

Commentary

Closing the gap of health disparities in urban communities: The role of the Seventh-day Adventist church

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The scientific literature is replete with information documenting the health disparities of African Americans, especially in urban areas. Yet, the Adventist Health Study-2 conducted by Loma Linda University presents a different profile for African American Seventh-day Adventists residing in similar environments. It is also well-documented that reducing health disparities requires a multi-pronged approach that includes the federal government, policy makers, private sector partners, medical professionals, and community resources, among others.

Closing the gap of health disparities among minorities has been a high priority item on the agenda of public health policy makers and the federal government in recent years (National Institutes of Health, 2012). According to the World Health Organization (2013), at the other end of the malnutrition scale, there is obesity which is one of today's most blatantly visible but most neglected public health problems (World Health Organization, 2013). Recent research reported that 36% of Americans are currently obese and that this is projected to increase to 42% by the year 2030 (Finkelstein, E., Khavjou, O., Thompson, H., et al., 2012). Recent statistics from the Centers for Disease Control and Prevention (CDC) indicate that approximately one-third of children and adolescents are overweight or obese (Centers for Disease Control and Prevention, 2013). Additionally, African Americans are disproportionately affected by the burden of type 2 diabetes and obesity-related conditions (Gary, T., Gross, S., Browne, D., LaVeist, T., 2006).

In the United States, disparities are well-documented in minority populations such as African Americans, Native Americans, Asian Americans, and Latinos. These groups have higher incidences of chronic diseases, higher mortality, and poorer overall health outcomes (Goldberg, Hayes & Huntley, 2004). According to the American Public Health Association (APHA) (2004), the cancer incidence rate among African Americans was 10% higher than among Caucasians, and adult African Americans and Latinos had approximately twice the risk as Caucasians of developing diabetes (APHA, 2004). Differences in overall health also exist between individuals in different social classes. Those in lower-status socioeconomic groups generally tend to have poorer health and higher rates of chronic illnesses such as obesity, diabetes, and hypertension (Hurst, C., 2007).

Hebert, Sisk and Howell (2008) have postulated that the degree to which one sees environmental factors and social context as shaping choices has important implications for the measurement of disparities and ultimately for directing efforts to eliminate them. (Hebert, P., Sisk, J., & Howell, E., 2008). Furthermore, it is generally known that policy makers have been aware for a long time that racial and ethnic differences in health do exist. Hence, the reason the federal government has made the elimination of health disparities a high priority.

In 2008, the Agency for Healthcare Research and Quality reported that compared with urban and suburban dwellers, individuals living in rural areas had fewer health care resources, less access to preventive services and were more likely to be poor, have chronic health conditions, and be in fair or poor health. In addition,

individuals of low socioeconomic status living in urban areas had similar barriers to access. Disparities were even greater for certain racial and ethnic groups, such as African American and Hispanic populations (Agency for Healthcare Research and Quality, 2008).

Financial barriers to access, including lack of health insurance, are also common among the urban poor (Kiefe & Hyman, 1996). Individuals studied as part of the HOPE IV project, a government-funded study of the problems faced by urban populations, were found to be roughly twice as likely as their non-urban peers to suffer serious conditions, including arthritis, asthma, depression, diabetes, hypertension, and stroke (Manjarrez, Popkin, Guernsey, et al., 2007).

With respect to the minority health issue of childhood obesity, the Centers for Disease Control and Prevention (2013), have established that the dietary and physical activity behaviors of children and adolescents are influenced by many sectors of society, including families, communities, schools, child care settings, medical care providers, faith-based institutions, governmental agencies, the media, food and beverage industries, and entertainment industries. They further state that schools play a particularly critical role by establishing a safe and supportive environment with policies and practices that support healthy behaviors. In addition, schools also provide opportunities for students to learn about and practice healthy eating and physical activity behaviors (Centers for Disease Control and Prevention, 2013).

