ABSTRACT

ADDRESSING HEALTH DISPARITIES AMONG AFRICAN AMERICAN WOMEN IN MECKLENBURG COUNTY: A MIXED-METHOD STUDY ON THE VILLAGE HEARTBEAT HEALTH PROMOTION PROGRAM

By

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Health Disparities negatively and disproportionately affect African American women in Mecklenburg County. Increasingly, partnerships between local health institutions and Faith Based Organizations (FBO's) like local churches are used as a way to create health equity in vulnerable communities through health promotion programs like Village HeartBEAT (VHB). This study used a mix-method quantitative and qualitative method to evaluate the effectiveness and challenges of the Village Heart B.E.A.T (VHB) 16-week health promotion program in addressing the health care disparities and spiritual formation among African American women in Mecklenburg County.

African American women are disproportionately affected by health disparities in Mecklenburg County. The Mecklenburg Health Department has identified priority areas that include chronic disease, mental health, access to health care, environmental health, healthy pregnancy, and violence prevention. Faith Based Organization (FBOs) and public health partnerships provide opportunities to address health disparities and inequities. However, good examples of such partnerships that include African American churches and women are lacking (Hawes-Dawson, et. al., 1). Village HeartBEAT, Building

Education and Accountability Together (VHB), is a Mecklenburg County health promotion initiative that may serve as a good model example.

This study is significant because it creates a precedence for community-based, public health and church partnerships that collaborate to create health equity among African American women. Village HeartBEAT developed a governance structure with African American pastors and lay leaders at the table as equal partners. It established activities to address county-wide health-priority areas that included congregational participation, multi-level health professional participation, technical-support collaborations between a local agency and the researcher. This study also evaluated the Christian spiritual growth and the impact on the faith of the women that participated in the 16-week health promotion program.

Cheryl Emmanuel, a visionary public-health servant, researcher, and lay leader in the Presbyterian Church (USA), is mentioned in this study as one of the main contributors to the creation and implementation of Village HeartBEAT and Faith-based organization partnerships. Several expert researchers from various fields were included such as theologians Erika Ellion, Angelique Walker-Smith, Marjorie Lewis, Courtney Bryant, Katie G. Cannon, Kameron J. Carter, and Willie Jennings. Moreover, respected scholars are found in commentaries such as the New Interpreter's Bible and the Sacra Pagina. I referred to key theorist in the fields of sociology, psychology, literature, and poetry such as Patricia H. Collins, Alice Walker, and Joy DeGruy. These women are referenced based on the intersectionality of issues related to African American women and society.

Finally, public reports from various sources were used to understand the statistical facts and complexity of the issues that affect African American women in the US. For instance, resources included statistics from the Centers for Disease Control and Prevention (CDC), the Economic Hardship, Racialized Concentrated Poverty, and the challenges of Low-Wage Work: Charlotte, North Carolina Report; the US Department of Health and Human Services, the Institute of Medicine, and the Mecklenburg County Public Department Health.

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by

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Finally, to my daughter Aluna Sirena Rodriguez Landrau, may you always know that nothing will be impossible for you because love is a force that can overcome all

things. Your own dedication will pave the way. Daughter, I pray that this work will contribute to a healthier, just, and more equitable future for you.

CHAPTER 1

NATURE OF THE PROJECT

Overview of the Chapter

This project addressed health care disparities among African American women in Mecklenburg County, NC. The research identified ways in which churches focused on concrete efforts to address health disparities within their congregations through friendly competitions, partnerships with institution-based programs, community advocacy, and leadership development. Most participants are African American women. Pastors and lay leaders also focused on preaching sermons about health, healthy living, and the need to transform policies that disproportionately affect people of color. The research identified the impact of the Village Heart B.E.A.T. (VHB) model.

This research identified best practices and the challenges encountered by VHB participants, pastors, and volunteers. It analyzed the best practices used by VHB to strategically integrate Christian communities through ecumenical cooperation along with their partnership with the Mecklenburg County Health Department and other local health care clinics. This chapter provides historical data, guiding research questions, and key theological themes used in the literature review.

Personal Introduction

My interest in investigating issues of health disparities and health equity were born from my pastoral experience with African American congregations. During my ministry, I served predominately African American congregations. I noticed that African American people in my congregations seemed to be affected by deaths related to hypertension, diabetes, obesity, and other preventable illnesses. Most distressing was that

women seemed to be at the front lines of struggling with their own health determinants in addition to being primary caretakers and the last to seek care in the household. I noticed that women of color were often disproportionately affected by these disparities.

Furthermore, this puzzled me because it was not different from the challenges, I witnessed growing up in Spanish Harlem in New York City. As a child, it was evident that many women in my immediate family suffered from obesity, heart disease, and hypertension. The memory remains vivid in my mind of my auntie Alisia dying of a heart attack in our living room. She had diabetes, was obese, did not exercise, and was riddled with stress as a Black, Puerto Rican woman in a stressful community and an urban environment. I witnessed these same challenges and behaviors in many of the women of the African American churches I worked with.

I noticed cultural barriers that placed these African American sisters at greater risk. In addition, there were theological discourses, doctrines, ideals, and concepts that perpetuated a mechanism that often-kept African American women at a disadvantage. Just like my Puerto Rican aunties, cousins, and friends in Harlem, women were supposed to accept their destiny. They had to care for their men and the children and deal with many ideals that had to do with God and their bodies. This God that was proclaimed was not the all-encompassing loving and just God that I have come to know today. The Black women in my childhood reminded me of the African American women and their plight.

Moreover, I learned about the theological discourses that perpetuated the health disparities suffered by African American women. Some of these sayings included things like, “women should always put their children and family first,” “women are supposed to take care of others, this is God’s will,” and “men are the head and women are the neck.”

My daily experiences as a Puerto Rican woman of African descent testify to the specific plight of women of color. We were survivors of health disparities. Very early growing up in Harlem, New York I saw the struggle of many people who lived below the poverty line. The women of color in my community were often the last ones to seek care. Many did not have a local church or faith community to provide advocacy, resources, spiritual guidance, or support.

The women in my own immediate family suffered from obesity, cardiovascular disease, hypertension, and diabetes. We often made poor nutritional choices, selecting foods that were not the healthiest. We also suffered from social determinants of health, which included poverty, lack of safety, and mental illness. As a result, many loved ones, friends, and acquaintances died prematurely due to preventable diseases and habits.

When people died due to high risk factors, I heard things like, “It was their time,” “God took them,” and “it was God’s will.” I quickly learned on the journey that the concept of “God” was unpredictable since the perception was that this deity took people without regard. For many people in my community there was not a concept that separated the reality of God’s actions from that of systematic health disparities that disproportionately affected inner city people.

Later I learned that many of these deaths, struggles, and trends were not always a result of lack of empowerment, faith, action, or responsibility. They were part of a larger complicated systematic, economic, racial, ethnic, and religious problem. Therefore, when I was ordained as a Minister of Word & Sacrament it became clear to me that our churches had the opportunity to positively impact people through a special focus on health and wellness. As the African American church experience shaped my spirituality,

prayer life, and theological formation, I saw many similarities between African American women and Latina women in my community. There too I witnessed the deadly effects of health disparities, health inequality, and the lack of health care resources and insurance.

My passionate puzzle began here in the intersection between church ministry and social justice work and advocacy. Along the journey, the witness of women of color like my mother, grandmother, and the many Black and Brown women I met along the journey shaped my passion for being a part of the restoration and healing of my sisters. Finally, as a pastor I have witnessed the death of church members and their family members due to complications that involved high risk factors. At a deeper spiritual and theological level, I witnessed a duality between life realities and theological concepts in some African American and Latin American congregations. There were deep disconnects between praxis and religious belief. Many people of faith encountered disproportionate struggles simply because of their social determinants and not their faith. Furthermore, my own personal development as a woman of faith, dancer, and teaching artist served as catalyst for this research. Along the journey, my desire has been to create a beloved community of healthy women of color who could have access to all that is good. Indeed, my own experiences of life and spiritual formation have given me the platforms to access various forms of physical healing, mental health, wellness, and spiritual awareness.

Statement of the Problem

First, African American women suffer from higher levels of obesity than white women. Premature death, chronic disease, disability are outrageously high sustaining the challenges of inequity in the United States (Dodgen, 1). While the ongoing causes of this phenomenon are complex, historical data and chronic societal ills point to some of the

reasons for these ongoing challenges. Many factors contribute to these health inequities including the aftermath of the transatlantic slave trade in the US, racism, discrimination, poverty, sexism, discrimination, and systematic blind spots (*Atlas of the Transatlantic Slave Trade*). Black women in America may also be more vulnerable to negative healthcare outcomes.

Second, the lives of African American women have a particular experience in the South that continues to plague them with healthcare challenges. North Carolina has a deep history of racism, segregation, and institutional injustices that may continue to create hardships for African American women. Women of color in the South have faced unbearable injustices that include economic poverty, dehumanization, and prejudices. Their physical, emotional, and spiritual health continues to be at stake today in Charlotte, NC (Nichol, 13). Furthermore, many theological frameworks and certain narratives of churches continue to uphold oppressive and damaging views of African American women within the church.

Purpose of the Project

The purpose of this study was to evaluate the effectiveness and challenges of the Village Heart B.E.A.T (VHB) 16-week health promotion program in addressing the health care disparities and spiritual growth among African American women in Mecklenburg County, NC.

Research Questions

In order to determine the effectiveness of the VHB 16-week health promotion program instruments were developed that answered three research questions.

Research Question #1

In what ways has the Village Heart B.E.A.T (VHB) 16-week health promotion program effectively addressed the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

Research Question #2

What challenges has the Village Heart B.E.A.T (VHB) 16-week health promotion program faced in addressing the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

Research Question #3

What practices might help improve the Village Heart B.E.A.T (VHB) 16-week health promotion program in effectively addressing the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

Rationale for the Project

First, this study matters because African American women continue to die at a disproportionate rate due to health disparities in the United States. In addition, African American women in Mecklenburg County continue to suffer the brunt of the negative effects of policies, poverty, and poor social determinants of health outcomes. Therefore, it is important to conduct this study to identify ways to continue to close the gaps in health disparities. This study researched models of partnerships with churches, FBOs, and Village HeartBEAT (VHB) that address these disparities by actively working to close the gap of inequality.

Second, health disparities continue to disadvantage African American women in Mecklenburg County. Health disparities in the community are a silent killer that should

concern people of faith. Jesus was a healer and healed women in special ways. Jesus took care of looking out for women. For example, he heals Peter's mother-in-law from a fever (Mark 1:30 New Revised Standard Version). There are many more healing encounters that call the church to the particular care of marginalized women. It is important that communities of faith, community organizations, and government county commissioners continue to partner in fighting non-communicable diseases that affect the most vulnerable in the community in higher proportions.

VHB has created initiatives that invite churches, pastors, and lay leaders to be key stakeholders in the process of bringing attention, healing, and justice to African American women. The visionary of VHB is a Presbyterian African American woman that works in public health and designed a program that would strengthen institutional and FBO collaboration. Collaboration with health institutions in the public and private sector may be a key component to help create health equity in the lives of African American women in Mecklenburg County.

What makes this program unique is that it boldly places Jesus as the center of healing by inviting church participants to be servant leaders. It invites pastors and lay members to become health ambassadors that seek to put in practice their faith convictions. It invites church leaders to wrestle with theological understandings that perpetuate the health disparities of African American women. While many men are an effective part of this initiative, women on the ground level are a valuable asset to the success of VHB. Programs like VHB have attained a lot of attention in the last couple of decades because they target minorities that face disparity and use funding that comes from the federal, state, and private sectors (Siegal B, et al, 5).

Third, healing is at the center of Jesus' healing ministry. One of the most challenging experiences of life can be dealing with a health crisis or illness (Tyler, 12) The writer of Romans reminds Christians that people's bodies are temples of the Holy Spirit (1 Corinthians 6:19). As temples of the Holy Spirit, Black women's bodies are temples and have the human right to be healthy and the spiritual right. While it is a reality that suffering and disease are a part of the human experience, any sector of God's people suffering disproportionately due to systemic injustice, racism, or poor policies is a call to the Church to act. When one member of the body suffers all the body of Christ is affected (1 Corinthians 12:26).

Definition of Key Terms

Health Disparities

Health disparities have to do with social determinants of health. Some determinants of health include differences in people's social status, race, income level, or where they live According to the American Public Health Association (APHA), racism is one of the main causes of health disparities. The APHA asserts, "Racism is a driving force of the social determinants of health (like housing, education and employment) and is a barrier to health equity." Finally, other experts assert and rightly define that health disparities for this project:

"A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their: racial or ethnic group; religion; socioeconomic status; gender; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion" (U.S. Department of Health and Human Services).

