

# An Assessment of Health Needs in African-American Churches in Omaha, Nebraska



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# Executive Summary

In 2015, there were 88,195 African Americans in Nebraska, representing 4.7% of the state population. Despite their modest share in the state population, African Americans in Nebraska bear a disproportionate burden of diseases. Among major racial and ethnic groups in Nebraska, African Americans have the highest rates of infant mortality and mortality caused by heart disease, stroke, HIV/AIDS, cancer, and homicide.

Churches and faith-based organizations have been an essential component of community life for many African Americans and are important platforms for health promotion. So far there has been limited documentation of health programs in African American churches in Nebraska and the extent to which these programs have helped address health disparities.

The purpose of this study was to (1) assess unmet health needs among African American church members in Omaha; (2) identify existing health services provided by the churches; and (3) help churches in African American communities make informed decisions about initiating or enhancing health programs based on the health needs of congregation members, their expressed preferences, and extant health programs.

To meet the goals of this study, we adopted a mixed-method approach in our data collection and analysis. In summer 2017, with the support from our community partners and participating churches, we conducted a survey to collect data from 411 participants from the African American churches in Omaha, Nebraska. Additionally, we had face-to-face interviews with eight pastors from these churches to get their perspectives on unmet health needs in their congregations.

## HIGHLIGHTS OF FINDINGS

- Out of the 411 participants, 388 or about 95% were African Americans. Seventy percent of the participants were female and the average age was 59 years. Over 47% of the participants were working full time and 34% were retired. Close to 28% reported an annual income of less than \$25,000. About 5% of the participants reported no health insurance coverage.
- The most commonly reported chronic conditions included hypertension (60%), allergies (41%), arthritis (36%), high cholesterol (35%), and diabetes (28%). During the interviews with the pastors, they expressed concerns over the high prevalence of hypertension, diabetes, and obesity in their congregations.
- Of particular concern was the observation that many participants were not aware of their overweight/obesity status. Based on self-reported body weight and height, about 84% of the participants were either overweight or obese; however, only 37% of the participants reported that they were diagnosed with overweight or obesity.

- Approximately 12% of the participants reported they received a previous diagnosis for some type of mental health conditions. However, when the participants were asked about their emotional wellbeing during the past two weeks before the survey, about 30% reported that they felt down, depressed, or hopeless for at least some of the days. Pastors echoed these results by singling out behavioral and mental health as pressing issues in their communities. Pastors were also concerned about the stigma associated with mental health as a barrier for many people to seek professional help for their emotional problems.
- Citing financial cost as a barrier, 17% of the participants reported they delayed seeing healthcare providers during the 12 months prior to the survey and 16% postponed buying medications during the same period.
- Participating churches offered a series of health programs including educational classes on physical activities, fitness, nutrition, blood pressure and diabetes screening, and cancer screening and awareness. Pastors explained how lack of participation and retention in these programs became an issue.
- Many participants in the survey would like to have their churches provide screenings for hypertension, diabetes, cholesterol, mental health, as well as support groups focusing on grief and loss, weight control, elderly concern, marriage and relationship counselling, and caregiver support.

## RECOMMENDATIONS

Based on the findings from the survey and interviews with the pastors, we suggest that churches in the African American communities, local health care providers, policy makers, medical academia, and other stakeholders work together to:

1. Develop and support church-based health programs as an integral component of community health in African American communities;
2. Increase program effort in hypertension prevention and control, the awareness and screening of obesity, diabetes, cholesterol, and mental health in African American faith communities;
3. Organize support groups on grief and loss, weight control, elderly concern, marriage and relationships, behavioral health, and provide inter-church collaborations in these areas if needed;
4. Develop and implement evidence-based strategies to enhance program participation, retention, and sustainability of church-based health programs;
5. Determine key partners necessary to assist in the development of specific health-enhancing strategies for implementation in a particular church;
6. Increase service capacity, affordability, schedule flexibility of local health care providers and establish collaborative referrals across care providers in the region to facilitate health care access for African American faith communities.





# Introduction

Health disparities disproportionately affect racial and ethnic minority populations in the U.S., with African Americans receiving the highest burden of illness (Healthy People 2020, 2017). Compared to non-Hispanic Whites, African Americans experience significantly higher rates of chronic diseases such as cancer, diabetes, cardiovascular disease, hypertension, and strokes (Bopp et al., 2007). Approximately 18.7% of African Americans have diabetes (diagnosed or undiagnosed), compared to 7.1% of Whites (Boltri & Davis-Smith, 2011). Among African Americans of ages 20 and older, 42.4% of men and 44% of women are hypertensive, which are the highest rates among all racial and ethnic groups in the U.S. (National Center for Health Statistics, 2016).

Similar health disparities can also be observed in the State of Nebraska. In 2015, there were 88,195 African Americans in Nebraska, representing 4.7% of the state population (U.S. Census Bureau, 2017). Despite their modest share in the state population, African Americans in Nebraska bear a disproportionate burden of diseases. Among major racial and ethnic groups in Nebraska, African Americans have the highest rates of infant mortality and mortality caused by heart disease, stroke, HIV/AIDS, cancer, and homicide (Nebraska DHHS, 2015a).

One of the fundamental drivers of these disparities is poverty. The median household income for African Americans in Nebraska is \$27,132, which is almost half of the median household income of Whites (\$52,683). About one third of African Americans in Nebraska live below the federal poverty line as compared to 9.5% among Whites (Nebraska DHHS, 2015b). Such a high rate of poverty among African Americans is concerning in light of the established associations between poverty and poor health outcomes (Brender, Maantay, & Chakraborty, 2011). Poverty has made it difficult for many African Americans to access health care, leading to a higher rate of visiting emergency rooms for needed care as compared to Whites (CDC, 2013; Cheatham et al., 2008). African American families are more likely to report less financial resources to pay for medical and dental care, as well as prescription drug services compared to Whites (Cheatham, Barksdale, & Rodgers, 2008).

In light of persistent health disparities and unmet health needs in African American communities, a growing number of churches have strived to address these issues through a host of health programs (Francis & Liverpool, 2009). Some of these health programs include health education, weight loss, smoking cessation, nutritional guidance, and mental health care (Bielefeld & Cleveland, 2013). Evaluations of these programs have shown that high levels of involvement with the community are associated with lower prevalence of hypertension, depression, drug and alcohol abuse, suicide, and criminal activity among their adult members. Additionally, increased levels of well-being, hope, meaning of life, and educational attainment have also been observed as a result of church-based health promotion programs (Hope, 2002).

African American faith communities in Omaha have long provided health services to their congregation members. So far there has been rather limited effort in documenting these services and assessing the extent to which they have helped address unmet health needs among African American church goers. This report summarizes the findings from a recent health needs assessment conducted in these churches.

# Objective

The purpose of this study was to (1) assess unmet health needs among African American church members in Omaha; (2) identify existing health services provided by the churches; and (3) help churches in African American communities make informed decisions about initiating or enhancing health programs based on the health needs of congregation members, their expressed preferences, extant programs and partnerships.

# Methods

This study was made possible through a partnership between African American faith communities in Omaha and the Center for Reducing Health Disparities at the College of Public Health, University of Nebraska Medical Center (UNMC). Eight churches and their congregation members participated in the study. The study was approved by the Institutional Review Board at UNMC in June 2017 (IRB Number: 335-17-EX).

We adopted a mixed-method approach in our data collection and analysis. In summer 2017, with the support from the eight participating churches, we conducted a survey to collect data from 411 church members by distributing and collecting survey questionnaires at events hosted by the churches. Additionally, we conducted face-to-face, semi-structured interviews with eight pastors from participating churches to get their perspectives on health needs, as well as existing health programs in their congregations. The survey instruments used in this study were developed and finalized based on discussions between the study team at UNMC and community partners.

Church members who expressed interest in participating in the study were given a consent form, which stated the purpose of the study and a confidentiality statement. With their informed consent, participants then completed the survey questionnaires onsite and returned them to the UNMC research personnel that was present. With the permission of participating pastors, we audio recorded the interviews with them and also took notes to avoid missing any important details that were shared during the interviews. Quantitative data from the survey were entered and analyzed using IBM SPSS Version 23.0 software for Windows. Qualitative data based on interviews with pastors were first transcribed before they were analyzed using NVivo 11 software.



# Results

## DEMOGRAPHICS AND SOCIOECONOMIC STATUS OF THE STUDY PARTICIPANTS

About 70% of the survey participants were female and over 95% were African-Americans. The average age was approximately 59 years.

**Table 1. Demographics of Study Participants (n=411)**

VARIABLES	N	%
<b>Gender</b>		
Male	122	29.9
Female	286	70.1
<b>Age Group</b>		
19-35	35	8.8
36-50	71	17.8
51-65	151	37.9
65+	141	35.4
<b>Race</b>		
African-American/Black	388	95.6
Caucasian/White	7	1.7
Other	11	2.7
<b>Ethnicity</b>		
Non-Hispanic	399	99.3
Hispanic/Latino	2	0.7

Table 2 displays the socioeconomic status of the participants. In terms of educational attainment, close to 39% of the participants had some college education and about 40% had a bachelor or higher degree. Over a quarter (27.5%) of the participants had an annual income of less than \$25,000. Nearly 48% of the participants were employed full-time, 34.4% were retired, and about 8% were unemployed. Approximately half of the participants were married. Almost all the respondents had telephone access or owned a cell phone, and 89% had access to the internet.