Likewise, I believe the church provides a fertile learning environment where best practices in a healthy lifestyle can be disseminated to a weekly captive audience over a relatively long term. What role then does the community unit of the church play in this major public health issue that affects their own parishioners? Furthermore, are non-profit organizations such as churches being given the resources and funding by our national health agencies to effect changes in urban communities that could help to close the gap of health disparities?

Over the last 40 years, Loma Linda University conducted several health studies widely known as the Adventist Health Study (AHS) among members of the Seventh-day Adventist church. This is a Christian denomination that encourages a vegetarian diet and calls for abstinence from all forms of alcohol and tobacco (Loma Linda University, 2013). According to the university, these long-term health studies explored the links between lifestyle, diet and disease. They also included an African American cohort - the Adventist Health Study-2 (AHS-2) with 96,000 Black participants who enrolled between 2002 and 2007. They reported that this study provided valuable data that helped answer why Blacks have different risks of certain diseases (Loma Linda University, 2013).

Loma Linda University (2013) reported that compared to other Blacks nationwide, those in the AHS-2 had lower rates of smoking, drinking and meat consumption. Rates of vegetarianism and water consumption were also higher for AHS-2 study members. Additionally, educational level was higher (35% held a bachelor's degree or higher) than for Blacks nationally (15% hold a bachelor's degree or higher). Data showed a progressive weight increase from a total vegetarian diet toward a non-vegetarian diet (55-year-old male and female vegans weighed about 30 pounds less than non-vegetarians of similar height). Levels of cholesterol, diabetes, high blood pressure, and the metabolic syndrome all had the same trend - the closer to being a vegetarian, the lower the risk in these areas. This was true for Black as well as non-Black participants. High

consumption of cooked green vegetables, brown rice, legumes and dried fruit was linked to a decreased risk of colon polyps, a precursor to colon cancer.

Cases of hypertension and diabetes were lower for Black Adventists than comparable national rates for both Blacks and non-Blacks, a noteworthy finding. They believe this may be explained by the fact that Black Adventists reported better health habits than Black non-Adventists. Obesity was more prevalent among the Black SDAs than non-Blacks (35% vs. 22%). However, their dietary and lifestyle habits resulted in a lower risk, than other Americans, for heart disease, several cancers, high blood pressure, arthritis, and diabetes (Loma Linda University, 2013). It is also noteworthy that the prevalence of obesity reported among Blacks in the AHS-2 population is 10% lower than that reported among Blacks in the 2003-2004 National Health and Nutrition Examination Survey (NHANES)

In 2007, Tonstad conducted research using longitudinal data of 7,172 Black Seventh-day Adventists participating in the Adventist Health Study-2. She found that, compared to non-vegetarian Blacks, vegan Blacks had a 70 percent reduced risk of diabetes, and lacto-ovo vegetarian Blacks (those who consume dairy, but no meat) had a 53 percent reduced risk of diabetes. One explanation for this was the protection associated with foods typically consumed in higher amounts in a vegetarian diet. Fruits and vegetables have a high fiber content, which may contribute to a decreased occurrence of type 2 diabetes. Whole grains and legumes have also been shown to improve glycemic control and slow the rate of carbohydrate absorption and the risk of diabetes. The study also showed that Black participants who exercised three or more times a week, compared to once a week or never, had a 35 percent reduced risk of diabetes (Tonstad, 2007).

There is currently increased multi-sector partnership among domestic and international partners to share best practices and enhance approaches being implemented in neighborhoods and communities to eliminate health disparities. As a vital part of most urban and rural communities, what role does the church have in closing the gap of health disparities among those ethnic groups in these communities? With the documented reduction in obesity rates among African American SDAs in the AHS-2 when compared to the national averages, a partnership between national and international health agencies and the SDA church organization could result in the sharing of best practices of healthful living espoused by this religious group. The utilization of these practices could enhance approaches being implemented in socially disadvantaged and underserved communities. The result - strides toward closing the gap and eliminating health disparities among minority populations.

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