Health disparity in African American communities disproportionately affect women (Wilson, 234). A health disparity is also a social and political reality that is complex in nature and has many tentacles. It often occurs due to disadvantages as a result of social, economic systemic racism or a combination of many things.

Health Inequity

Health equity is different than health disparities. According to the American Public Health Association (APHA), "*Inequities* are created when barriers prevent individuals and communities from accessing these conditions and reaching their full potential. Inequities differ from *health disparities*, which are differences in health status between people related to social or demographic factors such as race, gender, income or geographic region. Health disparities are one way we can measure our progress toward achieving health equity. Health equity is advanced by addressing systemic issues caused by racism and various forms of oppression.

Health inequity is transformed into health equity, and it is about creating opportunities for all of God's people to achieve their highest good. In the case of this study their highest good would be related to their health and the best outcome possible. Scripture is clear that if one part of the body is suffering "every part suffers with it" in the same way "if one part is honored, every part rejoices with it" (1 Corinthians 12:26).

Faith Based Organizations (FBOs)

A faith-based organization (FBO) may be defined in different ways. For this project a FBO is an organization with work founded on Christian beliefs and principles. Many FBOs may be affiliated with religious institutions and serve the social, spiritual, and cultural needs of the community they serve. However, many FBOs do not require

that the people who benefit from their services also practice the religion or spirituality they promote. Most FBOs that partner with churches to provide healthcare services do so by offering service to all people whether they are connected to a church or not. According to a study conducted by Mary Sutherland, "the church in the African American community is an essential component in the success of any health-promotion program" (Carver, 2). The participation of FBOs many times refers to public-private partnerships of organizations to influence changes in behavior and in policies that negatively impact African American women.

Village Heart B.E.A.T. (VHB)

Village Heart B.E.A.T., Building Education and Accountability Together (VHB) is a program created to promote healthier practices. It is designed to create better heart health consciousness and promote community partnerships and resources. VHB targets the African American and Latinx populations by coordinating efforts and health care models to address heart disease and obesity. The heart of the program is creating health equity. As Rev. Dr. Martin Luther King Jr. once said, "Everybody can be great because everybody can serve…You only need a heart full of grace, a soul generated by love, and you can be that servant" (Grhgraph's Blog).

The program invites FBOs to participate in a friendly fitness competition through a 16-week challenge. Each church gets the opportunity to select a team of ten participants. All of the members of the FBO and the pastors are welcome to participate as well. The journey includes quarterly training with a health ambassador, pre-challenge and post challenge Biometric screenings, a mentor FBO to assist in the process, grants for

participant churches, advocacy training, and healthy meal preparation classes. VHB has effectively engaged over 40 FBOs with mostly African American participation.

The 16-week program was designed to reduce the incidence of heart disease for traditionally underserved African American and Hispanic neighborhoods within Mecklenburg County, NC. These neighborhoods are part of a public health priority area with a population of 210,000 residents that are experiencing increasing rates of cardiovascular disease (8%), hypertension (29%), and high cholesterol (33%). For this community, heart disease is a leading cause of mortality associated with increasing rates of overweight/obesity (57%), decreasing consumption of fruits and vegetables daily (18%), and a lack of physical activity (18%).

For the Healthiest Cities challenge, the Mecklenburg County Health Department (MCHD) team and the network of community partners addressed population health and health equity by: (i) expanding the VHB program to include partnerships with other cross-sector organizations and increase the participatory approach of the intervention; (ii) using the VHB model to connect participants to community-based social-service providers to address social determinants of health; (iii) providing training for ambassadors to create local policy changes and outreach to promote health behavior change within their congregations, and (iv) engaging additional FBO partners using the extension model to extend the VHB program from 40 to 60 churches and to train a total of 600 community ambassadors.

The 16-week friendly competition rules are as follow:

1. Health factors: Each participant must have identified with at least one of the following health factors: 1. a smoker; 2. overweight or obese; 3. high blood pressure; 4. high cholesterol, or 5. pre-diabetes or diabetes.
2. Team membership: Each team must consist of 10–14 members (this may include 4 alternates). Everyone must take park in all activities.
3. Attendance: Participants must sign-in at VHB hosted events.
4. Biometric Screening: Team members will participate in mandatory pre- and post-assessment and testing opportunities to measure weight, body mass index, pre-diabetes, blood pressure, cholesterol, and overall health.
5. Trackers: The competition is based on a point system. Points are applied for individual and group activities recorded on trackers. Participants earned the opportunity to earn bonus points throughout the competition cycle.
6. Curriculum: Participants will attend educational sessions within the Community Health Leadership Academy. They will learn from the "With Every HeartBEAT is Life" curriculum that will cover topics specific to high blood pressure, diabetes, cholesterol, and tobacco.

The program structure advanced an existing intervention (The Village Heart B.E.A.T) that has effectively engaged 40 faith-based organizations (FBO's) and positively impacted biometric markers in over 250 participants. This program increased the reach of the existing VHB program to include 60 FBOs and train 600 Community Health Ambassadors. Ambassadors were provided the best evidence for changing health behaviors for tobacco use, nutrition, and physical activity. In addition, Ambassadors were trained in motivational interviewing and charged with changing local FBO or church

policies to enhance health outcomes for their entire congregation along with another 10-20 individuals in their community ("Our Churches").

Delimitations

This is not an exhaustive study on the impacts of faith-based health models to address the health disparities of African American women. Other studies may need to be done to explore the long-term impacts of faith-based programs on the health disparities of African American women. This study focused on health disparities among African American women in Mecklenburg County, NC that participated in VHB program. Since the focus was placed on African American women who participated in the VHB program through their local churches, it also included their pastors and lay leaders that participated in VHB.

The age range was 18-70 years of age. The study goes beyond the pastoral experience of the Presbyterian Church (USA) pastors and includes the greater ecumenical community, as other denominations participated in VHB. It included the experiences of African American women within the Presbyterian Church (USA) and other mainline denominations that participate in VHB and similar models. It included the experience and impact to African American women, their pastors, and VHB volunteers. Finally, the study was limited to female VHB participants that consider themselves to be African American s or women of African descent.

Review of Relevant Literature

First, the following project has been supported by the multiplicity and intersectionality of expert researchers from various fields as well as Biblical and theological foundations. Commentaries such as The New Interpreters Bible commentary

on the gospels and Sacra Pagina on the Gospel of Matthew and Luke were key. Many theological voices were also included. In the Spirit of unity and ecumenical inspiration, the researcher, as a member of the Presbyterian (USA) reformed tradition, consulted denominational statements on the subject of African American social justice and African American women. Reformed theological reflections of church fathers and mothers and the main source, the Book of Confessions, were consulted. The research considered how the particularities of denominational theological practice and commitment can strengthen the work of the Body of Christ.

Second, in addition to the Biblical and theological disciplines, other important contextual theologians were consulted in this study. To lift the voices of unique African American theological and Biblical perspectives, Womanist theologians like Erika Elion, Iva E Carruthers, Rev. Robyn Joynes, Courtney Bryant were consulted. Others include Caribbean theologians from Jamaica, Marjorie Lewis. In the arena of theological education and Christian ethics, pioneer Katie Cannon was consulted. In the area of theological anthropology, Michelle Gonzalez and others were consulted. To highlight the importance of theological education reform and women of Pan-African Decent, including African American women, expert researcher Angelique Walker-Smith was consulted. Other traditional African American thinkers such a as Du Bois, W. E. B. and his concept of "double consciousness" were included.

Third, prolific African American writers like Alice Walker, were included for the ways in which they relate the validity of the African American female experience. The sociology discipline was represented by thinkers like Joy DeGruy-Leary, and Patricia Hill Collins who are leading voices on African American themes. Another important field

consulted was psychology through Brenda Wade and Gail E. Wyatt, Professor of Psychiatry, because of their expertise on the legacy of African American s women in the US. The goal is to discover how these disciplines can contribute to the practice of ministry in innovative ways within local church health promotion programs.

Finally, the other main works used for this project to investigate came from national organizations and publications like the Centers for Disease Control, the Mecklenburg County Public Health Department Community Health Assessment, various US Department Bureau statistic reports, US Census records, statistical reports, and Faith Based Organizations' studies on African American clergy and their engagement with wellness programs which were focused on African American women. The goal was to determine how this study can add to best practices of FBOs' engagement in creating health equity for African American women in Charlotte, NC and what challenges church leaders must address to help strengthen partnerships within their local communities, churches, and health institutions.

Research Methodology

Due to the nature of this project, the best way to gather data is through a mixed-methods design. There was a survey with twenty-two questions in a post-intervention questionnaire to access the participant experience and results from the 16-week VHB program. After collecting the qualitative date, the researcher held Zoom interviews with fifteen African American women that participated in VHB. The questions were created to access the effectiveness of VHB. The African American women that participated in the 16-week challenge of VHB completed the survey which provided data for research questions 1 and 2.

To explore the third research question, the final data collection instrument was a focus group based on information gleaned from the answers to research questions 1 and 2 and from the literature review. The focus group was made up of VHB pastors and lay leaders that participated in VHB. The quantitative data collected from the survey and the qualitative data collected from the interview were the basis for the data gathered from the focus group to answer question 3.

Type of Research

The research methodology is post-intervention, evaluating the VHB 16-week friendly competition model and its impact on the lives of African American women. This model was designed by the leadership of VHB, which included the participation of the community engagement visionary Cheryl Emanuel who represents both the Mecklenburg County Public Health department and is a lay leader of the Presbyterian Church (USA).

Participants

The participants were African American women in Mecklenburg County, NC. Among 50 cities in the United States, Charlotte, NC, located in Mecklenburg County, is among the hardest for the economic upper mobility of African Americans (Semuels, 2). The participants in this study are African American women ages 21-65. Women in this age range were the greatest number of people that participated in Village HeartBEAT. Many more African American women than men participated in the VHB 16-week health promotion program.

The selection criterion was focused on African American women that participated in the 16-week VHB health promotion friendly competition among participant churches. The main criteria required were African American women 21-65 years of age that

completed the program. The criteria is important as it seeks to access a post-intervention approach that could evaluate the impact of this Christian program on the lives of African American congregants

Since African American women continue to be impacted disproportionately by the historic prejudice of race in the South due to the systemic challenges, this initiative lifts God's care for such vulnerable population. African American women may feel like commodities and that their lives are not given the value they deserve. They have been devalued and made treated as any raw material that makes the everyday products people consume and discard (Elion, 470).

Instrumentation

There were three research instruments used in this study. First was the researcher-designed, 18 question survey called the Post-Intervention VHB Survey. This was the quantitative portion of the mix-study design. It collected data on participant impact and wellness results after completing the VHB 16-week friendly church competition. The second researcher-designed instrument consisted of individual interview questions called the Post-Intervention VHB Spiritual Growth and Health Outcome Interview. This was the qualitative part of the mix-study design data collection, which focused on recording the individual experience of the participants. Collecting this important information allowed the researcher to record the lived experience that participants had within the VHB program without bias and in a confidential space. The third researcher-designed instrument was a focus group called the VHB Impact Focus group. This data collection tool was utilized after the themes of RQ's #1-2 were developed. This group was made up of pastors and lay-leaders of churches that had groups of 10-14 competitors within their

congregations taking part in the VHB 16-week friendly competition. This instrument was utilized to identify patterns, themes, and experiences on the impact of the program on the African American women who participated, including their spiritual formation and the overall impact on the life of the congregation.

Data Collection

The data collection in this project involved a layered process to look closely at the experience of African American women with VHB (Sensing, 194). It also involved looking at the macro-impact of the 16-week program using a survey. The survey was administered to 75 African American women that participated in the 16-week VHB program to gather quantitative data. The QuestionPro website tool was used to create and email the survey to African American women who participated in the program.

Following the survey, more in-depth interviews were conducted with 15 African American women that completed the 16-week VHB program to gather the qualitative data. Finally, to answer research question number three and to access the long-term impacts of the program on church leaders and congregants a focus group was convened via Zoom to analyze the findings.

Data Analysis

According to Creswell, “The process of data analysis involves making sense out of text and image data. It involves preparing the data for analysis, conducting different analyses, moving deeper and deeper into understanding the data representing the data, and making an interpretation of the larger meaning of the data” (183). The Post-Intervention VHB survey was utilized as the quantitative tool to analyze data. After receiving the survey from the subset group of African American women, the researcher

used a descriptive method to analyze the data. The survey included a variety of questions with options, questions with direct responses, and questions with scales from “very satisfied” to “very dissatisfied.”

