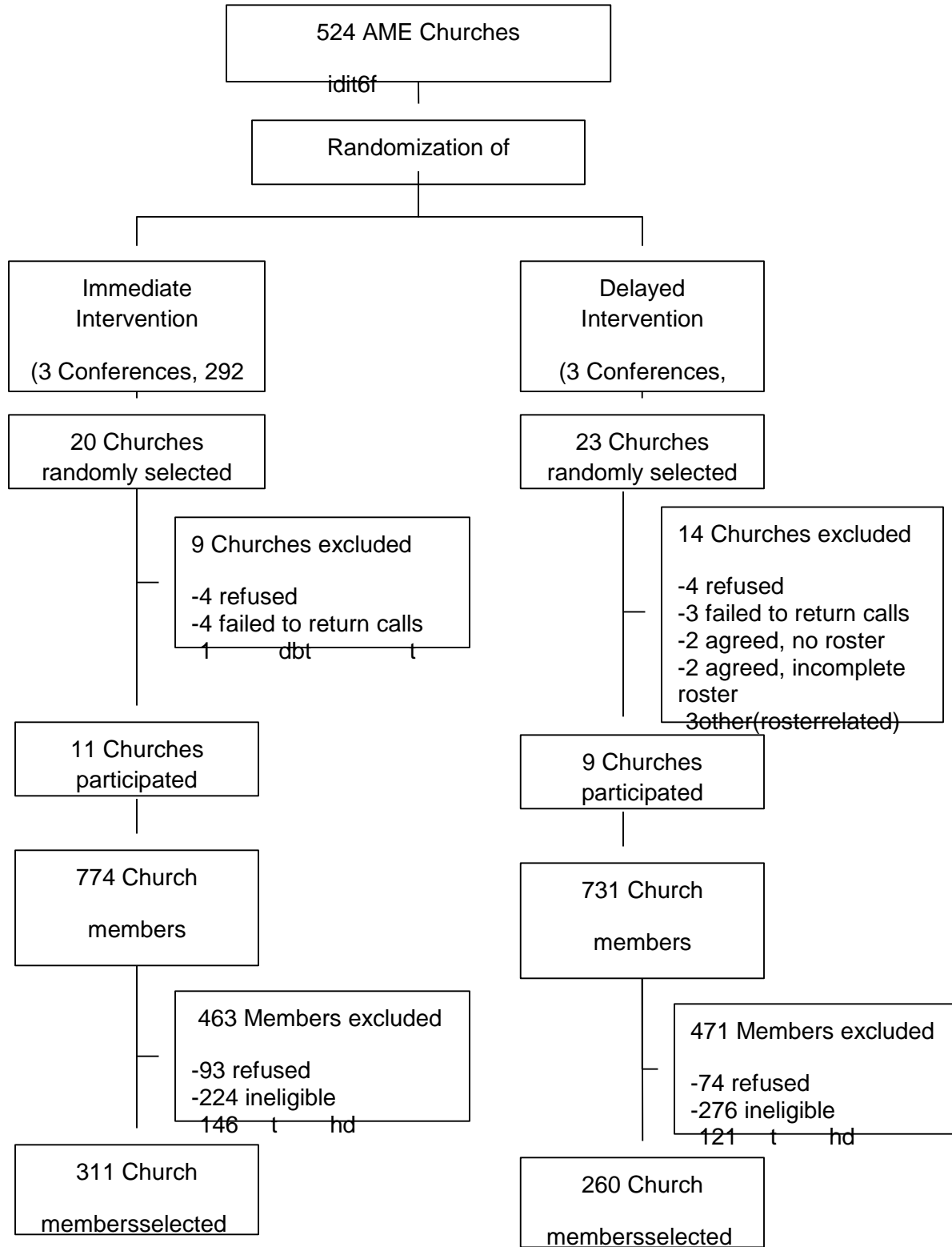
| Factor | Level | Regularly | | Sedentary Underactive | | p-value | | |
|--------------------|-----------------------|-----------|--------|-----------------------|--------|---------|--------|-------|
| | | Active | %(SE) | %(SE) | % | | (SE) | |
| Overall | | 27.82 | (2.02) | 17.30 | (1.18) | 54.88 | (2.02) | |
| Church Size | | | | | | | | 0.780 |
| | Small | 27.07 | (3.69) | 16.25 | (3.75) | 56.69 | (5.82) | |
| | Medium | 26.05 | (1.87) | 17.33 | (2.23) | 56.62 | (3.03) | |
| | Large | 29.14 | (2.97) | 17.60 | (1.24) | 53.27 | (2.05) | |
| Age (in years) | | | | | | | | 0.027 |
| | 18 - 34 | 36.76 | (7.05) | 10.15 | (2.77) | 53.08 | (7.49) | |
| | 35 - 49 | 31.96 | (3.14) | 10.62 | (3.55) | 57.41 | (4.07) | |
| | 50 - 64 | 26.87 | (3.03) | 20.21 | (2.65) | 52.92 | (4.41) | |
| | 65 + | 19.71 | (4.27) | 24.13 | (3.78) | 56.17 | (3.86) | |
| Gender | | | | | | | | 0.069 |
| | Women | 24.81 | (3.24) | 20.06 | (1.28) | 55.13 | (3.07) | |
| | Men | 34.22 | (2.53) | 11.42 | (2.50) | 54.36 | (3.13) | |
| Years of Education | | | | | | | | 0.115 |
| | Less than high school | 28.46 | (5.53) | 28.94 | (4.66) | 42.60 | (6.62) | |
| | High school or GED | 25.52 | (2.68) | 16.55 | (3.96) | 57.93 | (5.38) | |
| | Some college | 32.68 | (4.05) | 13.81 | (3.90) | 53.51 | (6.73) | |

| | | | | | | | |
|-----------------------------------|-------|--------|-------|--------|-------|---------|-------|
| College graduate | 29.11 | (4.88) | 9.72 | (3.19) | 61.17 | (4.67) | |
| Income | | | | | | | 0.110 |
| < \$25,000 | 23.01 | (4.23) | 21.14 | (3.57) | 55.86 | (3.74) | |
| \$25,000 - \$49,999 | 33.13 | (2.11) | 12.61 | (2.54) | 54.25 | (3.94) | |
| \$50,000 + | 30.70 | (5.25) | 9.97 | (3.62) | 59.33 | (5.27) | |
| Marital status | | | | | | | 0.526 |
| Married / marriage like | 30.60 | (2.69) | 11.66 | (1.94) | 57.74 | (3.48) | |
| Divorced or separated | 27.62 | (4.82) | 16.49 | (3.92) | 55.89 | (6.00) | |
| Widowed | 20.72 | (7.85) | 23.45 | (5.00) | 55.83 | (5.88) | |
| Single (never married) | 28.97 | (4.20) | 20.20 | (6.43) | 50.83 | (8.90) | |
| Overweight status | | | | | | | 0.571 |
| Normal weight | 27.80 | (3.91) | 19.17 | (5.32) | 53.03 | (4.37) | |
| Overweight | 27.62 | (5.30) | 13.39 | (2.41) | 58.99 | (4.91) | |
| Obese | 30.20 | (2.53) | 15.20 | (2.12) | 54.60 | (2.56) | |
| Smoking status | | | | | | | 0.019 |
| Current smokers | 25.18 | (8.16) | 22.77 | (5.59) | 52.06 | (11.14) | |
| Former smokers | 36.82 | (2.79) | 16.29 | (2.66) | 46.89 | (3.17) | |
| Non-smokers | 25.86 | (3.37) | 14.80 | (1.13) | 59.33 | (3.04) | |
| Health conditions (self reported) | | | | | | | |
| Diabetes | 24.22 | (2.58) | 18.81 | (2.45) | 56.97 | (3.71) | 0.351 |
| Hypertension | 25.58 | (2.22) | 18.66 | (1.36) | 55.76 | (2.22) | 0.188 |
| High cholesterol | 26.86 | (3.26) | 16.80 | (2.42) | 56.34 | (3.71) | 0.892 |

| | | | | | | | |
|------------------------|-------|---------|-------|---------|-------|---------|-------|
| Cardiovascular disease | 18.54 | (4.71) | 29.50 | (5.82) | 51.96 | (6.02) | 0.161 |
| Cancer | 37.83 | (10.08) | 16.55 | (5.67) | 45.62 | (11.26) | 0.675 |
| Self-rated health | | | | | | | 0.020 |
| Excellent | 41.03 | (11.08) | 11.32 | (4.21) | 47.65 | (8.17) | |
| Very good | 29.06 | (3.04) | 13.02 | (3.84) | 57.92 | (3.13) | |
| Good | 26.95 | (2.43) | 12.91 | (1.80) | 60.14 | (2.46) | |
| Fair | 21.38 | (3.03) | 27.91 | (4.69) | 50.71 | (5.23) | |
| Poor | 10.95 | (5.32) | 64.52 | (10.40) | 24.52 | (10.57) | |

Note: Percentages reported are row percentages (e.g., 16.25% of members in small churches are sedentary)

Figure 1. Sampling Flow Chart for the Telephone Survey



Dissemination of Physical Activity Promotion Interventions in Underserved Populations

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Abstract

Purpose: Achieving minimum physical activity levels of 30 or more minutes per day will require a variety of intervention strategies to engage each segment of an aging and increasingly ethnically diverse US population. This paper presents a focused review of the sparse literature on the diffusion of evidence-based physical activity interventions that are culturally appropriate for underserved populations.

Methods: Related literature and experiential insights inform this discussion, because so few published studies report outcome data beyond the first diffusion phase of intervention development and evaluation. Three brief case studies are presented to further illustrate and exemplify key concepts and processes at several different stages in diffusing physical activity interventions.

Results: Common considerations in approaching and engaging these disparate populations are captured in a number of the principles of community-based participatory research: relationship- and capacity-building; shared resources and decision-making; mutual benefit; cultivation of culturally salient leaders and role models; deference to community members' understanding of cultural practices and values in constructing or adapting intervention strategies; and emphasis on cultural assets and opportunities rather than deficits and barriers.

Conclusion: Successful engagement of underserved populations reflects a delicate balance between embracing group customs and values and recognizing the non-monolithic nature of any sociodemographically-defined group. The costs of failing to promulgate effective physical activity interventions in these groups continue to mount, in dollars, health and lives. Researchers, practitioners, decision makers and policy makers must partner to bridge the evidentiary gap so that the physically active lifestyle choices become the easier choices.

Introduction

The link between physical inactivity, weight gain and many common chronic conditions is now well documented.¹⁻³ Demographic shifts—such as the aging of the population and the growing ethnic diversity of Americans—have resulted in increases in the risk of inactivity-related health problems. However, we are least equipped to address these higher burdens of chronic disease among the most sedentary and understudied population segments:^{4,5} the aged, ethnic minorities, and lower income groups.

In the field of physical activity promotion, social ecological theoretical models that recognize the synergy between environmental-level change and individual-level change are increasingly recognized as having greater explanatory power than the traditionally invoked individual-level models.⁶⁻⁸ Environmental intervention is certainly indicated in ethnic minority and lower income communities, with their more substantial barriers to physical activity participation.^{9,10} Little high-quality data exist on effective and sustainable physical activity improvement from interventions targeting or including meaningful numbers of ethnic minority or lower-income individuals.¹¹ Even interventions identified as “evidence-based” and recommended by government advisory bodies have been shown to be less effective or ineffective in ethnic minority or low-income populations.¹² For example, Andersen and colleagues¹³ increased stair usage among whites in a suburban Baltimore shopping mall from 5.1% to 7.5% or 7.8%, depending upon the sign utilized; among blacks, however, stair usage changed from 4.1% to 3.4% or 5.0%. Similarly, in a random digit dial telephone survey evaluating the impact of walking trail construction and promotion in rural Missouri, Brownson et al.¹⁴ found that blacks and those of lower SES were less likely to have access to the trails and were less likely to use them if they had access. Among those using the trails, women and less formally educated individuals were more likely to report increased walking. However, significant increases in the proportion meeting CDC/ACSM recommendations were not reported and unlikely when 43% of respondents had to travel 15+ miles to reach a trail. This gap in

the literature represents a major obstacle to developing effective and cost-effective policies and programs at the national, state and local levels.¹¹

Population groups experiencing disparities in rates of sedentariness and related chronic diseases have generally been considered “hard to reach” by public health researchers because of their non-responsiveness to health promotion materials and messages targeting “general” (i.e. younger, white, urban, affluent) audiences.^{15, 16} Factors related to poor representation of these groups in medical/scientific research studies have been documented extensively and recently reviewed elsewhere.^{4, 11, 17-19}

The purpose of this paper is to present a focused review of the literature on the diffusion of evidence-based physical activity interventions culturally salient and appropriate for underrepresented populations, highlighting conceptual and methodological issues that are often underappreciated. Common considerations in approaching and engaging these disparate populations will be identified, along with population-specific challenges and concerns. To further illustrate these issues, brief case studies will be presented that elucidate various stages in the process of intervention diffusion,²⁰ including innovation development as well as issues in selecting and disseminating programs or policies with demonstrated evidence of feasibility and effectiveness. Lessons learned will be summarized, and avenues for new directions in physical activity promotion research and practice indicated.

Common Considerations across Underserved Populations

Assembling an evidence base—ecological models of physical activity promotion

The minimal evidence base for physical activity intervention efficacy in underserved populations, much less effectiveness, particularly for ecological intervention models, evokes many challenges with which scientists must grapple “in the dark.”²¹ These challenges include: identifying applicable theoretical behavior change models that may translate to more diverse populations; balancing the goal of achieving the internal validity characteristic of efficacy studies (associated with greater sample homogeneity and accessibility) with that of retaining the generalizability and exportability needed for

effectiveness and dissemination studies (associated with greater sample representativeness); and defining program success in populations that may have different priorities and resources. Although there is essentially no evidence base beyond the first (innovation development) phase of diffusion in intervening in underserved populations, valuable insights can be gleaned from related literatures (Table 1).

In order to develop effective physical activity promotion interventions in understudied and underserved populations, the conduct of research must allow group members to have input into and influence upon the content of the interventions, their evaluation and the dissemination of findings and approaches. These concepts are now most often grouped under the rubric, *community-based participatory research* (CBPR). By nature, CBPR is culturally appropriate for and congruent with the needs and values of the targeted group, since it emerges from the affected community as much as from the academic research team.^{22, 23}

By developing strong partnerships, researchers can foster the trust and mutual respect necessary for active community participation in the development and evaluation of interventions. A true partnership—shared decision-making, resources and recognition or “credit” with “cultural insider” key informants, marketing messengers, and/or investigators/research team members—creates a foundation for the institutionalization of the organizational support necessary for the sustainability of the interventions after the research is completed.²⁴ Further, such a partnership cultivates leadership by training group members in research skills and assisting them in developing collaborations that reach beyond the initial research goals. These leaders may then become catalysts for sustained health promotion efforts, as a key component of CBPR is direct intervention and/or the incorporation of research findings into community change efforts.²³

Social marketing or client-centered approaches derived from commercial marketing are consistent with many CBPR principles.²⁵ This framework takes into account individual and organizational “economic” considerations, e.g., participating in physical activity as fun, non-strenuous and enjoyable vs.

demanding, high-exertion work, promotional materials targeting employers focused on the “bottom line” in terms of improved productivity, enhanced morale (averting attrition costs such as training of new employees), and lowered rates of injury and illness (decreasing costs of absenteeism, disability) vs. “common good” messages more salient among public health professionals.

Recognition and integration of contextual factors

Effective physical activity intervention will undoubtedly involve ~~both~~ decreasing sedentary behavior and increasing moderate-to-vigorous physical activity to meet public health goals. At present, the more developed areas of environmental physical activity policy are premised on voluntary engagement for those culturally or economically situated to embrace active leisure, while monumental challenges in engaging the masses of adults have yet to be addressed.^{26, 27} In addition, early attention to intervention sustainability (potential for institutionalization) is more critical in low-resource settings with many competing health needs and priorities.^{24, 28} These challenges encompass sociocultural, physical and economic environmental barriers to physical activity participation, which differentially affect the various sociodemographic population segments,²⁹ including gender-related socialization and role expectations, age-related biases and role expectations, historical and sociopolitical contextual issues, culturally “normative” overweight status, the dominance of commercial marketing in conveying physical activity and inactivity promotion messages, and economic issues (Table 2).

While the importance of contextual factors, e.g., demand characteristics and tacit knowledge, is often verbally endorsed, specific cultural norms, values, and traditions facilitating physical activity engagement are commonly under-recognized. They represent missed opportunities for effectively intervening. Examples of such opportunities include: normative nature of movement to music among adults in African-American and Latino communities;^{30, 31} encouragement to “be strong at an early age” among Native Americans; and desirability of social engagement for seniors.

Population-Specific Considerations

The emerging research and practice evidence base for developing and disseminating effective physical activity interventions within underserved populations permits a few general observations. While this presentation is organized in terms of key sociodemographic characteristics, these characteristics are not independent, and interactions across multiple statuses (e.g., low income, female gender, minority ethnicity, aged, rural or low-resource urban residence, minority sexual orientation) may increase risk for unhealthy physical activity patterns and deleterious health outcomes.³² Furthermore, cultures are not monolithic, and individual differences and subgroup distinctions must also be recognized.³³ There is much within-group variation—such factors as language, income, educational level and acculturation can also greatly influence responsiveness to different intervention approaches, for example, cultural commonalities and distinctions between frail and elite elderly, between affluent and lower socioeconomic status African Americans or Mexican-Americans, and between rural whites in Appalachia and Native Americans residing on reservations.³² While many behavior change interventions are “targeted” to minority and other underserved population, there must be a parallel effort to “tailor” interventions to individual’s histories, beliefs and preferences in a way that is feasible and scalable to large population groups.³⁴

Approaches to particular underserved groups

Ethnic

Among African Americans, a number of cultural assets have been identified and cultivated in physical activity promotion efforts, including: the prominence of faith-based institutions and high prevalence of church involvement;^{35,36} collectivistic vs. individualistic orientation increasing the salience of positive ethnic identity, community unity, “common good” and empowerment messages;^{19,37} historical necessity, as a legacy of segregation, of community organizing across institutions and sectors to address unmet needs;²⁶ increased traction of messages emphasizing health promotion program participation as an entitlement (e.g., “your tax dollars are paying for it, so you should derive some benefit”);^{38,39} cultural

elevation of athletic excellence, resulting from limited educational and other avenues for success, with prominent African-American sports figures as inspirational role models and interested stakeholders;⁴⁰ and oral tradition in communication.³⁶

Latinos/Hispanics as a group, even less studied than African Americans, also have a number of cultural strengths that may foster the diffusion of physical activity interventions.^{11, 41, 42} Gender is an especially important consideration, as traditional female roles may govern perceptions of the appropriacy of certain activities, e.g., individual exercise as a luxury or selfishly diverting time from home and family.³⁸ Faith involvement, intergenerational activities, and linkage of group physical activity to traditional celebrations (fiestas) have been identified as key assets in physical activity promotion efforts,^{38, 43, 44} and used to advantage, in varying combinations.⁴⁵⁻⁴⁷

Each of the 512 federally recognized American Indian tribes has its own history, social and cultural patterns, and political and economic structures. However, these nations share many cultural concepts and values, including the oral tradition, intergenerational activities, and orientation to health through ceremonial ways, that may provide a foundation for physical activity promotion.³⁸ Interventions built on the recognition that scientists and educators must work in partnership with communities,⁴⁷ including teachers, parents, and school administrators as key stakeholders, are likely to be more culturally relevant and sustainable.

Extremely little physical activity promotion research has been conducted in the Asian/Pacific Islander communities, despite their lower levels of physical activity.³⁸ The major challenge for these communities is their diversity: the multiplicity of languages, insular urban geographic enclaves, and social classes and cultures encompassed. For example, in contrast to the “model minority” stereotype⁴⁶ engendered by the economic successes and superior health status of acculturated third and fourth generation Chinese and Japanese Americans, Southeast Asians remain largely poor, linguistically isolated and lacking in formal education.⁴⁵ Pacific Islanders have a very high prevalence of obesity often masked

by the low rates for Asian Americans as a whole.⁴⁸ Further, there is early evidence that chronic disease morbidity increases begin at lower, even non-overweight, BMIs among certain Asian subgroups.⁴⁹ The few published interventions targeting these populations⁴⁵ build on such cultural assets as collectivist values, intergenerational living, reverence for elders, a tradition of group physical activity participation, especially dance and martial arts (e.g., early morning tai chi in parks), and strong business support.

Age

Given the public health recommendations for being physically active at all ages, it is important to take a life-course perspective in promoting physical activity.^{17,50} While there are some similarities across all ages, e.g., the importance of access to safe and appealing physical environments, there are also unique opportunities and challenges for each age segment of the population.

Children and youth. Physical activity promotion efforts among children and adolescents have primarily centered on their availability as captive audiences in schools, with infrastructures dictated by state and local policies.^{51,52} In fact, a major focus of state obesity control legislative policy has been the promotion of school-based physical education, though to a lesser extent than the policy focus on restricting access to nutrient-poor foods and increasing availability of nutrient-dense foods.⁵¹ This school focus is particularly appropriate for youth in low-resource environments, in which extracurricular recreational opportunities are limited.⁹

Promoting physical activity throughout the day in school and school-related activities, outside of formal physical education instruction, is also receiving increased attention, e.g., policies mandating recess periods of certain durations. One promising approach, *Take 10!*, aims at increasing physical activity levels among schoolchildren by integrating 10-minute exercise breaks into the regular curriculum. The program trains non-physical education teachers in conducting these breaks. Earlier studies of *Take 10!* have demonstrated the feasibility and utility of this approach in regularly engaging students and teachers in exercise of sufficient length and intensity to count toward the minimum 30-minute per day CDC daily

recommendation.⁵²⁻⁵⁴ In the current NIH-funded randomized controlled trial of this intervention, the gradual increase in the number of teachers engaged each year and the number of minutes provided (>50% achieving the 90-100 minute/wk goal) is evidence of promulgation of a sociocultural norm change.

Older adults and disabled populations. Older Americans are among the most sedentary population segment, with ethnic minority elders doubly disadvantaged.⁵⁵ There are several promising trends in spurring further development and dissemination of best practices for promoting physical activity in older adults, including engagement across multiple societal sectors and industries. For example, the Administration on Aging has funded a Prevention Research Center at the National Council on Aging to coordinate the dissemination of evidence-based research within the aging services network, and launch a public media campaign.⁵⁶ Similarly, both non-profit foundations and for-profit corporations in the private sector have recently begun supporting active aging programs.⁵⁷ More than 50 organizations have coalesced to set a programmatic and policy agenda to reduce barriers to physical activity in the home, community, health care environment, and workplace, including endorsement and distribution of a set of best practices.⁵⁸

Age-related disability necessitates tailoring of active programming to the individual's capacities and limitations, including prudent injury and risk management guidance. The CDC-supported National Center on Physical Activity and Disability is a clearinghouse for materials providing guidance in designing appropriate physical activity experiences for individuals with a wide range of disabling conditions.

Other underserved/understudied populations, e.g., sexual minority women

Lesbians and bisexual women have been documented to be less sedentary than their heterosexual counterparts in some studies, despite their higher overweight rates.⁵⁹ Perhaps one barrier to recognition of the increased need for physical activity programming in this population is the stereotype of lesbians as athletically inclined and physically fit, with their higher overweight prevalence reflecting greater

muscularity than their heterosexual counterparts. Yancey and colleagues,⁶⁰ however, demonstrated that levels of physical inactivity and obesity among lesbians and bisexual women in a large California snowball sample were inconsistent with this stereotype: sexual minority women were less likely to have BMIs between 25-29.9 kg/m² than heterosexual women and reported lower exercise frequency. Intervention research targeting this population is essentially absent from the scientific literature.

Case Studies

In order to provide a more complete illustration of efforts to implement physical activity recommendations in underserved populations, we present the following case studies: *Lift Off/Take 10!/Pausa para tu Salud*, *Participatory Action for Healthy Lifestyle*, and *Active for Life*. Each represents a different phase in the diffusion of innovations process, setting, diffusion route, and target population, as detailed below.

Lift Off/Take 10!/Pausa para tu Salud: innovation development (1st phase of diffusion)

Research question. This case study addresses the challenge of designing low-cost, efficacious interventions for sedentary minority populations in low-resource environments. The development of structured ten-minute exercise breaks integrated into organizational routine, operationalizing the multiple short daily bouts endorsed in the federally recast physical activity recommendations, occurred independently by several researchers/practitioners in public and private sector public health practice settings outside of academia. This “minimal intensity” environmental intervention approach paralleled such tobacco control organizational practice changes as banning smoking from certain locations. Its pragmatism was informed by each practitioners’ understanding of the barriers (e.g., lack of recreational/physical education facilities, outdoor safety concerns, high obesity rates and low fitness levels deterring participation in physical activities necessitating substantial exertion and perspiration) and facilitators (e.g., collectivist values, cultural salience of dance and music, strong desire for social engagement and conformity) in predominantly African-American and Latino communities.^{12, 26, 35, 52, 54, 61-}

⁶³ The high rates of sedentariness in these communities demand an intervention approach that could engage unfit/overweight individuals at early stages in the activity behavior change continuum, while accommodating others with a range of fitness levels, athleticism, and functional abilities.

Lessons learned: feasibility and efficacy testing. The burgeoning evidence base for the rationale, feasibility and/or efficacy of organizational integration of experiential physical activity, though early in stage, includes at least 12 studies published or in press in peer-reviewed journals,^{12, 26, 35, 52, 54, 61, 64-67} one submitted⁵³ and one in preparation.⁶⁸ Feasibility-related outcomes for the *Take 10!* intervention in schools were described earlier. Regarding the acceptability to adults of incorporating exercise breaks into worksites and other organizations, more than 90% of workers elected to participate in these breaks during a randomized, controlled trial conducted in staff meetings and training seminars in a local health department.¹² Yancey and colleagues,²⁶ Crawford and colleagues,⁶¹ and Wilcox and colleagues³⁵ have also demonstrated substantial organizational receptivity to and success in integrating 10-minute exercise breaks into daily routines in community-based health and social services organizations serving African Americans and/or Latinos in California and South Carolina. Small but statistically significant and “clinically” meaningful effects on self-reported physical activity,⁶³ one or more components of fitness including body composition,^{62, 64, 67} psychological variables^{12, 53} and physiological outcomes^{62, 64} have also been reported.

Next steps. The second generation of this approach includes the incorporation of this short exercise bout intervention into formal research studies with rigorous designs, as either a central feature (NIH-funded, University of Kansas)⁶⁹ or as one component of a broader-based organizational wellness intervention (CDC-funded, Community Health Councils, Inc.; CDC-funded, University of South Carolina; and NIH-funded, Wake Forest University). This represents a concrete example of a response to the assertion that in order to succeed in implementing more “evidence-based practice,” more practice-based evidence (testing of interventions arising in practice settings, and, hence, inherently more generalizable) is needed.⁷⁰

Participatory Action for Healthy Lifestyle: development & dissemination (1st & 2nd phases)

Research question. In response to growing concerns about the rapid increases in obesity and diabetes among American Indians, *Pathways*, a unique collaboration among the NIH, five universities, and seven American Indian tribes was developed to test theory-based, culturally targeted school interventions. A number of indigenous learning modes were identified and incorporated into the *Pathways* intervention.⁷¹⁻⁷³ This was accomplished by designing experiential activities and presenting concepts through storytelling, games, and other creative expression. Historical and cultural sharing, built on native traditions of healthful eating and active lifestyles, were integrated throughout the curricula to reinforce students' cultural identity.

Lessons learned. Upon *Pathways* study completion, one of the participating communities, along with researchers at the University of New Mexico, initiated the Participatory Action for Healthy Lifestyles (PAHL) project to prospectively investigate intervention dissemination. Groups from three sectors participated—a local community, a state health department, and a regional site in a nearby state. Key elements of CBPR are followed and partners from each of the sectors are involved in the process of examining the facilitators and barriers to dissemination. Preliminary data, including field notes, interviews, and meeting minutes, indicate the presence of some of the same challenges identified during intervention development. These include staff turnover, competing priorities, and lack of resources. Facilitators include involving a program champion, timing project activities to match the local agenda, and addressing needs held in common.

Next steps. Findings may be used to inform large-scale dissemination studies in other American Indian communities, and studies examining the next phases of diffusion, adoption, implementation and maintenance in the currently targeted PAHL communities.

Active for Life: adoption/adaptation & implementation (3^d-4th phases)

Research question. *Active for Life*® was designed to export two evidence-based lifestyle change programs (Active Choices and Active Living Everyday) to more diverse settings, providing structured social marketing support and independently evaluating effectiveness at both the individual and organizational levels. The primary goals of this Robert Wood Johnson Foundation-funded initiative were: to learn the ways in which the selected program models must be adapted to be acceptable to community organizations and intended constituents (“real world settings”); to determine whether the adaptation is consistent with the core elements of the original program; to ascertain the comparability of the effect size achieved to that of the original efficacy studies; to assess site characteristics associated with program success and long-term sustainability; and to examine environmental factors facilitating or impeding individuals’ attainment of their physical activity goals.^{71, 72, 74} The specific research plan calls for enrolling a diverse sample of more than 8000 adults, aged 50 years and older, distributed among nine grantee sites across the US.

Lessons learned: Results based on 838 participants enrolled in the pilot study⁷⁵ demonstrate that evidence-based research can be successfully implemented in larger, more varied, and more sociodemographically diverse settings. Initial study successes⁷⁵ include increases in moderate to vigorous physical activity, decreases in depressive symptoms and stress, increases in satisfaction with body appearance and function, and decreases in body mass index, with the magnitude of outcome change similar to those reported in more controlled efficacy trials.

While definitive results from this program initiative are not yet available, many lessons about program expansion to these settings have already emerged. The initial pilot study has demonstrated that community-based organizations are motivated to improve the physical activity levels of their clients and can implement evidence-based protocols with extensive technical assistance (not typically available in a third generation dissemination study). This was possible, in part, because community organizations—not

academic researchers—were the source of recruitment and program delivery. Few difficulties were encountered, despite the many different recruitment strategies employed, and the requirement that organizations with traditionally middle-class constituencies specifically target the underserved.^{50, 76}

Early experiences with program adoption/adaptation suggest that community providers do not necessarily want to throw out “the baby with bath water” but want to be sure that evidence-based programs are responsive to their clients’ educational levels and cultural preferences. Recommended adaptations have been at the margins rather than core or sweeping programmatic changes. Fitting into organizational missions is another important factor, causing some organizations to suggest changing population targets in future iterations or combining lifestyle programs with ongoing activities.

~~Next steps.~~ Assessment tools are needed that assist community organizations in identifying who they are actually reaching, and in extending to those who have not previously responded but may significantly benefit. Attention to cultural sensitivities, linguistic competencies, and opportunities for feedback to both providers and consumers is also a critical next step. The intent is to avoid approaches that result in productive yields, but do not push programs beyond engaging their current clientele.

Synthesis of Lessons Learned and Implications for Future Directions

Whether defined by ethnic minority status, age, or place, there are similarities in successful intervention approaches in underserved populations. To the extent possible, physical activity interventions should be built into the philosophies and cultural practices of the communities targeted. Proposed interventions must be part of a seamless web of ongoing community rituals and practices that **incrementally** and unintrusively mold norms and values (e.g., recognizing that many of these cultures hold more collectivistic than individualistic cultural orientation). As a corollary to this collectivist cultural orientation, instead of engaging different age groups separately, promoting intergenerational intervention approaches, where both young and old can help and be helped by one another will likely meet with greater success. This will undoubtedly require an infrastructure investment, if only in

relationship building, which cultivates community capacity and culturally salient leadership and role modeling. Respect for the dignity and preferences of potential program participants or those affected by policy initiatives is key. Therefore, the importance of highlighting assets rather than deficits cannot be over-emphasized. Providing a menu of choices to make programs more adaptable and flexible in accommodating real world circumstances is another key ingredient of success.⁷⁷

Behavioral scientists and program developers must also recognize and accommodate the ways in which interventions are implemented in field settings that depart significantly from the tightly theory-driven interventions that were originally designed. A critical question is how much and what type of adaptation can and should be made, while retaining essential components. There is always a delicate balance between fidelity and adaptation/reinvention to fit particular settings.⁷⁸ Communities must be encouraged and empowered to inform researchers about what works and doesn't work in their settings, and have their recommendations meaningfully incorporated. Evaluating an unacceptable intervention is not really a good test of program reach and effectiveness. A comprehensive process evaluation may be critical in capturing detailed descriptions of these adaptations, the rationale for the adaptations, and their influence on outcomes.

Enormous challenges await both researchers and practitioners in working to develop, test, and further disseminate innovative evidence-based physical activity programs that meet the needs of the most sedentary Americans. Yet the cost to society of “business as usual” is also enormous, in dollars, health and lives. This is not simply a “minority health” issue—the costs associated with insufficiently effective or comprehensive physical activity promotion policy and programmatic approaches will accrue to all Americans. Researchers, practitioners, decision makers and policy makers must partner to bridge the evidentiary gap in realizing a central tenet of health promotion, making the physically active choice the easier choice.

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Table 1. Topics for examination utilizing relevant scientific and program literature.

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| Recruitment to studies and programs |
| Retention in studies and programs |
| Social marketing of public health messages |
| Cultural targeting of intervention approaches |
| Intervention sustainability—adherence and effects |
| Cultural adaptation of interventions developed for “mainstream” (white affluent) populations |
| Culturally grounded intervention design and development, i.e. that originating within the cultural context —values, norms, resources—of the targeted population |
| Intervention generalizability/exportability |

Table 2. Barriers to physical activity participation in the aging and increasingly ethnically diverse,

US population

| Potential Barrier | Ethnic Group(s) Affected | Examples of Specific Deterrents |
|------------------------------|-------------------------------------|---|
| Gender-related socialization | All | Adolescent girls' primary deterrent to PA is not wanting to disturb hair & make-up |
| | | Most girls and women prefer dancing and non-competitive social physical activities to sports and other competitive physical games ⁷⁹ |
| | | Many younger women prefer apparel intended to enhance aesthetic appeal at the expense of comfort, e.g., close-fitting skirts and high-heeled shoes, not conducive to lifestyle integration of PA |
| | | Middle-aged and older women may not perceive "sweating" as appropriate to their gender/class role ("ladylike") |
| | | Elderly women may discourage girls' vigorous exercise, fearing that certain types of PA, e.g., horseback riding will rupture girls' hymens, thereby adversely affecting their marital prospects. ^{41, 80-82} |
| Age expectations and biases | All | Especially at the ends of the age spectrum, exercise may be discouraged because of role expectations about what is appropriate for individuals at different ages |
| | | Parents may be concerned that walking or bike riding is not safe for their children, especially girls |
| | | Schools emphasize academic subjects at the expense of physical education |

| | | |
|------------------------------------|---|--|
| | | Older adults, or their younger relatives, may fear injury in initiating a new physical activity, or society simply promulgates the attitude that seniors “deserve a rest”. ^{17, 80, 83} |
| Communicating PA messages | All | Dominated by commercial media advertising of sports/ fitness equipment and rigorous gym workouts, featuring muscular men and sleek-bodied white women in affluent-appearing surroundings may erode self-efficacy and decrease the likelihood that “exerciser” status will be incorporated into older/overweight individuals’ personal identity |
| | | Little fitness-promoting venues/equipment advertised and preponderance of promotion of sedentary transportation and entertainment (Williams, 2005; Yancey, SBM, 2006) ⁸⁴ |
| | | Public health messages (research and practice) reflecting more conflict than consensus, leaving impression that only amounts meeting recommendations are beneficial ⁸⁵⁻⁸⁸ |
| Economic trends and constraints | All | Increased prevalence of single parent or two-wage earning parent families in lower SES groups, diverting potential available leisure time to extended paid work or household responsibilities |
| | | Labor-saving devices at or outside of home (remote controls, leaf blowers, riding lawn mowers, mechanized car washes) increasingly affordable |
| | | Inconvenient and/or incomplete mass transit options ^{86, 88, 89} |
| Sociopolitical/ historical context | African Americans and, possibly, Latinos, Native Americans, some Asian American subgroups | Forced labor, necessity for manual labor for survival, deprivation/poverty necessitating walking inordinately long distances (e.g., inability to afford private transportation), even if generations removed, colors cultural attitudes, resulting in active avoidance of PA or lesser prioritization ⁹⁰ |

| | | |
|----------------------------------|--|---|
| <p>Weight and fitness levels</p> | <p>African Americans, Latinos, Native Americans, Pacific Islanders</p> | <p>Higher prevalence of overweight/obesity, sedentary behavior, low fitness levels and chronic illness/disability:</p> <p>(1) increase perceived exertion at any given level of PA for heavier/unfit vs. leaner/fit individuals deters more vigorous energy expenditure, e.g., stair climbing;</p> <p>(2) necessitate incremental change approaches from realistic baselines^{91, 92} and passive behavior change strategies that engage captive audiences, relying less on individual motivation; and</p> <p>(3) create misperceptions, particularly among youth, that obesity is normative, genetically predetermined and unavoidable, except among Asian Americans and white women.^{93, 94}</p> |
|----------------------------------|--|---|

Appendix C