**Table 2. Socioeconomic Status of Study Participants (n=411)**

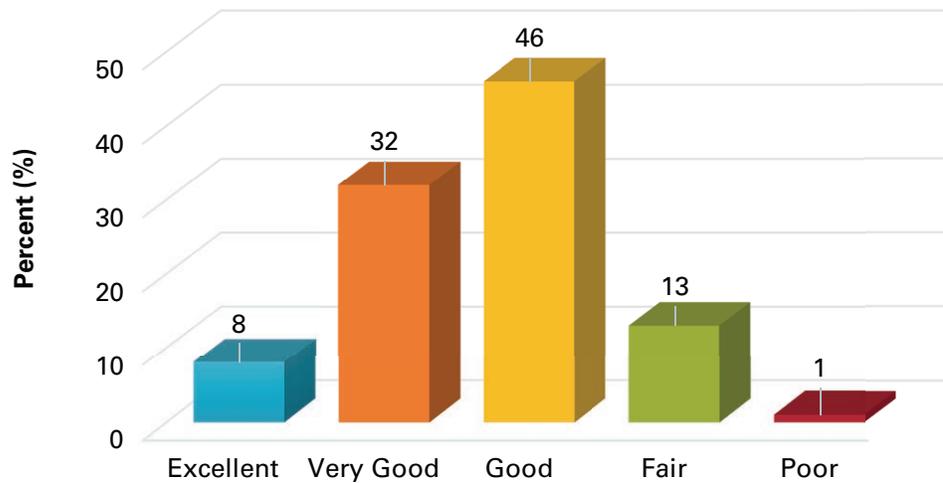
VARIABLES	N	%
<b>Education</b>		
Never Attended School	1	0.2
Grade 1-8 (Elementary)	2	0.5
Grade 9-12 (Some High School)	23	5.6
High School Graduate	59	14.5
1-3 Years of College or Technical School	158	38.7
Four or More Years of College	99	24.3
Master's Degree	43	10.5
Professional Degree (MD, JD, PhD, etc.)	23	5.6
<b>Employment Status</b>		
Full-time	194	47.7
Part-time	41	10.1
Retired	140	34.4
Unemployed	32	7.9
<b>Individual Annual Income</b>		
Less Than \$10,000	40	10.3
\$10,000-\$24,999	67	17.2
\$25,000-\$49,999	140	35.9
\$50,000-\$74,999	69	17.7
\$75,000-\$100,000	48	12.3
More than \$100,000	26	6.7
<b>Marital Status</b>		
Married	201	49.3
Partnered	12	2.9
Widowed/Widower	48	11.8
Divorced	71	17.4
Legally Separated	3	0.7
Single/Never Married	73	17.9
<b>Home Ownership</b>		
Own	263	64.6
Rent	119	29.2
Other Arrangements	23	5.7
Don't know/Not sure	2	0.5
<b>Telephone Access</b>		
Yes	404	98.8
No	5	1.2
<b>Internet Access</b>		
Yes	361	88.7
No	46	11.3
<b>Own Cell Phone</b>		
Yes	394	95.9
No	17	4.1



## HEALTH CONDITIONS

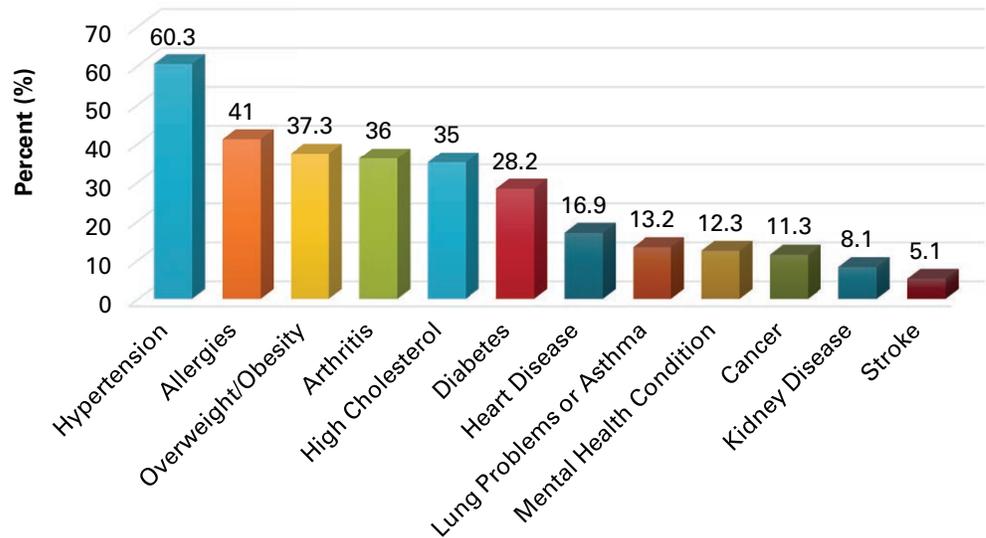
Regarding overall health status, 8% of the participants rated their health as 'Excellent', 32% as 'Very Good', 46% as 'Good', and 13% as 'Fair' (Figure 1).

**Figure 1. Self-Rated Health Status**



Participants were asked if they had been diagnosed with certain chronic diseases. Figure 2 shows the self-reported chronic conditions. The most frequently reported conditions were hypertension (60.3%), followed by allergies (41%), overweight/obesity (37.3%), arthritis (36.0%), high cholesterol (35%), and diabetes (28.2%).

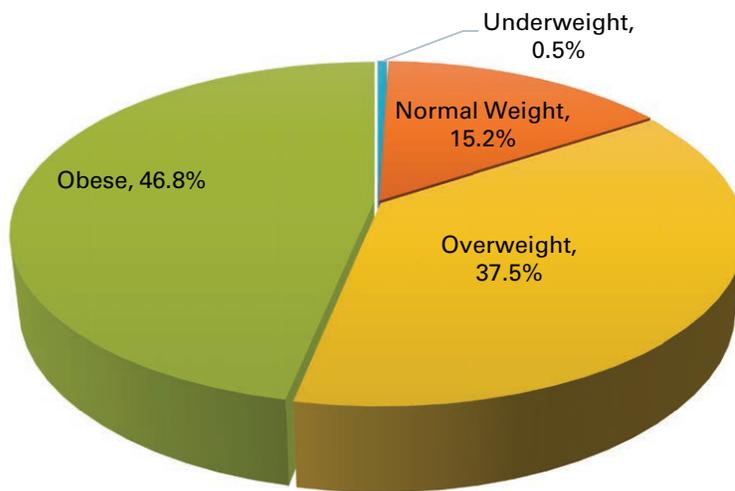
**Figure 2. Self-reported Chronic Conditions**



## OVERWEIGHT AND OBESITY

Body mass index (BMI) was calculated based on the reported body height and weight of participants. The mean BMI was 31.1. As shown in Figure 3, close to 47% of the participants were obese and over 84% of the participants were either overweight or obese based on the prevailing classification standard of BMI.

**Figure 3. BMI Status of the Participants Based on Self-Reported Height & Weight**



During the interviews with the pastors, when they were asked to identify unmet health needs in their congregation, most of them agreed that hypertension, diabetes, and obesity are common and pressing health issues in their congregations. For example, some of the pastors said the following:

*"...the issue of obesity and lack of exercise is another... so that would be an issue, obesity and lack of exercise. Of course, on the tail end of that, you know without exercise and without healthy eating, diabetes is a serious issue in our church and our community as a whole, so I would say that would be, you know, one of the top issues..."*

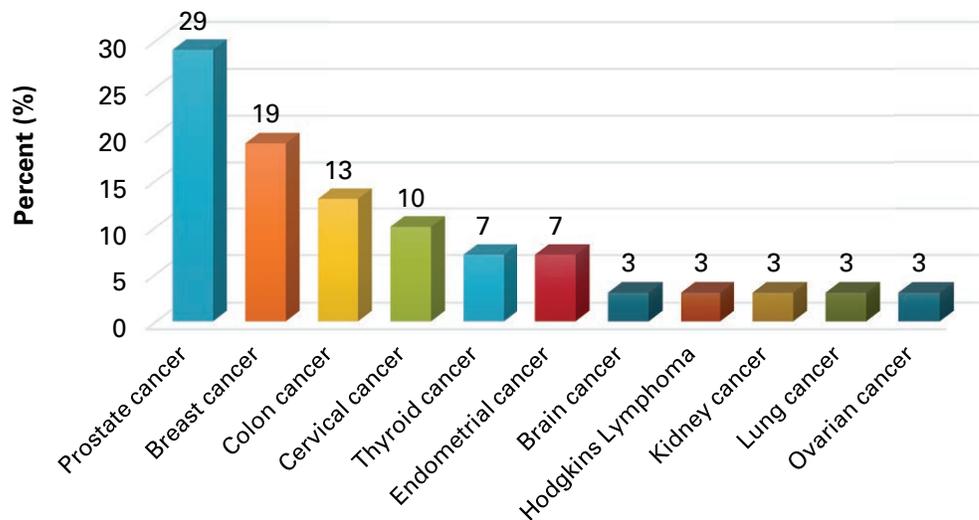
*"Diabetes, cholesterol, blood pressures, those types things are the main concerns..."*



## CANCER

Approximately 11% of the respondents had been diagnosed with cancer. Out of all the participants with cancer, 29% had prostate cancer, 19% had breast cancer, and approximately 13% had colon cancer. Males had almost twice the rate of being diagnosed with cancer as compared to females (17.5% versus 8.8%). Figure 4 shows the percentage distribution of different types of cancer among the participants who reported cancer diagnoses.

**Figure 4. Types of Cancer among Participants Diagnosed with Cancer**



Several pastors expressed their concerns over the threat posed by cancer in their congregations.

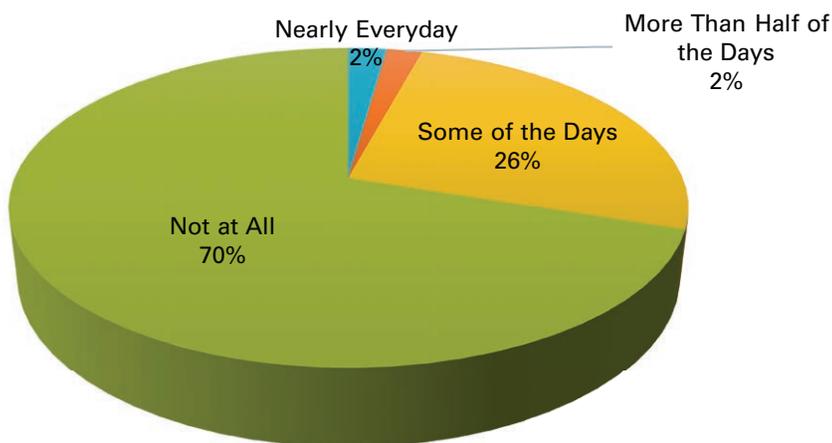
*"...for whatever reason, most of... some of our older members who have passed on have been tied to colon cancer..."*

*"I'm concerned about the increasing number breast cancer in the African American community, and prostate cancer..."*

## MENTAL HEALTH

Over 12% of the participants reported that they had been previously diagnosed with a mental health condition. As indicated by Figure 5, about 30% of the participants indicated that they felt down, depressed, or hopeless for at least some of the days during the past two weeks.

**Figure 5. Frequency of Feeling Down, Depressed, or Hopeless**



Several pastors believed that mental health conditions and stress were areas that are not being addressed and where people needed more awareness and education.

*"I think one area that we have not dealt with is mental health. We haven't dealt much with mental health, and we see that as an increasing issue in our community in general, so I think that's something that we'll be doing more with in the future. I don't know exactly what it will look like, but several of our members have expressed concern that we do something in that area."*

*"...the one health need that I would like to see more is behavioral health or mental health and we're still trying to figure that one out as a society what those needs are and whether or not in the African American community, that we would acknowledge that we need help, so that will be a concern."*

The stigma associated with mental health and not considering mental health as a priority has hampered efforts in addressing mental health issues in African American communities, as indicated by the following comments from pastors.

*"There is stigma of dealing with mental health issues. There are some people who believe mental health issues are really spiritual issues and they attempt to use the tools of theology to address mental health. And so typically in the African American community, we have assumed that if someone was seeking mental health, it meant that they were unstable, that they were dangerous, and that they were crazy, in quotation marks. And there's still, in 2017, still a stigma associated with mental health issues..."*

*"I would say that mental health issues probably exist... That probably exists, and people are more reserved about talking about that over against about weight and health..."*



## BARRIERS TO HEALTH CARE ACCESS AND UTILIZATION

Ninety-five percent of the participants had some form of health insurance coverage; however, cost was still a barrier to health care access. Over 17% of the participants reported that they delayed seeing a health care provider during the 12 months prior to the survey and 16.3% postponed buying medications during the same period. About 8% of the participants mentioned that they had to cut their medication by half due to cost (Table 3).

**Table 3. Cost as a Barrier to Health Care Access in the Past 12 Months (n=411)**

VARIABLES	N	%
<b>Delayed seeing Healthcare Providers due to cost</b>		
Yes	70	17.1
No	331	80.7
Did not need to see a Provider	9	2.2
<b>Postponed buying medication due to cost</b>		
Yes	67	16.3
No	336	81.8
Did not need to buy medication	8	1.9
<b>Cut medication in half due to cost</b>		
Yes	37	8.3
No	375	91.7

Consistent with feedback from congregation members, pastors cited cost as an important barrier to accessing health care and healthy food.

*"...although we have some fairly affluent persons in our congregation, we also have those who struggle financially, so access to healthcare would be the number one issue..."*

*"...economics, being able to pay but then the fear of what if something happens to me and I'll have to go to the hospital and who's going to do this so it's a whole lot... there's an economic tie into health as well. And so, some people, in order to maintain the economics, "Well, I'll just do the best I can and I'll suffer through it," which may be the most detrimental thing you could do..."*

*"Healthy food choices cost. There's an associated cost with that. And then getting people acclimated to eat healthier choice foods..."*

## CURRENT HEALTH PROGRAMS AND SERVICES OFFERED BY PARTICIPATING CHURCHES

Approximately 80% of the participants said that they were aware of health programs offered by their church and out of those participants, 72% said that they had participated in those programs. The programs commonly offered by the churches included exercise classes, nutrition classes, fitness classes, blood pressure and diabetes screening, cancer screening and awareness, health fairs, and walking clubs.

In the interviews with the pastors, they were asked what health-related programs and services were offered by their churches. All the pastors mentioned that their churches offered several health programs for their congregation members. Various health topics were discussed in these programs such as diabetes awareness, weight loss education, hypertension, and STD awareness programs. Several pastors mentioned that they followed the national health topic for the month and provided information to people regarding that topic in that month. The churches also collaborated with different organizations where experts came and presented on various health topics.

*"The Health and Wellness Ministry has sponsored Healthy Temple Seminars... We've had persons present on various topics: diabetes, weight-loss, preparing healthy foods, preparing healthy meals, dealing with hypertension..."*

*"...our health ministry does the calendar, monthly...health awareness topics... They did drug and alcohol topics, facts for teens...drugs and alcohol facts for teens...They did colon cancer awareness. And then each individual month, there was awareness like for...May was stroke awareness, June was men's health awareness..."*

Several churches also have exercise classes, including Zumba and line-dancing. Some have weekly classes while some have classes twice a week. Most of the churches advocate and promote walking, and some have set up walking trails either outside or inside their churches. All the pastors that we interviewed mentioned that they were partnering with Creighton University on the REACH program (Racial and Ethnic Approaches to Community Health) which promotes exercise and physical activity in the African American communities in Omaha.

*"...we are part of a REACH program...So, we have signs throughout the church that encourage people to use the steps instead of taking the elevator..."*

*"...we started a walking club. We use to walk outside. Now the walking club pathways are to health, we walk inside...So on Saturdays, that walking-mile club comes from 9-10 and exercise..."*

*"We've had line dancing classes, we've had that a couple of different times. We've also had some Chicago step classes that we offered to the community as well..."*

*"...on Monday night, we do our Zumba. On Tuesday night, it's a women's workout. On Wednesday night, they have volleyball, they have sorted activities. Thursday is Zumba again. And then Friday, we have a regular work out there..."*

Several pastors also mentioned that their church participated in health fairs where different organizations come and give health education sessions and screening programs. These churches offered blood pressure, diabetes, and cholesterol screenings. Some churches also had cancer screenings, such as colon cancer screening. Few churches offered HIV/STD screenings for the youth population along with education sessions on STDs and pregnancy prevention. All of the churches have promoted healthy food choices. They have started to provide healthful dinners and





snacks. The Culinary Ministry works with the Health Ministry to provide people with healthful food options.

*"...After service, I think it's every fourth Sunday, they (Health Ministry) do blood pressure screenings. And then some months they do diabetic checks and on the fourth Sunday, they do it after service for any person that wishes to be a part of that..."*

*"They (Charles Drew) have brought the mobile and they do the blood pressure screening, the cholesterol screening. Different...the little simple screenings that they would have so we invited and partnered with them to come be on the LOT. We also have done HIV, STD screenings every year..."*

*"... some of our policy, especially with church dinners and little things changing what we serve. Get off the fried foods and the chicken and then the soda and the punch and we're pushing water or juice things that are healthy..."*

Pastors also explained how lack of participation and commitment to church-based health programs became an issue.

*"... four or five years ago, we did the Biggest Loser. We did the Biggest Loser, and I tell you, I think we had like 200 people came out. Oh, I said "wow!" and I told them it was going to be over the summer, 13 weeks. I ended up graduating something like about 20-something people..."*

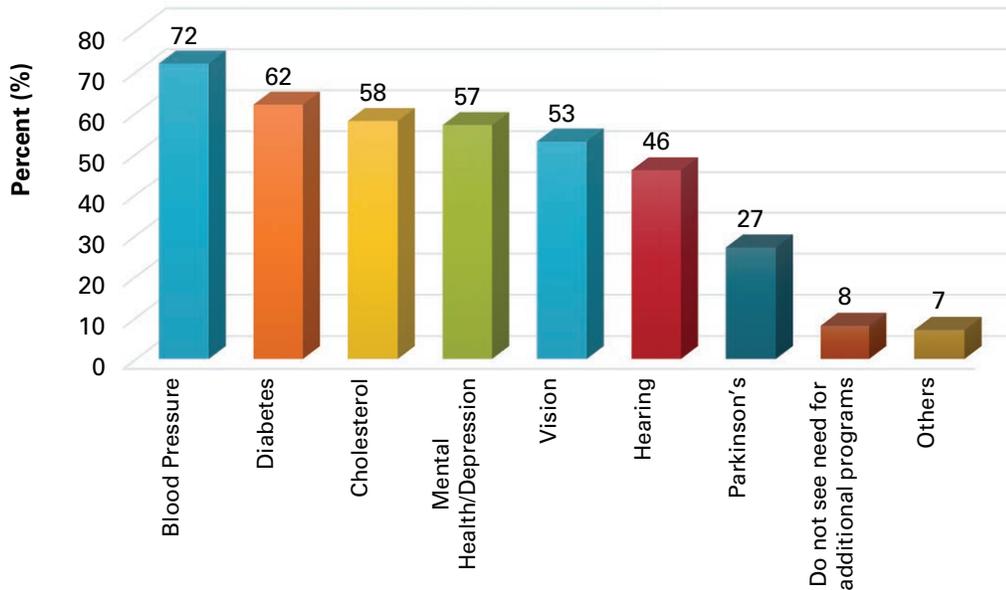
*"You know, it's not mandatory... program is being offered and some individuals... mostly our older generations participate in that. I don't see too many young ones participating... women attend our fitness class, you know, and so. Our brothers may not want to go... They just feel out of place..."*

*"... part of that is a lack of will, but you know, a lot of our members, their schedule is so busy and full with kids and jobs and second jobs..."*

## HEALTH PROGRAMS CONGREGATION MEMBERS WANT TO HAVE

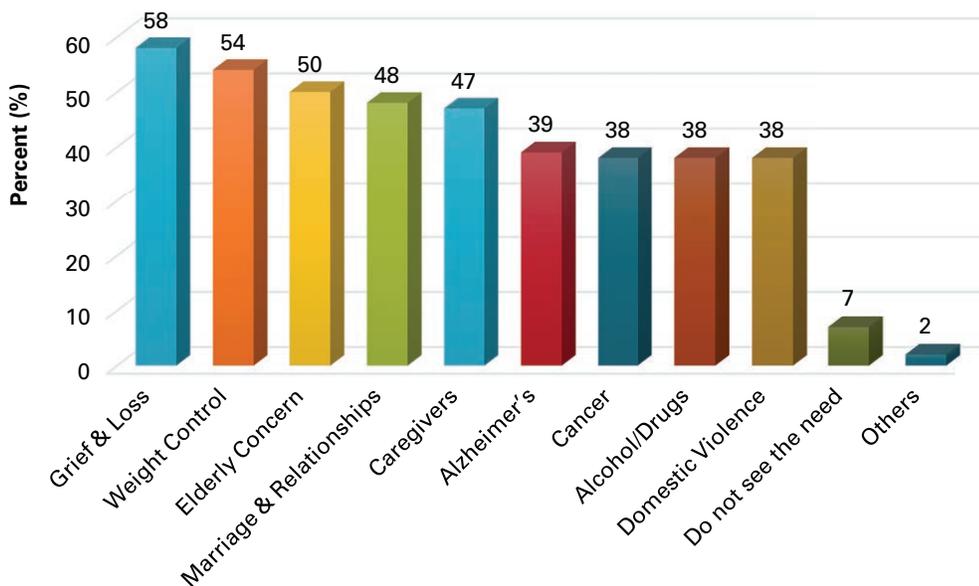
When asked what screening programs participants wanted their churches to provide, 72% of the participants wanted blood pressure screenings, 62% wanted diabetes screenings, 58% wanted cholesterol screenings, almost 57% wanted mental health screenings, 53% wanted vision screenings, and 46% of the participants wanted hearing screenings. Other screening programs that participants wanted included AIDS/STD screening, obesity, cancer screening in general, and prostate cancer and colon cancer screenings (Figure 6).

**Figure 6. Screening Programs Participants Would Like Their Churches to Provide**



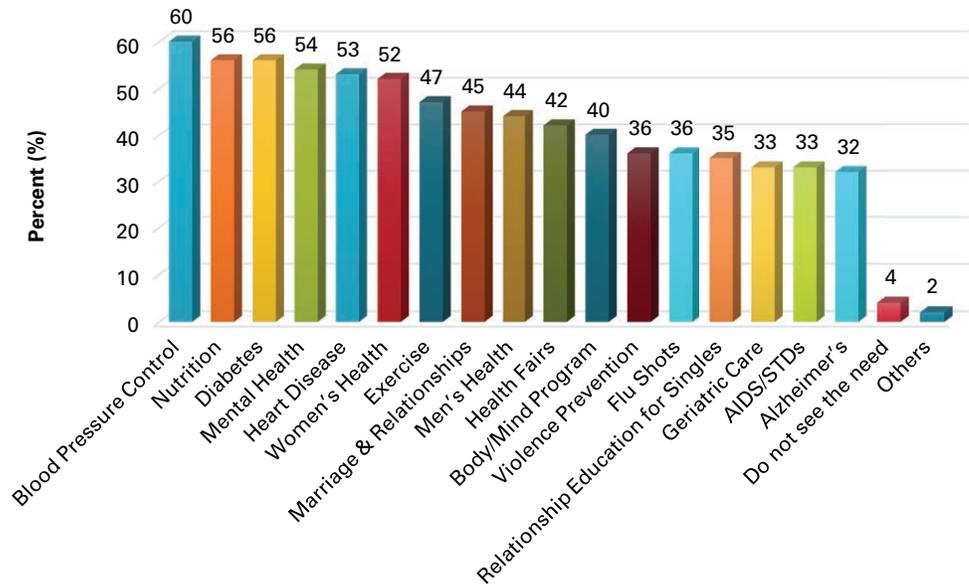
Participants were asked what support group programs they wanted their churches to provide. A majority of them wanted support program on grief and loss relief (58%), followed by weight control (54%), elderly concern (50%), marriage and relationship counseling (48%), and caregivers support (47%).

**Figure 7. Support Groups Participants Would Like Their Churches to Provide**



Participants wanted their churches to provide the following health education programs (Figure 8). Sixty percent of them wanted blood pressure control education (60%), followed by nutritional education (56%), diabetes education (56%), mental health education (54%), heart disease education (53%), and other health education programs.

**Figure 8. Health Education Programs Participants Want Their Churches to Offer**



# Discussion

Based on recent data collected from eight churches in the African American communities in Omaha, we assessed prevailing chronic conditions and unmet health needs in these churches, identified extant church-based health programs, and highlighted the specific health programs congregation members would like to have in their churches. Consistent with previous studies documenting health disparities in the African American population (Bopp et al., 2007; Noonan, Velasco-Mondragon, & Wagner, 2016), we found high prevalence of hypertension, obesity, diabetes, and high cholesterol among African Americans who participated in this study. The most common cancers among the participants were prostate cancer among males, breast cancer among females, and colon cancer in both groups, which is also consistent with corresponding findings among African Americans at the national level (American Cancer Society, 2017).

Of particular concern is the exceedingly high rate of hypertension among study participants. Over 60% of the participants were found to be hypertensive (59.2% of the males and 60.7% of the females diagnosed with hypertension). These rates were substantially higher than the national rates of 43% for males and 45.7% for females (CDC, 2016). Implementing evidence-based, culturally appropriate programs focusing on hypertension prevention and control should become a priority in the churches.

Another important health issue of concern is the overwhelmingly high percentage of congregation members who were overweight or obese. Over 84% of the participants in this study were either overweight or obese based on their self-reported BMI, whereas the national rate of African American adults who were overweight or obese was 76.3% (US Department of Health and Human Services Office of Minority Health, 2016). Even more concerning was the observation that only 37.3% of participants in our study recalled that they were diagnosed with overweight or obesity. This discrepancy shows that more awareness needs to be raised among the church members regarding their body weight status and its associated health risks.

Over 12% of the participants reported being diagnosed with a mental health condition, which is higher than the national average. Nationally, approximately 9% of African Americans are found to be suffering from some type of mental health conditions (US Department of Health and Human Services Office of Minority Health, 2014). Based on feedback from participating pastors, the stigma associated with mental health issues has hampered open discussion over these issues in the churches. Pastors mentioned the need of providing more programs on mental health education, screening, and care, as some congregation members had approached them regarding their mental health issues. This can also help explain why 57% of the participants in the study requested mental health screening programs and 54% wanted mental health education programs offered by their churches.

One of the major reported barriers to health care access concerns the cost of care, which had caused 17% of the participants to delay seeing a health care provider during the 12 months prior to the survey and 16% to delay buying medications during the same period. Other reported barriers included a lack of trust in the system, long waiting time for getting appointments, and being too busy with work. Increasing





service capacity, care affordability, and schedule flexibility of local health providers and collaborative referrals across health providers in the region could help address or alleviate some of these barriers.

In response to these barriers and prevailing unmet health needs in their congregations, churches in the African American communities in Omaha have started a series of health programs for their congregation members such as health education sessions on various topics including diabetes, hypertension, nutrition, cancer, and so forth. The Culinary Ministry in some of the churches has started to provide healthful foods to church members. Most of the churches also offer exercise classes, dance classes, and walking clubs. Since churches differ from each other in size, capacity, and experience in organizing and implementing these programs, it might be helpful for churches in the African American communities to learn from and support each other as they strive to improve the health of their congregation members. This is especially important in consideration of the low participation and retention rates for some of the church-based health programs as mentioned by several pastors. One of the concerns as mentioned by pastors was that the size of their church congregations was not large enough to offer various support groups demanded by their members. The pastors mentioned that this could be addressed if different churches collaborate to develop support groups together or if some organizations are willing to collaborate to provide services.

It should also be mentioned that addressing many of the unmet health needs of the African American faith communities would require not only inter-church collaborations, but more importantly, collaborations between the faith communities and other stakeholders such as local health care providers, medical academia, policy makers, health insurance companies, and so forth so that concerted efforts can be made and sustained to reduce health disparities. These partnerships are crucial for developing and implementing evidence-based strategies to enhance program participation, retention, and sustainability of health programs in the African American faith communities.

# Limitations

Several limitations of this study are noteworthy. First, our use of data from a convenience, rather than a population-based, random sample of participants in this study calls for cautions when generalizing findings from this study to the whole African American faith community in Omaha. Most of the participating churches are Baptist churches, making it questionable to extend our findings to reflect unmet health needs in other denominations. Second, recall biases can potentially impact the quality of some of the collected data. For example, questions on diagnosed chronic conditions and health care utilization during the past 12 months might be peculiarly vulnerable to recall biases. Finally, several pastors mentioned that they might not be the best person to provide information on health needs and health programs in their congregations and they recommended further contacts with those who were in charge of Health Ministry in their church to get more accurate and updated information. Despite these limitations, this study represents a rare effort in documenting unmet health needs in African American churches in Omaha, extant health programs offered by these churches, and remaining gaps in addressing health disparities through church-based health promotion.

# Recommendations

Based on the findings from the survey and interviews with the pastors, we suggest that African American faith communities, local health care providers, policy makers, medical academia, and other stakeholders work together to:

1. Develop and support church-based health programs as an integral component of community health in African American communities;
2. Increase program effort in hypertension prevention and control, and the education and screening of obesity, diabetes, cholesterol, and mental health in African American faith communities;
3. Organize support groups on grief and loss, weight control, elderly concern, marriage and relationships, and behavioral health. Provide inter-church collaborations in these areas if needed;
4. Develop and implement evidence-based strategies to enhance program participation, retention, and sustainability of church-based health programs;
5. Determine key partner necessary to assist in the development of specific health-enhancing strategies for implementation in a particular church;
6. Increase service capacity, affordability, schedule flexibility of local health care providers and establish collaborative referrals across care providers in the region to facilitate health care access for African American faith communities.





## Conclusions

There are substantial unmet health needs in the African American faith communities in Omaha, Nebraska, as indicated by not only high prevalence of chronic conditions such as hypertension, overweight/obesity, diabetes, allergies, arthritis, and high cholesterol, but also significant barriers to health care access. While churches and other faith-based organizations in these communities have strived to implement a series of health programs to address some of the health disparities, more effort is still needed to enhance these programs in terms of their reach, efficacy, and sustainability, and to initiate new programs in light of the persistent health needs and expectations of congregation members as indicated by findings from this study. Accomplishing these tasks would require partnerships and collaborations between the faith communities and other stakeholders such as local health care providers, medical academia, policy makers, health insurance companies, and the private sector so that concerted, impactful efforts can be made and sustained to reduce health disparities.

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