Second, a phenomenological design was used for the qualitative data analysis for the VHB Experience Interview and the Post-Intervention VHB Focus group. The design was used to explore the in-depth experiences of African American women with VHB regarding their health and spirituality. Sensing indicates the effectiveness of integrating a mixed or blended approach to analyzing data (195). After themes and patterns were carefully collected from the interview questions and focus group, the researcher analyzed the contextual realities, and the essence of African American women experience with VHB in their local church and community. This blended method included coding and categorizing the data in order to uncover the main themes of the findings and the major lessons of the project.

Generalizability

This project may transfer to other settings such as other urban cities with a significant population of African American women. Other urban cities may struggle with the challenges of health care disparities and inequity similarly to Mecklenburg County, NC. Black women in most metropolitan cities in the Southern parts of the US could benefit from duplicating the Village HeartBEAT program models. Most importantly, they could benefit from creating partnerships with institutions like public health departments, FBOs, and others dedicated to creating healthcare reform and equity for African American s.

Project Overview

This project seeks to evaluate how health disparities affect African American women in Mecklenburg County. It will examine the impact of the Village HeartBEAT 16-week program designed to decrease social determinants of health for African American women. Chapter 2, the literature review, engages research experts about theology, Biblical interpretation, health disparities, health equity, and African American women and their lives in the United States. Chapter 3 includes a detailed explanation of the nature of the project, research questions, participants, methodology tools used to gather the data, instrumentation, project design, and the data collection strategy. Chapter 4 identifies the evidence for the project, the research questions and description of evidence for each one, and a summary of the major findings. Finally, Chapter 5 showcases a learning report of the major finding of this project.

CHAPTER 2

LITERATURE REVIEW FOR THE PROJECT

Overview of the Chapter

Chapter 2 addresses the research on the issues presented in the problem statement of health disparities as they relate to African American women. The purpose of this study was to evaluate the effectiveness and challenges of the Village Heart B.E.A.T 16-week health promotion program for churches in addressing health equity and health care disparities among African American women in Mecklenburg County.

Biblical Foundations

The Hebrew Bible (Old Testament) and the New Testament are full of powerful examples and encounters between God and women. Women of African descent, particularly African American women, have found their experiences reflected in the stories of women in the Bible. The narratives in the Bible present the challenges, injustices, and efforts for justice carried forth in women like Esther, Hagar, Deborah, Mary of Nazareth, and the woman with the issue of blood.

In the New Testament the story of the woman with the issue of blood proves to be a strong biblical foundation for the importance of healing in the lives of African American women. The story of the unnamed woman is told by several of the gospel writers (Matt 9:20-22, Mark 5: 25-34, Luke 8:43-48). Each gospel writer gives insight on the importance of Jesus’ encounter with this woman and the subject of healing. Most importantly, Jesus’ care for women is an invitation to readers to understand what is at stake for the healing of African American women.

First, Mark 5 provides insight on the encounter Jesus had with the unnamed woman. It is important to note that, like the experience of many African American women in the United States, the woman with the issue of blood experiences social segregation (Culpepper, 188). This social segregation has to do with her status as an unclean woman and is similar to the way many African American women may have felt in the experience of segregation spiritually, and societally in the South. This unnamed woman experiences a health issue for twelve years. Only women can imagine the consistent pain, discomfort, and shame that come with an unceasing bleeding condition.

This woman's segregation serves as a biblical foundation to the struggles that many African American women in historically marginalized communities encountered in the past and today. As much as this narrative is one that may impact the faith of any person of faith whether male or female, it is clearly a story of a person of the female gender and represents the unique struggles within the spheres of a woman's body. Her segregation and uncleanness must have caused what Ericka Elion, refers to as "soul trauma" (Elion 468).

Soul trauma is caused by the awful experiences that women of African descent and Black women have faced in the United States and beyond. Elion describes soul trauma as "the generational spiritual consequences of racism, victimization, marginalization, and isolation experienced by women of African descent" (468). The woman with the issue of blood serves as a Biblical foundation of the experience of soul trauma. She was marginalized in a society hostile to her kind. She was a victim of a health care system in her time that could not heal her.

The message recounts that the woman "had spent every penny she had on doctors but not one had been able to help her" (The Message Bible, Luke 8:44) The woman went through the equivalent of the health care system of her time nad did her part, until poverty struck. This narrative is about her faith, her economic and social economic status, her salvation, the healing of soul trauma, and the healing of her body. As much as modern day interpretations would like to separate the bodily experience from the spiritual experience, this radical miracle should be embraced in its entirety. Considering the woman's desperate trust, Jesus pushes the boundaries of gender, race, and disease to pronounce faith, dignity, and a full humanity.

Second, in the Matthean narrative the writer focuses on the importance of the woman's unlimited faith and trust in Jesus (Commentary 1). This connection of faith translates into a literal outcome of physical healing. This female had done everything in her hands to find healing, and it was only after encountering Jesus and touching his garment that she found a solution (Mark 5: 29). It is important to note that the narrative does not undermine the health care system. Instead, the woman is an example of the power of including faith and Jesus in the praxis of health care and wellness. Thus, trust and faith in Jesus creates a different kind of empowered space for the restoration of African American woman.

In the Matthean gospel of this narrative the writer uses the verb *sozo,* which indicates that her healing was a divine deliverance (Boring, 71). This is the same verb used in Matthew 8:25, when the storm comes on the disciples and Jesus while they were on the boat. Jesus companions plead, saying, "Master save us! We're going down" (Matthew 8:.25). Another poignant example of divine deliverance was when Peter was

going under water, and he cried, "Lord, save me!" (Matthew 14:30). The verb implies a deliverance that is both spiritual and physical. Both acts are deeply intertwined. Jesus pushes the boundaries of his time to heal a woman marginalized by physical suffering and sickness.

Chronic Disease

The story of the woman with the issue of blood highlights an important aspect of human existence that should not be ignored (Perkins, 507). Namely, chronic disease is a part of the human experience. It is a painful part of life that complicates all areas of existence. What is particularly challenging in this narrative are the consequences that chronic disease brings about in the life of this woman. The result was a woman ostracized in a society in which her blood condition made her ritually impure. Thus, Jesus provides health care. Emilie M. Towers defines health care as "the restoration of health, as it includes activities that foster healing and wholeness using the individual and communal components of health" (Elion 472).

Chronic disease is a phenomenon that impacted the unnamed woman's life in tangible ways that touched her spirit, mind, and body. Jesus heals in community and calls out the action of faith and his power to heal as things to be acknowledge in the context of community. Emilie Townes observes, "Health is a cultural production in that health and illness alike are social constructs a dependent on social networks, biology and environment" (Townes, 2). Since disease interrupts all aspects of human life and Black women's lives, it is also a spiritual reality. Therefore, this narrative does not separate salvation from healing. Matthew's gospel connects salvation and healing as being intricately connected. Salvation is the woman's experience of life with God.

Townes goes further to say, health "is embedded in our social realities, health also includes the integration of spiritual (how we relate to God), the mental (who we are as thinking and feeling people) and the physical (who we are biologically) aspect of our lives" (Townes 2). Just like the woman in this narrative, African American women in the US have experienced harmful "medical theories and medical apartheid" coupled with sexism that persists in modernity (Elion 472). Some examples of medical theories that ostracized African American women come from the 1800's. Women's skulls were measured along with the length of their bones and the number of their cells to determine that they were a weaker sex (Townes, 107). These theories were more devastating and unfortunate for Black women since "white women/western women were the benchmark of femininity" (Elion 472).

Fibroids and Black Women

According to JDM Derrett in the Sacra Pagina, the woman with the issue suffered from a "menorrhagia," which could have been perhaps from fibroids (Harrington, 474). This medical illness manifests in uterus fibroids and affects African American women in disproportionate ways. Fibroids are most common in Black women compared to other racial groups (Brown, 10). As a group, women of African descent are more vulnerable to this condition. A 36-year-old woman shared an example of this challenge, and her words of concern bring to mind the experience of the unnamed woman:

> "The word fibroids entered my vocabulary as subtly as the mass grew in my body. More and more I found myself talking about it, thinking about it, fearing it. In my body now grew "something." Some matter that fed on my blood, reacted to my increasing stress level, and even supposedly responded to my diet. When I asked

> my doctor why this was happening or what I could do to get rid of them, she gave a short, noncommittal response. "No one knows why most black women them have," "Well just have to wait and see." Her answer did nothing to alleviate my concerns" (Brown, 10).

Although the narrative does not name what exact medical condition of the woman, it does leave room for interpretation. The pain of a bleeding condition may correlate to the struggles of African American women being affected by such a condition. Only women can really relate. Brown provides examples of symptoms women with fibroids may experience such as, "heavy periods, bleeding in between periods, anemia, fatigue, distortion of abdomen, frequent urination, constipation, painful intercourse, cramping, premature labor, infertility, miscarriage and depression" (27).

The story of the women with what is called Haemorrhoissa (Mark 5:24-34) may display the issues of faith and despair in the life of women. The physical pain is clearly unbearable suffering. The twelve-year period of suffering recalls the historic pain of suffering of African American women within the health systems in the South. At that time, the woman's boldness "was seen as crossing the boundaries of decency" (Baert, et. al., 664). Her uncleanness by law was a form of despair.

Like the lives of African American women in North Carolina and the rest of the United States, this story is complex. The complexity comes from the interface of faith and despair. From the "relationship between touching and healing… to the specificity of her illness, her so called issue of blood-impure by law" to her interaction with Christ, the theme of faith in the midst of despair is the recipe for a miraculous healing. Elion suggests that healing practices teach "Black women how to experience the process of

being" (477). In this case the despair and painful reality of suffering result in healing that came from the sick person's initiative to touch Jesus. This process is then what gives sense to the practices of wellness, healing, and health relevant for African American women seeking equity in the context of faith.

From Despair to Faith

In the same way, the woman with the issue of blood suffers her disparity based on her gender, sickness, and social economic status. Yet, she did not give up hope. She insisted on her full humanity by her act of faith, which Jesus also acknowledges and commends. A miracle is created as the touching of the garment is understood as faith. Jesus' action disrupts the patriarchy of his time in the intervention of the oppressed woman. African American women's souls have long dealt with such oppressions. What may be troubling in the souls of African American today is the ways in which their lives are taken for granted. According to Sonya Mann-McFarlane, "African American females have historically been labeled as inferior, assuming the bottom rung on the societal ladder (59)." Thus, one can only imagine the level of despair and trauma lived by this woman in this narrative and its connection to African American women's lived experience.

This story is the first of a set of miracles cycles that involve the female gender, the woman and then the girl child. One disadvantage of the Matthean narrative may be that it is believed by some commentators that Matthew abbreviates the story of Mark 5:21-43 (Boring et al., 87). As a result of these omissions, the writer loses the connection between the stories of the daughter of Jairus and the women with the hemorrhage. However, the healing story still connects with healing in community and the plight of

African American sisters. The prophet Jeremiah and the daughters of Zion come to mind. Jeremiah's lamentation speaks to the despair:

> Hark, the cry of the daughter[s] of my people from the length and breadth of the land: Is the Lord not in Zion? Is her [Sovereign Power] not in her? For the wound of the daughters of my people is in my heart wounded, I mourn, and dismay has taken a hold of me. Is there no balm in Gilead? Is there no physician there? Why then had the health of the daughters[s] of my people not been restores? (Jeremiah 8:19, 21-22)

The reality of despair and faith is a critical component for the biblical foundation of this project since many African American may relate to the particularities of this text. This narrative of pain, despair, faith, hope, and healing allow many women to visit the wounds of their sufferings. Woundedness is a part of the human experience. As Rev. Dr. Marjorie Lewis asserts, "Wounds are a source of suffering and can also be opportunities to reflect theologically about the nature of suffering" (546). Suffering is transformed by faith. Therefore, the unnamed woman's faith may show that power is found in Jesus when the oppressed press their way in a hostile environment. This very principle is what motivates many African American churches and community FBOs to live into a spirituality that changes the health disparities of African American woman.

Jesus' Healing Ministry

Overall, an important aspect of the Biblical foundation for this research project is Jesus' healing ministry. The gospels record thirty-seven miracle stories. Most of these miracles had to with healing and transforming lives (John 4:43-54; Matt. 8:14-15; Mark 5:25-34; Matt. 9:27-31). Jesus was a healing agent on earth establishing The Kingdom of

God (Matt. 6:31-33; Matt. 13; Mark 9:35-37; Mark 4:30-32). Many of his works on earth were related to healing individuals and communities. His mission was to bring a messianic hope. Thus, healing meant to bring forth a new reality and a Kingdom that was not of this world (John 18:36).

Jesus delineates a process of healing and deliverance for those oppressed and marginalized. He healed the lame; he healed the blind; he healed the sick, and he healed women in controversial ways. Jesus came to lift the brokenhearted. Luke 4:18 declares, "The Spirit of the Lord is on me, because [God] has anointed me to proclaim good news to the poor. [God] has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to set the oppressed free." Jesus was often moved by compassion to heal people in a way that would transform their lives forever (Matt. 9.36).

Theological Foundation

Presbyterian Church USA's Ministry with African American Women

While this study will acknowledge the richness of theological thought and contributions of the ecumenical family, it will also highlight the reformed tradition, particularly the Presbyterian Church (USA) (PCUSA). The PCUSA has a longstanding history with struggles of social justice, disparities, and the human condition. This section will delineate the theological thoughts that guide the denomination's concerns for African American women. Much more must be done to dismantle theological understandings that contribute to the oppression of African American women and girls.

The Disparities Experienced by Black Women and Girls Task Force made groundbreaking concrete recommendations to the 224th General Assembly (2020) of the PCUSA. It sought to hold PCUSA agencies such as the Presbyterian Mission Agency and

the Office of the General Assembly accountable to the issues of social justice and witness to African American women and girls Some of the areas that were named in the report included: eradicating systemic violence, changing toxic theological discourses, conducting research on the experience of Black women, and provide training to church professionals and congregations on racial injustice (224th GA, 2020).

This report was prepared in response to the immediate effects and long-term consequences of interpersonal and institutional violence perpetrated against Black women and girls in US society and in the PCUSA. This intersectional (race/gender) and multidimensional (physical, mental, emotional, and spiritual) violence manifests in dehumanizing expressions of Black womanhood (e.g., pejorative stereotypes) and in theo-political sanctioned and socially accepted practices of disenfranchising (e.g., policing, silencing, making invisible, and criminalizing). The dehumanizing tropes are intended to negate Black female identity, and the disenfranchising practices serve to restrict Black female access to resources and opportunities otherwise afforded to those who enjoy hegemonic race, gender, or sexual privilege (224th General Assembly, 2020).

The report called for an active response from Christian siblings in the denomination to address the long-term effects of institutionalized violence and assault on Black identity. However, the assembly voted down the item of the task force and deferred it to the 2022 General Assembly. This unfortunate action happened at a time of a double pandemic of COVID-19 and its disproportionate effects on Black and Native communities as well as the plight of Black America in the midst of racial unrest over police brutality. The disappointing outcome of voting these recommendations down may indicate a need to be persistent in holding a predominately white denomination

accountable to responding to the cries of African American women and girls within the denomination and in the broader society. What follows are several important aspects to address theologically that will make a huge change in the lives of African American women of faith in the PCUSA and possibly in other Christian communions.

Eradicating Toxic Theology

First, in her work as a Christian Ethicist, Dr. Katie Cannon was a pioneer in addressing the theology and ethics that dehumanize African American women in the United States. Cannon was known for teaching her students the importance of becoming moral agents. The idea was to expose wrongdoing in the same way that Scriptures exposes that Jesus was innocent of the crimes (Luke 23: 4; Matt. 27: 3-4; Heb., 4:15; 1 Peter 2:22). Thus, Cannon sustains that her own experience as an African American woman begins with her formation as a child, “My experience was that my mother exposed me to the world as it was without protection, and she also taught us how to cope with it, so we all learned our place” (Troutman, 41). In the same way, African American women have come to learn their place within the Church and in an American Christianity, which is full of theological discourses that have denied them access to abundant life.

Second, in the Christian journey there are traditional theological principles that are used to deny African American women, and all women, equality as “image bearers of the living God” (Gonzalez, 10). These theological discourses have historically benefited male authorities by strengthening a patriarchy in the Church that has undermined African American women. Michelle Gonzalez, closely examining Genesis 1:27, suggests that

Christian male authors have historically not characterized the relationship of men and women as egalitarian. She argues:

> Women are seen as possessing the image deficiency, for example, or only in relationship with men. Interpretations such as these have falsely denied the full image of God in women, equated her with bodily ness, and elevated men as the ultimate representation of rationality and spirituality, the expression of the image in its fullness. (Gonzalez, 20)

Third, these kinds of toxic theological interpretations have historically affected African American women in detrimental ways. For instance, from lacking in the image of God, African American people were known to be descendants of Ham and thus cursed by Noah to be servants. This toxic theology not only condoned the idea of the inferiority of African American women in relation to men, including African American men, but relegated them to servants and enslaved subjects. This false claim dehumanized and humiliated African American women, and crimes against them and their perpetrators often went unpunished. African American women were treated as commodities and objects of physical, mental, emotional, and spiritual abuse (Ellion, 471; Joynes, 498; DeGruy 25; Carruthers, 00: 03:00-00: 10:00). Toxic theological interpretations of Biblical narrative interpretations that affect the lives of African American women in negative ways must be transformed with theological insights that heal, lift up the plight of the oppressed, and showcase Jesus' gift of full humanity to African American women.

The Great Ends of the Church

First, for decades, Presbyterian mission has been guided by a statement created in the 20th century that is referred to as the six Great Ends of the Church. These important

tenets frame an understanding on what is means to be reformed. These six principles are as follows:

- The proclamation of the gospel for the salvation of humankind.
- The shelter, nurture, and spiritual fellowship of the children of God.
- The maintenance of divine worship.
- The preservation of the truth.
- The promotion of social righteousness, and
- The exhibition of the Kingdom of Heaven to the world. *Book of Order* (2017–19), F-1.0304)

The Great Ends propose a challenge that calls the church to live into a holy reality guided by the power of the Holy Spirit. They call believers to examine how they "live and move and have [their] being" in the midst of a world impacted by sin (Acts 17:28). All the Great Ends demonstrate ways in which the Lord Jesus Christ offers a journey with him. Believers are called to not just attend church on Sunday mornings; they are called to be the Church. Rev. Eryn Mera asserts, "We have to rethink what church is. Worship isn't only what we do on Sundays" (Blackman, 2).

Second, The Great Ends offer a strong calling for Presbyterians to be involved in all areas of society proclaiming a Living Christ (John 1:4; 6:33; 10:10). Presbyterians are called to proclaim the gospel of salvation to all humanity. Jesus is the light of the world, and as he himself declared, "I am the bread of life (John 6:48). Presbyterians trace their rich heritage to the Protestant Reformation of the 16th century. From the reformer and lawyer John Calvin (1509-1564) to the movement of early Presbyterians in Europe and America, the proclamation of the gospel was at the heart of their conviction.

Some of the principles articulated by Calvin are "the sovereignty of God, the authority of Scripture, justification by grace through faith and the priesthood of all believers" (Calvin, 625). God is therefore the highest authority that guides Presbyterians' lives. Their purpose is shared in the Bible, and the gift of justification through Jesus Christ is delineated in the New Testament in the life of Jesus Christ. "Humankind" is supposed to include all people independent of how they look or their race, skin color, or gender. For far too long humanity has been divided. The Presbyterian Church continues to struggle in how to make the proclamation of the gospel a more inclusive reality for all of God's people.

Even while the proclamation of the gospel was spreading abroad from Europe to the British Isles and into the Americas, there were conflicts in the process. Many of the conflicts and injustices happened to Native Peoples in the Americas and then to African siblings through the sin of institutionalized slavery and racism. The American colonies brought new opportunities for religious freedoms, unfortunately that was for a few. African American s were not invited to that table of freedom. The 400 years from 1609 until now, marked the struggles of people of African descent and their grim journey. As Terry E. Brown puts it:

> "I would like to encourage people from all around the world to be a witness to the 400th anniversary of the first enslaved Africans in English North America – where enslaved Africans stepped off an English privateer, beginning a 400-year odyssey for generations of descendants which shaped the course of this nation. In the end, we'll be judged as a nation by how we tell our story (2).

This project must include a theology from the perspectives of people of African descent in the US. This rich theological experience must include the voices of African American women. The task here is multi layered in seeking to name the rich elements that shape what the Presbyterian Church believes and ought to strive to be. Furthermore, the Great Ends of the church create room within the denomination for African American women to tell their stories of struggle, injustice, suffering, and redemption in Jesus Christ.

Third, the PCUSA adoption of the Belhar confession is an example that strengthens the witness of the church in issues of race, specifically the last two Great Ends: the promotion of social righteousness and the exhibition of the Kingdom of Heaven to the world. This poem by Elizabeth Sewell, an African American woman that witnessed the struggles of the Civil Rights movement in the 1950s and 1960s, captures a theology from the margins that must be heard:

You can sense it when you're lying, open-eyed upon your beds,

O the iron and the weeping such as loving eyes afford,

When the tigerish divisions tear Christ's body into shreds,

O the iron and the weeping where the grapes of wrath are stored.

Through the worship, through the concert, through the phalanx of police,

Where merely to be coloured is disturbance of the peace,

And you begin to wonder if this sound will ever cease –

O the iron, O the weeping, O inexorable Lord.

(Sewel, "Five Mississippi Poems")

The Belhar Confession of 1986 was adopted into the Book of Confessions of the PCUSA in recent years. The Belhar confession was "written as a protest against a heretical theological stance by the white Dutch Reformed Church that used the Bible and the Confessions to justify the harsh and unjust system of Apartheid" (Rogers). The Belhar confession provides a powerful theological foundation that addresses systemic racial injustice and holds believers to the authentic meaning of unity. The following portion of the Belhar confession highlights the theological context of this project:

> **Therefore, we reject any doctrine**
>
> • which, in such a situation sanction in the name of the gospel or of the will of God the forced separation of people on the grounds of race and color and thereby in advance obstructs and weakens the ministry and experience of reconciliation in Christ… (Belhar Confession, 1986… 3)
>
> **We believe**
>
> • That God has revealed himself as the one who wishes to bring about justice and true peace among people.
>
> • that God, in a world full of injustice and enmity, is in a special way the God of the destitute, the poor and the wronged
>
> • that God calls the church to follow him in this; for God brings justice to the oppressed and gives bread to the hungry.
>
> • that God frees the prisoner and restores sight to the blind;
>
> • that God supports the downtrodden, protects the stranger, helps orphans and widows and blocks the path of the ungodly;
>
> • that for God pure and undefiled religion is to visit the orphans and the

widows in their suffering;

• that God wishes to teach the church to do what is good and to seek the right;

• that the church must therefore stand by people in any form of suffering

Therefore, we reject any ideology

• which would legitimate forms of injustice and any doctrine which is unwilling to resist such an ideology in the name of the gospel. (Belhar Confession, 1986…4)

The adoption of the Belhar confession in the PCUSA, a predominately white denomination with a complex racial history, was an unprecedented accomplishment. While it is a different context from the African American civil rights movement it highlights the issues of apartheid in relation to African American people in the US in significant ways. It is an acceptance of the sin of racism and the involvement of the church and the need for the church to continue to make amends to African American s and People of Color in the US. It is a theological victory to help dismantle theological ideologies that perpetuate any form of injustice. Despite this advancement, the General Assembly Committee on Inter-Religious and Ecumenical Relations has acknowledged that more should be done and a confession of repentance to African American siblings for the sin of racism and enslavement should be ratified in the near future.

Foremothers Courage in the Face of Danger

First, Moses' mother, Jochebed, was one of the first advocates for justice in the Bible. She was a woman full of courage who believed that her son had a great purpose in life. She defended him, even if the action could cost her own life. In the face of dancer,

this foremother is a powerful example of trust in God in the face of genocide. Hebrews 11:23 mentions her as a key woman of faith strategically positioned in the plan of God: "By faith Moses' parents hid him for three months after he was born, because they saw he was no ordinary child, and they were not afraid of the king's edict*."* Women like Jochebed may represent modern-day women of Pan-African descent and African American women who have fought to protect their children, families, and communities in the face of brutal unjust societal systems. Black women today continue to encounter many challenges that range from unfair societal structures, colonialism, sexism, economic disparity, racism, and unbearable poverty (Joynes, 499; DeGruy, 33; DuBois, 150).

Second, one of the most unfortunate outcomes of injustice was crushing poverty. In the same way this has made African American women in the US the "devalued other" (Joynes, 500). Hyunju Bae sustains, "Exploitive economic systems give rise to ever-growing injustice in society, destroy human relationships and communities, and dehumanizing both the oppressor and the oppressed" (Bae, 2). Therefore, "Women in the global jungle, who suffer from the feminization of poverty, bear the brunt of economic injustice" (Bae, 1). Public theologian Joynes encourages the devalued other of women's and faith communities to engage in a pedagogy of becoming to strengthen Black women's agency (501). The becoming of African American women in the church includes the care of their temple and full selves. The spiritual renewal in becoming may cause a careful examining of the hermeneutics that perpetuate the "devalued other." For, as Michelle Obama asserts, there is already an invisible fight that poor African American women and girls have to face with being female and Black & Brown (Fox.).

Theological Pilgrimage of Women of African Decent & African American Women

This project uses the definition of “Pan-African” utilized by Rev. Dr. Angelique Walker-Smith and other researchers that connect the transatlantic moment to those that identify with the ancestors forcefully taken to many parts of the world including North, Central, and South America:

> Pan-African refers to the diversity of people of Africa and of African descent. Minkah Makalani of Rutgers University captures the original understanding of the term by stating that it is the belief that African peoples, both on the African continent and in the diaspora, share not merely a common history, but a common destiny. This sense of interconnected pasts and futures has taken many forms. Women of faith are a way to talk about the importance of faith among women of Africa or African descent. Black Women & African American Women (Walker-Smith, 227).

Many African American women of faith relate and connect their heritage back to the African continent. They see themselves as descendants of the children of God that were stolen and brought by force to the United States.

First, Angelique Walker-Smith is an advocate for women and lifts the plight of women of African descent, particularly African American women, in her work to end hunger and poverty. She asserts that women of African descent are excessively affected by misery and suffering (Walker-Smith, 231; Lewis, 545, Elion, 480). Walker-Smith draws attention to the ways in which Jesus gave special attention to “those who were vulnerable-physically, materially, or spiritually. Like Jochebed in the Hebrew Bible,

African American women lead their communities and churches. Indeed, the journey of "Pan-African and [African American] Women of faith have been one of transformative hope found in their narrative of celebration, suffering and faithful resilience" (Walker-Smith, 227).

Second, Walker-Smith uses the three theological focuses of the World Council of Churches, Pilgrimage of Pain and Hope to place the journey of African American women in perspective. These focus areas include: (1) Via positive: celebrating the gifts; (2) Via negative: visiting the wounds, and (3) Via transformative: transforming injustices. In this journey, believers are invited to develop courage to learn from the margins. The margins are rich with stories and testimonies of African American women that carry unique lenses of theology and are rich in nature. They affirm and celebrate the gifts of women of African descent, particularly African American (Walker-Smith, 228).

Third, as the journey of pilgrimage is expounded, the foundation comes from journeying with Jesus on the road (Luke 24:13-35). Black women have been affected disproportionately by injustices within the church. They have been subjected to institutional abuse in many instances. Black female theologians have for decades struggled with Biblical interpretations and theologies that pertain to female bodies (Walker-Smith, 230). There is much debate on the ways that toxic theologies affect the flourishing of women of faith in the church. Thus, these three theological focuses aid in understanding the importance of contextual theologies that empower African American women to heal.

First, the pilgrimage of faith begins with *Via positive*: celebrating the gifts of pan-African women of faith, which includes African American women in the US. This

celebration is especially important within and lived in community. The pilgrimages of many Black women have been ones of celebration and of knowing who they were before slavery, segregation, and Jim Crow. They walk in love as Pan-African women in the reality of this journey, because every journey has a beginning. Gustavo Gutiérrez asserts this neighborly love and argues that because of that love they walk in each other's paths (Gutiérrez , 207). Pan-African women of faith within this ecumenical movement assert:

> As women of faith from Africa and the African Diaspora representing diverse cultures and nations, we are called to serve our God and to honor the cause of our ancestors. We declare that our history did not begin, as many would believe, with the visitation of our colonial counterparts from nations outside of Africa who arrived on our African shores or on the distant shores separate from Africa after the travail of wretched slave ships in the Middle Passage. We recognize that long before we were shackled to the hulls of ships like the La Amistad and the Henrietta Marie, we were royalty. We were emperors, empresses, kings, queens, pharaohs, rulers, military leaders, poets, philosophers and strategic and organizational geniuses. Today we are politicians, church leaders, social activists, mothers, daughters, and sisters (Walker-Smith, 228).

The theological tradition that sustains the experiences of many African American women in the US is known as womanist perspectives or womanist theology. A pioneer of this is Renita Weems. She offers a reflection on the story of Hagar. The story is the drama of the Egyptian woman Hagar and the Hebrew woman Sarai and provides an example of race, class, and exploitation (Weems, 23). The narrative of Genesis 16 demonstrates the dynamics of an enslaved woman of African descent and a master

matriarch woman, Sarai. Hagar's body is given to Abraham without consent. Her status affords her no power and autonomy. She had no say over her reproductive health and had to exist within a construct that did not regard her full humanity (Andrews, 305).

According to Weems, it is important to treat with care the comparison of the modern context of racial divides with the ethnic challenges of Hagar's time; however, similarities can be drawn. The ethnicity differences are clear in the narrative, and it is named as such. This is a story that shows ethnic prejudice in addition to family dysfunctions exacerbated by the challenges of emotional, economic, and sexual mistreatment (Weems, 25). Many Christian African American women have related to this narrative in ways that draw on their experiences of persistent societal injuries. These injuries are lived out by many African American women of faith within Christian communities. The local church is one of the safe spaces African American choose to bring up the challenges brought about societal discrepancies. It is in those spaces that they seek the healing touch of God as a balm in Gilead within their lives.

Second, the pilgrimage of Pan-African Women of faith continues with the next step of pilgrimage, *Via negativa*. The via negative is about visiting the wounds. Dr. Walker-Smith draws on the wisdom of LaVerne McCain as she strengthens the witness of African American women in the US. The theological wisdom she provides visits the wounds of African American women by connecting them to the rich Biblical stories of women of African descent (Walker-Smith, 228). One example is the story of Zipporah, and the way Moses saves her from being assaulted. She then rescues Moses through the wisdom of her traditional knowledge.

The prolific Rev. Jeremiah Wright concurs with McCain. In "Africans Who Shaped Our Faith," he emphasizes Zipporah's role as the daughter of a priest and the wife of a preacher. Wright ascribes to her a spiritual wisdom and attentiveness to rituals and traditions that form the foundation for the way in which God leads her in immediate response to Moses' attack. Wright paints the picture of a woman who is wise beyond her years and uses the African rituals of her father to save the life of her husband. McCain Gill and pastors like Wright support Zipporah as a woman of African descent and her own role in the salvation history (McCain Gill, 30; Wright, 97; Walker, 229).

One of the greatest injustices that Pan-African and African American women of faith mourn is their disproportionate rates of hunger and poverty. The Bread for the World Institute indicates that today women of African descent all over the world suffer disproportionately from hunger and poverty. In the case of the United States, “One in three single African American mothers are food insecure, compared to one in five mothers in the general population. In addition, African American mothers are three times as likely to live below the poverty line as the general population” (Bread for the World, 1; Walker-Smith, 232). Hunger and poverty are only two of the many problems that concern African American women and Pan-African women of faith. Other wounds include gun violence, lack of access to higher education, police brutality, environmental racism, gentrification, lack of access to equitable health care services, food deserts, HIV/AIDS in Black communities, human trafficking, injustices with sexual minorities of color, and homelessness. The wounds many African American women visit are difficult, and the women of faith and all God’s people are invited to the pilgrimage.

Thus, visiting the wounds is about the experiences of pain that people have encountered as a part of life. Visiting the wounds also involves testifying and remembering how the Divine has intervened in support to relieve human suffering. It involves the acknowledgement that, as Jesus clearly said, "In this world you will have trials and tribulations, but be of good courage because Jesus has overcome the world" John 16:33). This is why the theological image of pilgrimage and visiting the wounds may provide a sense of hope for African American women. It echoes the American Black Church saying, "God sits high, but looks low." The wounds of African American women are particularly painful, and they tell many stories others must hear.

Third, the final step in the invitation to the pilgrimage of women of African descent and African American women in the US is the *Via transformativa.* Village HeartBEAT includes at its heart the theological praxis of transformation. They do this by inviting the spirituality of churches to connect with faith and action. The pilgrimage of African American is one of hope toward transformation. The path of transformation is one of commitments that Pan-African women of faith, including African American women, have made to positively impact women and girls worldwide.

Therefore, these recognitions are in line with the theological vision of VHB as a program founded by a Christian African American woman in public health. Its commitment is to strengthen faith, health, mental health, and advocacy to eradicate inequity with and for African American women. Pan-African and African American women of faith recognize that many women and girls of color around the world are disproportionately affected by poverty, hunger, and other ills. Parallels can be drawn as a

prophetic theology of action that seeks to transform the lives of African American women and girls by declaring:

- We are listening to and working in solidarity with women affected by hunger and poverty.
- We must engage gender and cultural diplomacy to exchange. We carry authority
  in our gender, culture, and in simple acts of kindness.
- Justice work must be balanced and wrapped in prophetic discernment and self-care.
- We need to create "alternative economies" to fund our efforts to live out our freedom.
- We have everything we need (not to get free) but to be the free that we are.
- We need to cultivate the spiritual gift of listening to the voice of God heard and seen in our midst.
- We embrace the leadership of young people who are contributing to this inter-generational movement, learning from them while serving as guides and advisors alongside them.
- We must challenge and agitate oppressive institutional structures and social and
  cultural norms that perpetuate discrimination and place barriers in front of women and girls.
- We affirm the necessity of working in compassionate partnership to break the powers that hinder our goal to end hunger and poverty.

- We acknowledge that in order to achieve the Sustainable Development Goals,
- Including the goal of ending hunger by 2030, we must work differently in our
- diversity.
- We must strengthen local capacity and support local solutions.
- We acknowledge that the United Nations Decade in Solidarity with People of African Descent offers a unique opportunity for us to come alongside the nations of the world in achieving our advocacy goals (Walker-Smith, 236).

Village HeartBEAT as a Modern Day Sankofa

First, by closely examining the theological value of VHB within the community one may evoke the powerful image of Sankofa. The definition of Sankofa is based on the ancient understanding of the past serving as a guide for planning the future. This understanding conveys the importance of wisdom in learning from the past which ensures a strong future (Ellion, 479). The spirit of Sankofa creates an educational space that connects African peoples to their heritage then and now. Ellion suggests that the practice of Sankofa serves as “a form of holistic medicine in the repair of Black souls” (Ellion, 480). The partnership of FBOs is not a one-dimensional approach but instead is one that may serve to strengthen the spiritual healing and spiritual connection with Christ of participants that seek to empower themselves.

Second, VHB practices in its Christian principles valuing the “devalued other” while inviting African American church leaders, lay leaders, and congregants to examine how African American women have both been affirmed and victimized by a system that affects all aspects of life (Joynes, 497). VHB also creates space to interrogate how African American male domination and patriarchy have left a negative mark on how

African American women view themselves and in the ways they care for their bodies. It affirms the pastoral care that is already being offered by caring pastors, while opening new spaces to dismantle unconscious toxic theologies about African American women.

Historically, African American women were considered the primary and sometimes the only caretaker of the household. In addition to issues of systemic structures that disabled African American women from having equal access to health care. African American encounter the double sword of church theologies that both affirmed them and at the same time subjected them to keeping their "proper place" in the church. An example of this was the inability for women to become ordained by their denominations, as was the case at one point in the PCUSA.

Dismantling Racial Faith

Many modern-day Christian structures struggle with patriarchal and racialized frameworks within their congregations. Dr. Willie Jennings claims that many of the challenges of Western Christianity have to do what he calls "racial faith," which has to do with "Gentile forgetfulness" (Jennings, 6). The continual oppression of women and girls speak to this forgetfulness in which the oppressed have become the oppressor. Subsequently, Black female bodies continue to exist as commodities of conquest.

Christian belief in God begins with the astounding claim that God was present in a Jewish man, Jesus of Nazareth, a vagabond rabbi who came to his own people, Israel, rather than to Gentiles. Gentile Christians were outsiders to Israel. They were on the margins of the covenant, crafted in. Therefore, engagement with Jesus was engagement from the margins, not from the center of power or privilege.

In fact, anyone who claims connection to Jesus is called into a "margins" experience. They became what theologian Shawn Copeland calls "a thinking margin… Somewhere, probably in many places and many times, Gentile Christians got tired of remembering that they were a thinking margin that had been included in Israel's promise" (Copeland, 226). Black women in the South existed in the margins of society, and today disparities remind them of their continual "marginalized" experience. African American sisters are reminded by society, by erroneous church doctrines, and by negative health outcomes which affect their physical bodies.

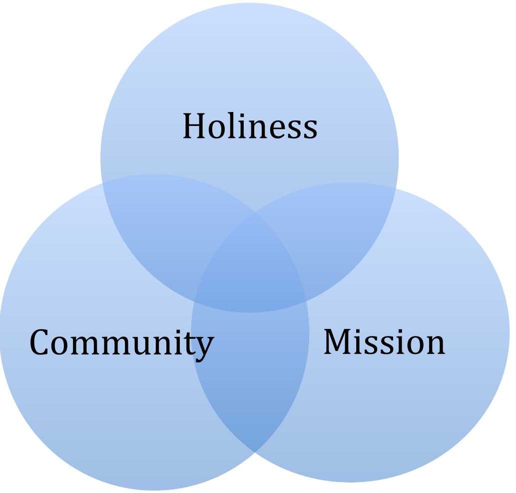
Richard Bauckham also describes the process of inclusion through the promise of Abraham. The promise of Abraham expands to the nations and to all the families of the earth. He says, "The trajectory that moves from Abraham to all the families of the earth is the trajectory of blessing. The trajectory that moves from Israel to all the nations is the trajectory of God's revelation of himself to the world" (Bauckham, 27). Believers are given the opportunity to partake of great promises and blessings in Jesus Christ and for his sake.

Deuteronomy 26:1-11 centers on God as giver and models the response to God in worship as an act of remembrance, gratitude in giving, and obedience. The text demonstrates that giving and worship are inseparable. An emphasis on the stewardship of all of life leads believers to reflect upon God's giving nature and their response as worshipers in action. Worshipers in action take care of the entire community. Black women are important members of the community that deserve care. The movement of this word goes beyond into the way the community treats the marginalized and oppressed. What believers do for each other's bodies as the Body of Christ matters.

Giving begins by being transformed by the essentiality of being in a community shaped by God's giving nature.

For instance, one way to engage the place of women in the Bible is to use the model presented by Dr. Bryan Russell on the DNA of the Bible. In his model, the DNA of Scripture is composed of three areas: mission, holiness, and community (Russell). Black women in the South have always been at the center of that DNA. At the center of the three is God's will.

Figure 1.1a: The DNA of Scripture



Another way to present this notion is by placing God, the Church, and the world with Jesus' atonement in the center. Associate Old Testament Professor, Stephen Chapman explains the covenant by naming Israel, the Nations, and the Church in each circle with God's will at the center (Chapman). Although each perspective invites examination of the idea differently, the heart of re-alignment happens when all three circles can converge. It is converged in the Holy Spirit creating a space, which Jesus realized in the Resurrection.

The reformed tradition asserts that Jesus mediates his presence, coming to a crescendo at the center where all three meet in perfect union. Women were at the center

of this crescendo, their bodies being the carriers of the good news of the gospel (Matthew 1: 1— 5; Luke 1: 46 –55; Ruth 1: 16 –18). Thus, the Divine calls the community to defend the place of all women, especially disadvantaged sisters, as those crafted into Christ. In the Hebrew Bible there is the witness of women who saved the life of great men such as Moses (Exodus 2:1, Numbers 26: 59).

Historic Woundedness of People of African Descent: A Remembrance

People of Pan-African descent from the mainland United States, the Caribbean, and Latin America have a long history of disparity that continues to impact health and all areas of life in general. This history has been marked by the great conflicts and pain of slavery and enslavement, economic exploitation, human commodification, rape, murder, racism, and sexism, just to mention a few. To understand the complicatedness of health inequity, health disparity, and health care disparity, it is essential to recall the history of enslavement in the United States and the Caribbean. These realities hallmark present struggles of disadvantage for women of color and African American women in the US. When a society subjects black and brown bodies to inequity, it creates a snowball effect that affects all aspects of the life and the mental, spiritual, emotional, psychological and physical health of its peoples.

One of the consequences of the human trafficking of black and brown bodies is the inception of health disparities in the United States and the Caribbean. A map of the transatlantic slave trade, 1501-1867, estimates over 10 million peoples were stolen and brought into enslavement during those periods (Atlas of the Transatlantic Slave Trade). The Declaration on Race and Racial Prejudice notes that "the gravest concern that racism, racial discrimination, colonialism and apartheid continue to afflict the world in ever-

changing forms" (Declaration on Race & Racial Prejudice, 2). It is important to call to recall some of the root causes of health disparities of women of African descent, including African American women in the US. The Christian tradition calls its followers to the spiritual practice of remembrance (Psalm 77:11; Isaiah 43:26; Jude1:5; 1 Corinthians 11:25).

Therefore, the estimates mentioned below are reminders of what God has done for his children. It also provides a sobering reminder of the ills that began with the sin of injustice long ago. Believers must grasp, reflect, and weep at the historic magnitude of harm and critical challenges that peoples of African descent faced. These past actions continue to have detrimental results for Americans of African descent in the United States, especially women. The atrocities committed on African American women during that period in the US were devastating for generations to come. Most disheartening was the Christian church's participation, which created a permanent stain on the witness of the God of love and justice (Hosea 12:6; Prov. 21:15; Amos 5:24).

Transatlantic Injustice

Enslaved peoples were taken from Africa by many routes that sailed through many seas and regions. For instance, an estimate of roughly 211,000 slaves were brought into the Carolinas and Georgia regions alone. Many of the African American women that participate in VHB from predominately African American church traditions self-proclaim themselves as women of African descent. Other regions of the United States, such as the Chesapeake received 129,000 Africans; the Gulf Coast 22,000, and Northern US 27,000 (Atlas of the Transatlantic Slave Trade). These numbers highlight the inherit

disadvantage that these peoples faced through their enslavement in the "New World." Many stories of devastation, oppression, and institutionalized racism have been recorded in many history books for posterity. The names of many women were erased from the historic memory of those ships of pain. Ana Stevenson describes the condition as "all women as born to slavery" and many African women recalling "being born to freedom" (Stevenson, 23).

Similarly, the Caribbean was the first to receive of enslaved Africans before the US. This first wave occurred after the genocide of the Taino Peoples of the Caribbean. Anthropologist Geoffrey W. Conrad suggests that the idea of globalization really began with the encounter between Taino indigenous Peoples and Christopher Columbus. He states, "After that everything is different from the way it was before…plants, animals, diseases, and ideas…In a sense they are the first People in the path of the storm" (Hanes, 00:011:45-12:31). The aftermath of devastation brought upon an entire Taino nation gives way to the subsequent powerful globalization and horrific transatlantic slave trade of African Peoples.

Third, as a result, in the island of Puerto Rico it is estimated that 27,000 Africans were delivered brought the period mentioned above. In addition, the Dominican Republic received about 792,000; Jamaica, 1, 020,000; Cuba, 779,000; Antigua, 138,000; the British West Indies, 72,000; St. Kitts, 134,000; Guadalupe, 75,000; Barbados, 493,000, and the list continues into the millions (Atlas of the Transatlantic Slave Trade). The transatlantic slave trade was the catalyst to every kind of disparity and depravity. These unfortunate circumstances were the inheritance of many Peoples of African Indigenous

decent. African women are the brave ancestors of of many African American women in the US. This is a short remembrance in the region of the new world, and Christians too recall such similar stories in the Biblical Canon.

African American Women on the Journey of life

The journey of African American and Black women in the US is diverse and different. Not one personal story or experience is the same. Therefore, the notions, ideas, and stories presented in this study do not represent the experiences of all African American women in the US. Many African American women may share similar challenges and experiences, but one must acknowledge their right to self-determinations and how they may identify themselves. Scott Appelrouth states, “Despite the common challenges confronting African American women as a group, individual Black women neither have identical experiences nor interpret experiences in a similar fashion” (Appelrouth et al.). For instance, middle class professional African American women may have a particular experience of institutional racism that may be different from that of low-income African American women. Even with these differences, “Black women fave a very high risk of being stuck in poverty…” (Winship et al., 5). Although distinct, both middle class and low-income African American women may share in the same experience of struggles due to racism.

The Biblical narratives present a constant witness of the importance of retelling and recounting the stories of many people who encountered enslavement (Gen. 39). Many women like Hagar and unnamed women that Jesus healed are often highlighted as the best examples of these liberations. The Biblical narratives do not hide the social

political, cultural, or economic realities that the beneficiaries of the blessings face. Throughout Scripture, there is a call to remember a particular event in which God's hand delivered from slavery, oppression, and despair. There are also stories about God's inaction in the face of pain that may challenge theological sensibilities.

There is also a call to remembrance combined with moves from the Divine to deliver people who have been oppressed. Through many signs and wonders Yahweh gives freedom to a group of oppressed people who need help (Exodus). Women like Hagar was made a promise (Gen. 16.13); Deborah is given insight (Judges 4), and Mary of Nazareth is given the strength to conceive the Son of God (Matthew 1:18). In addition to the theological, ethical, and moral interpretations and reflections of women in Scripture, researchers in other fields ask similar questions. With these important practices, other sources outside the canon must be employed alongside Scripture to comprehend the issues of health inequity and disparities of African American women in the US.

Health Disparities in the United States

Health inequality is the "difference in health status or in the distribution of health determinants between different population groups" (Beadle et al, 2). Black Americans represent about 41.4 million people in the US and are the second largest group (U.S. Department of Health and Human Services Office of Minority Health). Most Blacks live in the South where they account for an estimated 58% of the population. The ten states that represent most African American people are Louisiana, Virginia, Maryland, Illinois,

California, New York, Florida, Georgia, Texas, and North Carolina, where this project focuses (U.S. Department of Health and Human Services Office of Minority Health). The concept of health disparities is a broad one with multiple important aspects. Health disparities can be defined in various ways that will be delineated in this study. Healthy People 2020 propose another working definition of health disparity that sufficiently covers the focus of this project:

> We propose that health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established. This definition, grounded in ethical and human rights principles, focuses on the subset of health differences reflecting social injustice, distinguishing health disparities from other health differences also warranting concerted attention, and from health differences in general (Braveman, et al., 2).

Health disparities in the United States encompass a host of diseases, challenges, and issues that range from state to state and city to city. They include important categories such as mortality, morbidity, access to health care and preventive health services, behavioral risk factors, environmental hazards, and social determinants of health. The living conditions of people and their circumstances may determine their health and social outcomes. Social determinants are critical aspect for understanding health disparities' deadly effects in the US

The Centers for Disease Control and Prevention reports its findings on health disparities and inequalities by showing all the categories mentioned above. For instance, premature death, stroke, and coronary heart disease are higher among non-Hispanic

blacks than whites (National Center for Health Statistics). This suggests that blacks are more than likely to die before age 75. Premature deaths do not only affect adults in many black communities, they also disproportionately affect infants. This has a high impact for African American women, who tend to be at higher risk of infant mortality in the US. For example, infant mortality rates for black women were double than that of non-Hispanic white women in 2005 and 2008 (National Center for Health Statistics.)

Recent studies on US infant mortality show positive progress in decline of these. However, the data still points to persistent inequality trends among African American women. For instance, there were improvements in gestational health for Black women. However, despite this positive sign, these improvements mainly benefited white women at a rate of 48%, followed by non-Hispanic blacks at 31%, and Hispanic women at 14%. Infant mortality rates and preterm birth rates have decreased between the years 2007 and 2013, yet African American mothers are still disproportionately affected. Preterm birth rates are the main factor associated with death in the first year of an infant's life (Smith, I. et al., 3).

Another study measured the levels of state-level structural racism and infant mortality among white and Black populations across the US, found that structural racism continues to be at the center of this phenomenon (Wallace et al., 145). Structural racism continues to have serious implications on the health of Black women in the US today. For instance, compared to White women (37.9% vs. 19.4%), Black women tend to die from cardiovascular diseases (CVD) before the age of 75. In general Blacks have a higher prevalence of all major CVD risk factors than any other group. The American Heart Association emphatically recommends lifestyle interventions for reducing CVD

risk, prevalence, and related health disparities. Faith-based organizations represent viable settings for implementing sustainable heart-healthy lifestyle programs (Wallace et al., 150).

Other statistics on African American women show important reasons why health disparities affect this group in particular ways. Women make up a significant part of the population, about 50.8%. Women suffer disparity at a higher rate based on their race and ethnicity in the US. Black women are further affected by things like their socio-economic status, health behaviors based on their culture, lack of access to health care, environmental factors, and direct and indirect forms of discrimination (Wolfson, 2).

A study done in 2000 by the Institute of Medicine focused on the excellence of healthcare for racial and ethnic minorities. The findings delivered insight on the areas of disproportionate care compared to white Americans. The disparities were found in these areas: cardiovascular disease treatment, diabetes management, amputation, cancer treatment, HIV treatment, pain management, referrals for clinical tests, and physician communication (Mullins et al., 3). There are many realities that experts assert create these healthcare inequalities for African American women. These reasons include bias, prejudice, discrimination, and stereotyping (Marsh, 16).

In summary, women have unique experiences related to their health. African American women have higher risks related to reproductive health, mental health, and other challenges related to their gender, race, and social determinants of health. For instance, the Black poverty rate is double the White poverty rate. According to recent important economic inclusion research projects, African American men, women, and children experience inequality in all areas of life, including employment, education,

housing, legislations, and health care, which reflect the intense government sanctioned policies (Semuels, 3). African American women with lower social economic status continue to experience health disparities and are often uninsured or underinsured. This persists even in the twenty-first century when health care reform and improvement to health care systems have taken place. These healthcare disparities and inequities continue to persist for African American women and other women of color in the US.

African American women have been the victims of an unequal system of wealth distribution that spans from enslavement and persists. They do not receive the same quality of resources and access as their white counterparts. African American women may suffer disproportionately when accessing adequate healthcare services, education, employment, housing, loans, economic growth opportunities, or political representation. They are underrepresented in important decision-making spaces due to economic policies that disadvantage them and their communities (Mitchell, 4).

African American women also suffer disproportionately from social determinants of health (SDOH). According to the Office of Disease and Health Prevention (ODPHP) SDOH's are:

> Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality

of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins (Office of Disease and Health Prevention)

Finally, African American women and men experience a great number of SDOH's and have higher mortality rates as well as more diabetes, tuberculosis, hypertension, asthma, obesity, end-stage renal disease, HIV, and heart disease. African American women experience these disparities and die from them at a greater proportion compared to white counterparts (Centers for Disease Control and Prevention; Keefe, 237; National Center for Health Statistics; Owens, 319; Thomas et al., 339). More alarming is the death rate for African American people due to heart disease, cancer, influenza, pneumonia, diabetes, strokes, and homicides compared to their white counterparts. In addition, African American women encounter more infant death, reproductive health challenges and miscarriages than their white female counterpart (Center for Disease and Control).

Health Disparities and African American Women in Mecklenburg County, NC

The national concern about health disparities for African American people is high. Locally, a 2019 Community Health Assessment (CHA) for Mecklenburg County, NC indicates that 12.1% of the population lived in poverty, and 230,000 of the 819,512 adults in the county did not have primary health care (2019 Mecklenburg County Community Health Assessment, 16). Access to quality healthcare is critical to solidify effective community health and promote longevity. It is disheartening that African American

women suffer disproportionately from death due to chronic disease compared to their white counterparts, at a 1 to 1.4 ratio from death due to female breast cancer, a 1 to 1.4 ratio from heart disease, and 1 to 3 ratio from diabetes (2019 Mecklenburg County Community Health Assessment, 20). African American mothers were also two times more likely to have a preterm birth than their white counterparts. It is a fact that "uncontrolled chronic conditions, such as hypertension and diabetes, can cause problems during pregnancy for women and their developing babies" (2019 Mecklenburg County Community Health Assessment, 33). African American women experience infant mortality rates in Mecklenburg County at double the rate of their white and non-white Latinx counterparts (8.8 compared to a 3.9 for whites and 3.8 for non-white Latinx).

The VHB project is a unique initiative in Mecklenburg County that partners with FBOs such as local churches in an ecumenical approach and clinics led by faith communities. In a recent study, there were 544 women (82.2%) and 115 men (17.4%) who had baseline data available. Of these, 369 women and 74 men had pre- and post-program data available. Change in biometric variables of interest were similar for men and women except for systolic blood pressure (men had larger blood pressure reductions than women). Table 1.1 below shows these changes. If the number is negative, it means the value decreased from the beginning of the program to the end, which is the desired direction. Diastolic blood pressure went up, but everything else went in the desired direction.

Table 1.1 Village HeartBEAT Variable:

Variable (Change from Pre – Post)	**Men (n=74)**	**Women(n=369)**	**p-value**
Weight (lbs.)	-1.78 ±9.00	-1.50 ± 8.59	0.80
BMI (kg/m2)	-0.26 ±1.34	-0.27 ± 1.49	0.93
Waist Circumference (inches)	0.98 ±6.51	-0.47 ± 7.73	0.13

Systolic Blood Pressure (mmHg)	-6.11 ±15.06	-1.92 ± 15.91	0.04
Diastolic Blood Pressure (mmHg)	0.14 ±9.83	4.43 ± 37.20	0.33
Total Cholesterol	-13.12 ±27.35	-16.84 ± 39.16	0.44
HDL	-2.19 ±7.09	-2.80 ± 10.50	0.63
LDL	-8.41 ±26.28	-15.19 ± 36.46	0.13
Triglycerides	-15.20 ±63.25	-1.59 ± 63.41	0.09
Hemoglobin A1c	-0.11 ±0.58	-0.03 ± 0.76	0.36

Unconscious Bias and African American Women

Unconscious bias is learned behavior within society based on a person's formation. A combination of things like development and conditioning, family interactions, social circles, and the media determine unconscious biases. For instance, if a person said that one parent was a construction worker and the other parent a secretary, one may assume that the construction worker was a male, and the secretary was a female. People with biases are not necessarily aware of it or with ill intent. Jennifer L. Eberhardt has researched bias extensively and offers important insight into both the damaging effects of bias and the human nature aspect of it:

> The sort of categorization that allows such [damaging/negative] board generalizations to somehow seem reasonable is a product not only of our personal experience and social messaging but also of our evolution as human beings. Categorization—grouping like things together—is not some abhorrent feature of the human brain, a process that some people engage in and others do not. Rather is a universal function of the brain that allows us to organize and manage the overload of stimuli that constantly bombards us. It's a system that brings coherence to a chaotic world; it helps our brain make judgments more quickly and

> efficiently by instinctively relying on patterns that seem predictable. (Eberhardt, 23)

Bias is not about good people versus bad people. From the human element, people form their world view based on a combination of elements and experiences.

People may have biases about many different physiognomies such as skin color, age, color, gender, or weight. Bias towards African American women in the US based on their gender, skin color, weight, hair, or lifestyle is unacceptable. Many of these biases negatively affect the health of African American women. For instance, there is an unconscious and conscious bias between blacks and whites in the US, and that dynamic has had detrimental consequences in this society that endure and cause harm (Eberhardt, 11).

Research suggests that making people aware of their unconscious biases may increase them. Several studies about this topic were conducted by Prof. Michelle Duguid and Prof. Melissa Thomas-Hunt. They conducted a study on stereotypes and whether women were more career orientated or family orientated. They found that “even when instructed to ‘try to avoid thinking about women as less career-oriented,’ participants who were told that stereotypes were common still viewed women as less career-oriented” (Thomas-Hunt, 2). This leads to the realization that the spaces that are supposed to notice and correct these problematic ways of being with African American women may perpetuate them. Researchers have shown that some of these spaces are in healthcare, and these kinds of issues continue to contribute to health disparities among African American women. It is not appropriate to suppose that because every human being has a bias, these

negative impacts will not be corrected. In fact, what needs to be driven into the consciousness of society is that unconscious bias is unacceptable and must be eradicated.

Lack of Trust in the Health Care System

The lack of trust in the healthcare systems has been perpetuated by healthcare institutions and faith communities by biases, on the one hand. On the other hand, other impacts may be based on prejudice, discrimination, or sexism against African American women. Prejudice “refers to a positive or negative evaluation of another person based on their perceived group membership i.e., in-group versus out-group” (Devine, 5). Discrimination refers to “behavioral manifestation of bias, stereotyping, and prejudice; it is the way others are treated” (Devine, 10). These problematic behaviors in society are manifested in the way many African women avoid medical care and life-saving support over the decades. African American women live sicker lives and tend to die younger that Caucasian women largely as a result of heart disease. According to the U.S. Centers for Disease Control and Prevention (CDC) reports that nearly 44 percent of African American men and 48 percent of African American women have some form of cardiovascular disease (Centers for Disease Control and Prevention).

This lack of trust may persist because health disparities persist in historically marginalized communities (Mitchell, 5). The impact and health outcomes of African American women continue to be of concern due to the gaps that exist amongst ethnic groups. Often some African American women may feel scared to trust in medical professionals due to the historic trauma faced. Even as overall many people in the US may enjoy more access to health care, for African American people the “(dis)advantages” persist at various levels of society (Braveman, 167). A recent report from Duke

University “examining the issue of infant mortality showed that babies born to black women with doctorates or professional degrees are about three times more likely to die than babies born to white women with only high school diplomas or GEDs” (Smith et al., 1).¶

Black populations and other minorities in the twenty-first century continue to experience disfranchisement from a system that, more often than not, values affluence. Compared to white counterparts, African American women experience limitations and often lack access to healthy foods, education, health care, and safe environments, while experiencing health inequalities (Keefe, 238; Owens, 320; Smedley et al. 3, 2013; Thomas, Quinn et al.729). The challenges get worse when African American women have a lower socioeconomic status or lack of access to education (Syme, 456). As a result of these factors, African American women may have a difficult time trusting healthcare institutions in general. These historically white institutions have failed them many times.

Critically, mistrust in the health system affects African American women’s reproductive health. In addition to the alarming infant mortality rates, African American women face discrimination when attempting to get basic reproductive health care. For example, African American women are six times as likely as non-Hispanic whites to be diagnosed with chlamydia, twelve times as likely to be diagnosed with gonorrhea, and five and a half times as likely to be diagnosed with primary and secondary syphilis (Centers for Disease Control and Prevention). These and many other critical concerns for African American women, have motivated African American churches to take a more proactive role in addressing these detrimental social ills and social determinants.

Although the Affordable Care Act provided a path for lower-income women to receive health care; under the Hyde Amendment, US citizens still cannot have health insurance in an equitable way. This creates a high barrier for African American women, especially low-income African American women, to attain certain services because of the high cost. Health statistics indicate that in 2011 the risk of death from pregnancy complications was nearly three and half times higher for Black women than for their white counterparts (Centers for Disease Control and Prevention). Black women and young girls also have more unintended pregnancies, especially if they are poor, compared to white women and young girls (Lawrence, 5). While most private insurance carriers cover reproductive health services, about 55% of African American women are more than likely to be uninsured compared to their white counterparts (Kaiser Commission on Key Facts). Even more distressing is that Black women are twice as much likely to die from cervical cancer compared to their non-Hispanic white counterparts (Carratala, 2).

Finally, researcher Nataniella Soto suggests that the consequences of racism reflect negatively on the medical field and health care system (Soto, 8). Health care should be a human right and not a privilege. According to UN mechanisms human rights continue to be violated today and "things get more complicated when a person is poor and Black" (Soto, 7). Gender and sexual orientation or identity, while being Black, can exacerbate experiences of prejudice. As Professor Khiara M. Bridges states in her article "*Implicit Bias and Racial Disparities in Health Care*:"

> "In 2005, the Institute of Medicine—a not-for-profit, non-governmental organization that now calls itself the National Academy of Medicine (NAM)—released a report documenting that the poverty in which black people disproportionately live cannot

> account for the fact that black people are sicker and have shorter life spans than their white complements. NAM found that "racial and ethnic minorities receive lower-quality health care than white people—even when insurance status, income, age, and severity of conditions are comparable (Bridges, 1)."

These incidents limit the health potential of African American women in all areas of life, including reproductive health and mental health. Since African American women continue to be the bread winners of their families, it is imperative that they enjoy access to equitable health care, prevention, treatment, and mental health care.

Discrimination and African American Women

First, the lives of poor African American women are very different than that of their white counterparts or of other ethnic/diverse affluent women (which include African American). Liberation theologian Marcella Althaus-Reid talks about the areas of exclusion in theology. These areas of exclusion have to do specifically with poor women. She refers to the "lemon vendor" and the diversity of women that are deemed indecent precisely because of their impoverished circumstances. In her context, poor women in Latin America come to mind. Althaus-Reid asserts, "The life experiences of poor urban women have the toughness of the struggle for survival in the dangerous and chaotic conditions of big cities" (Althaus-Reid, 5). In the same way, poor or struggling middle-class African American women in the developed city of Charlotte, NC negotiate how to navigate the complex social-economic and social-political landscape they have inherited. Liberation theology is a lens that can be used to properly discourse the struggles of these women in their context of the South.

Liberation theology boldly looks at the results of forcefully transporting masses of West Africans from their natural environments. Due to these incidents many people of African descent today continue to have detrimental health outcomes, which include traumatic cellular memory that affect their health negative ways. Michael J. Halloran speaks of the terror, "The effects of African American enslavement transmitted through successive generations cannot be underestimated; the trauma of enslavement is argued to have been carried by African Americans and manifest in contemporary social, psychological, and physical problems" (Halloran, 46). Historical memory is not the only factor that creates health disparities for women of color, it is also the resulting poverty. Poverty affects all aspects of women's lives since women tend to be the main caretakers in their households. Realities that contribute to these challenges include unequal pay, cultural taboos, gender injustice, and theological ideals about the place of women.

African American s are among the groups impacted by high levels of poverty in the US. African American that live in areas that are socioeconomically deprived are greatly at risk of segregation. For instance, since many African Americans are geographically segregated, they get exposed to greater environmental and psychosocial stressors such as poverty, pollution, and crime (Gee, et. al., 2). Experts submit that this form of segregation relates to poor health and continues to undermine the progress of this demographic. (Kramer et al., 5).

Sociological Realities of African American Women in the South

First, African American women in the Southern regions of the United States have a complicated relationship with race, their bodies, and history. Their struggles were based

on the very survival of their lives and identity. Sociologist Patricia Collins, for instance, suggests African American women in the South had to reckon with ownership of their bodies (Collins, 223). This went beyond access to health care or the expectation of receiving any type of care from the system over them. These situations were about their literal survival. Activist Fannie Lou Hamer said, “A black woman’s body was never hers alone” (McGuire, 191). These challenges are a peril for Black women in the US that create vulnerabilities that affect their health and stress levels in daily life.

One consequence may be what Joy DeGruy called Post Traumatic Slave Syndrome: “A theory that explains the etiology of many of the adaptive survival behaviors in African American communities throughout the United States and the Diaspora” (DeGruy, 4). This condition comes as a result of the oppression that enslaved African Americans faced. This is also a condition that persists today through institutionalized racism. This multigenerational trauma is one DeGruy believes is passed on from generation to generation from the people that were the victims of slavery (DeGruy, 250). The impact is that African Americans may carry the belief (real or perceived) that they do not have access. Further, Ellion sustains that “soul trauma” is a direct result of PTSS (Ellion,470).

Second, soul trauma presents a sociological reality that prevents access for low-income African American women and other Black women in a place like Charlotte, NC, a city with great economic power. The Atlantic declared Charlotte, NC one of the most vibrant cities in the south and one of the places in the US with the worst upper mobility for African American people. Data gathered as noted that Charlotte, NC is a dead-end for people that are making the effort to overcome and escape poverty (Semuels, 2). Charlotte

faces immense disparities and real depravation according to UNC Law professor, Gene Nichol. He sustains, "In a city of immense economic prowess and noted civic pride, economic deprivation of such magnitude and intensity presents a potent and haunting moral question as well (4)."

Sociologically, the Equality of Opportunity Project found that Charlotte has to reckon with disparities that affect African American s disproportionately. In fact, an analysis on economic mobility stated that the city is one of the hardest places for the economic mobility of Blacks in America's 50 largest cities (Chetty et. al. 11). This is the reality in Charlotte because it is segregated racially; it has more than the national average of poverty, income inequality, and single mothers, and it has a history of inequity that predates modern times (Semuels, 5). As author Hatchett states, "Segregation had to be in invented" (Semuels, 1). For instance, today African American and Latinx women are more likely to die from breast cancer in Mecklenburg County, although white women are diagnosed at a higher rate (Mecklenburg County Community Health Assessment). More disheartening is that 1 in 6 women live in poverty in North Carolina, and People of Color are 3 times more likely to live with hunger and in poverty compared to their white counterparts (Bread for the World, 1). These and many other determinants of health and societal and religious pressure perpetuate the Strong Black Women myth.

The third point to highlight comes through scholar Courtney Bryant's exposition of the human needs of Black women (351). The internalization of strength of the African American women has led to the injury of her soul, emotions, well-being, sexual expression, and health. There is a great need for Black women to employ a "womanist ontology or isness" that allows for a reunification of the body and soul. This should

occur so that these women can live into the connection between emotional, spiritual and physical health and healing. (Bryant, 355). However, the lack of conciseness that exists in the lives of many African American women in the levels of multidimensional dis-ease perpetrates the disconnectedness from their health, healing, and body.

Fourthly, Walker-Barnes states that when explaining the Strong Black Woman myth most people use superficial characteristics to describe it:

> During the American slavocracy, Black women were routinely depicted as being unusually strong; possessing physically hardiness that dark exceeded that of women of other races and even rivaled that of men. In contrast to the "delicate" White woman… They could work through sickness and needed little recovery time after childbirth. And they were able to endure separation from their children and families. Indeed, the unfeminine strength of Black women was seen as evidence of their inferior humanity. (19)

Many of these notions are alive and well in church communities in the South where the Black women is seen as the caretaker and the one who only seeks help when she can no longer hold on in the midst of sickness. Theological notions embedded in the core of patriarchal systems have furthered placed Black women in the church in peril as they perpetrate narratives of false "strength." Courtney Bryant proposes a remembering utilizing the holy method of confession as a path to understanding (360).

Finally, this is sustained by what sister theologians encourage as self-awareness intervention and confession as a practice to become conscientious, taking seriously the womanist ontology of being. This ontology of being or "isness," is one that the church must integrate. It is precisely what models such as VHB and others have sought to do

while confronting soul trauma. These kinds of interventions take African American women seriously while creating a "unified relationship between the body and the soul by attending to the inextricable connection between emotional, spiritual, and physical health" (Bryant, 351). At the core, this is what it means to partner with Christ and become the Body in action. It is to enact models that will expedite healing in all forms and lead with awareness by and for African American women and others that suffer.

Research Design Literature

This project used a mix-method research model using quantitative and qualitative tools. This study included a post-intervention study of the Village HeartBEAT (VHB) 16-week Health Promotion program instituted in local churches in Mecklenburg County, NC. The goal of this project was to evaluate the impact of the VHB in the health equity of African American women that participated. In addition, it sought to inquire if there was any benefit to the faith and spiritual formation of the women that participated. Thus, it was important to use a quantitative survey called the Post-Intervention Survey, which collected facts and numbers once the data was analyzed.

To answer the research questions, the researcher also gathered experiential data, which are often critical for DMin projects. Sensing indicates, "The D. Min is an advanced program oriented toward ministerial leadership. The purpose of the D. Min is to improve the practice of ministry" (72). As a program that seeks to strengthen the field of practical theology, it is imperative to find data that can be translated into action" (77). Therefore, building on the respected research of health care professionals on the impact of VHB, this study sought to engage in a new angle. This angle was to understand the spiritual impact

of VHB and to see if, in addition to impact on the physical body, there was spiritual growth in faith.

It is important to consider the purpose statement when making methodological decisions (Sensing, 228). Thus, the quantitative portion of the study was used to collect hard facts and create a structured chart to validate the hypothesis. The goal was to answer an important question, was the problem real or a perception? This is why qualitative findings were collected using two instruments. The first one was post-intervention one-on-one interviews with African American that completed the 16-week health promotion program within their local church. The third tool was a focus group with pastors and lay leaders that participated and committed their churches to the VHB program rules. Qualitative research is "grounded in the social world of experience and seeks to make sense of lived experience" (Sensing, 57). Both instruments contained open-ended questions to put a human voice with life stories and cultural contexts to evaluate the patterns and trends in the results. The hope was to serve the church in developing future ministerial programs on health and wellness and to strengthen VHB's partnerships with health agencies and local FBOs.

Summary of Literature

Kesho Yvonne Scott, once said, "Black women both shape the world and are shaped by it… [They] create their own black feminist theory. They come to feminist theory and practice out of the oppression they experience as people who are poor and black and women" (Guy-Sheftall, 1). Women of faith from the Pentateuch, New Testament women like Mary the mother of Jesus, and African American feminist abolitionists like Maria Steward, Sojourner Truth, and Frances E. W. Harper all helped

shape a African American feminism that is interconnected to the theology of Jesus in his preferential treatment for the oppressed (Guy-Shefttall, 5). This literature review stands on the shoulders of pioneer African American feminist women of faith and shows that African American women continue to struggle for liberation in the United States in the twenty-first century. African American women continue to confront both a "woman question and a race problem" (Gines, 2). Expert researchers assert with clarity that the general health outcome of Americans has improved over the decades but in spite of the dawn of the Patient Protection and Affordable Care Act health care disparities, health inequity, and health inequality persists among historically oppressed and underrepresent groups (2019 National Healthcare Quality and Disparity Report, 7; Collins, et. al., 5; Mitchell, 2). One of the most disadvantaged groups is African American women in the US.

Reflecting and understanding these findings uncovers a fundamental reality. The Church of Jesus Christ, born of a poor young woman, Mary, has work to do. FBOs like churches must continue to strengthen and confront the multilayer levels of injustice in society and within the very structures of the church. African American churches and communities must continue to accept the invitation to create holistic ministries that deal with the whole person, with the whole woman. This literature review also offers insight on what Christian ministries are doing to solidify their place in the world as necessary and indispensable entities in communities of color. Indeed, the church is alive and well. VHB offers a Christian model connected with secular partners that at its core is not new but has been innovated. It is invigorated by the intersectionality of sociology, practical theology, political action, advocacy, learning theory, non-judgmental behavioral change

principles, and grass root efforts where the historically oppressed are at the table as equal partners. VHB challenges churches to question, “What is secular and what is holy?” What is of God and what is of the world? What is ordinary or mundane and what is essential? Theologically this can be compared to a Peter aha moment:

> Then a voice told him, “Get up, Peter. Kill and eat.” “Surely no!” Peter replied. “I have never eaten anything impure or unclean.” The voice spoke to him a second time, “Do not call anything impure that God has made clean.” This happened three times, and immediately the sheet was taken back to heaven. (Acts 10:13-16, NIV).

The Divine was calling Peter to a reformation of thought, action, and ministry without dismissing the holiness of what was. In the same way, a main theme is that of reflection. Cheryl Emanuel, an African American woman and VHB visionary, and others have in the past and continue today to reform themselves in order to serve the purpose of greater good, enacting the golden rules and building the Kingdom of God. Then, this Kingdom that Jesus proclaimed is carried inside each person and put to action in the healing of the oppressed, letting justice roll down like waters (Amos 5:24; Luke 17:21; Matthew 4:17).

Finally, the main themes that emerge have to do with the critical nature of attending to the scientific and research instruments to understand the systemic nature of health disparities among African American women and how this undermines their spiritual growth and faith. Reports and data gathered by a dedicated researcher can serve the church in strategically engaging in theological and educational models that create healthier churches and communities. In essence, people that become fully human can deepen their internal and outer healing. For “the thief comes only to steal and kill and

destroy, [Jesus] has come to that they may life and have it abundantly" (John 10:10 ESV).

Hence, because of Jesus' mandate, African American women in Mecklenburg County represent those that are precious to God. They represent all other underrepresented and marginalized groups in the US. Thus, this ministry project sought to review the landscape of African American women and their health experience and outcomes within their local communities. It seeks to engage a model like Village HeartBEAT (VHB) by evaluating its impact as a health promotion program and a faith-based organization's partnership with social institutions and especially on the spiritual faith journey of African American women.

CHAPTER 3

RESEARCH METHODOLOGY FOR THE PROJECT

Overview of the Chapter

African American women continue to suffer disproportionately due to health care disparities and inequities in Mecklenburg County. Many faith-based organizations like churches recognize the need to address these discrepancies as part of the spiritual practice of African American women. This project highlights how churches in Charlotte, NC partnered with health and wellness initiatives in their congregations like Village HeartBEAT (VHB). VHB creator and visionary, Cheryl Emanuel, asserts that the faith-based collaborative program addressed chronic disease and Public Health Department priority areas for African American s in Mecklenburg County. Churches are a strong foundation for such programs because they are like a family taking care of one another and the community (Healthiest Cities & Counties Challenge). African American women were the focus of this study because many VHB participating churches are composed of a greater female membership than male.

This chapter explains the research method employed for the ministry transformation project on evaluating the 16-week Village HeartBEAT faith-based friendly competition and its impact on the health outcomes and spiritual transformation of the African American women that participated. A more in-depth look at the research methodology employed is developed here. The nature of the project, instruments used to answer the main three research questions, ministry context, participants, data collection, and data analysis are explained in this chapter. This ministry context was imperative to

further the work of health equity and spiritual growth of African American women in Mecklenburg County.

Nature and Purpose of the Project

The purpose of this study was to evaluate the effectiveness and challenges of the Village Heart B.E.A.T (VHB) 16-week health promotion program in addressing the health care disparities and spiritual growth among African American women in Mecklenburg County. The study was focused on evaluating the program after the African American women participants completed the friendly competition. Thus, this was a post-intervention project.

Research Questions

In order to complete this study, the following questions were identified.

Research Question #1

In what ways has the Village Heart B.E.A.T (VHB) 16-week health promotion program effectively addressed the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

The hypothesis was that VHB impacted habits, attitudes, mindsets, and the spiritual formation of African American women that participated in the 16-week health promotion program. Since this was a faith-based collaboration between church and community health institutions, another level of this investigative analysis emerges. