Background. U.S. health disparities are documented by race/ethnicity, socioeconomic, gender, and geographic demographics. Since federal health record keeping began, regardless of other demographic factors, Black people continue to record statistical significant health disparities. Since federal health record keeping began more than 100 years ago, Black people continue to record statistical significant health disparities. The foundation of some religious beliefs is based on the concept of soul, which provides definition of the transcendence of faith.

Faith and spirituality are closely linked, and an important factor in spirituality is the need for the discovery of something unknown [iv]. There is a growing body of evidence linking religion and faith, health, and health-related behaviors. There is increased attention for leadership opportunities is directed to the faith community to improve individual and group well-being [iii].

The purpose of this presentation is to highlight critical issues on the synergy between faith, health, and healthcare among a selected group of Black Christian congregants, Black Baptist.

Faith-Health Synergies Among Black Baptist
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Abstract

Study Design
A survey on faith, health, and health care was conducted on January 24-26, 2005 in Nashville, Tennessee. The survey was the first time the four largest Black Baptist conventions had gathered as the Joint National Baptist Convention for a conference. The eligibility criteria for participation included being Black, 18 years of age or older; and a resident of one of the 10,000 conventions participated in the study. A sample of 2,000 Black men and women from among the 10,000 conventions participants participated in the study. Exactly 1,327 of these surveys returned were completed and used in the analysis. Five hundred persons completed surveys by personal interviews utilizing a hand-held personal digital assistant (PDA) device; due to a computer malfunction the information was non-retrievable.

Methodology
In 2005 a convenience sample of 2,000 Black persons among 10,000 Joint Baptist Convention participants in the study 1,327 completed and returned an 80 item questionnaire. 350 surveys were lost due to computer malfunctions. Due to a computer malfunction the information was non-retrievable. Most of the time surveys returned were completed and used in the analysis. Five hundred persons completed surveys by personal interviews utilizing a hand-held personal digital assistant (PDA) device; due to a computer malfunction the information was non-retrievable.

Survey Instrument Used To Collect the Information
The assessment tool was a 24 page, 70-question survey consisting of three major sections including relevant demographic characteristics. The survey is designed to collect the following information:

Demographic variables included sex, marital status, number of persons living in the household, educational level, employment status, and yearly household income.

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Section 2 of the survey consisted of 10 items that measured knowledge, attitudes and behaviors about health care practices including access to health services, health information and finances, screening practices, and prevalence of spiritual health conditions.

Section 3 of the survey instrument included 27 questions and assessed the knowledge, attitudes, and behaviors relative to religious, religious influences, and decision-making.

Survey results included:

- 84.2% were told by their physician to have chronic disease, (5.4%) were told to have liver disease, (31.3%) diabetes, (15%) asthma, and (8%) cancer.

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Faith, Religion and Health results included:

- Most of the time, 19.2% hardly ever talk to their pastor about health problems.

- 85.4% were told by their physician to have kidney disease, (53.4%) were told to have liver disease, (31.3%) diabetes, (15%) asthma, and (8%) cancer.

Limitations
A number of qualifications may limit the interpretation of the findings from this study. A sample of convenioneers was used for this study. The use of a sample of convenioneers may not be representative of the Black Baptist community. The sample consists of a higher proportion of ministers of high socioeconomic status than does the national population of African American.

References

[ii] See John Chissell, "The Black Church has history in social justice and empowerment by religious fervor to interpret their health status as positive; they must also balance perceptions with evidence-based health decision making, health practices, and sustained healthcare utilization.

Conclusion
A thoughtful activity of the constructs of health and health care enable a new paradigm – Optimal Health – to emerge. The Black Church has and must forever be the institution that helps Black people to continue to grow and develop their faith in journeying to reach their best possible emotional, intellectual, physical, spiritual, and socio-emotional greater state of aliveness, which is Optimal Health.

In order to maximize the synergy between faith, health and health care, individuals, groups, and communities must harmonize physical, social, psychological, and spiritual well-being. The spiritual component can serve as the foundation on which the other three components rest. Consecrating many in this study who attended church or religious services three (3) or more times within the past 30 days and they rarely talked to their pastor concerning health problems or what their physician told them; the religious church service can unite families, Sunday school, Bible class and various ministrations can serve as a platform for health promotion in the Black Church and the Black community.

Acknowledgements
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Figure 1.1 Demographic characteristics of convenioneers.

Figure 2.2 Mental health responses of the convenioneers.

Figure 3.1 Responses to have you been told by your physician to have a chronic disease.

Figure 3.2 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 3.3 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 4.1 Responses to have you been told by your physician to have a chronic disease.

Figure 4.2 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 4.3 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 5.1 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 5.2 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 5.3 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 6.1 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 6.2 Results of respondents talking to their pastors regarding what the physician tells them.

Figure 6.3 Results of respondents talking to their pastors regarding what the physician tells them.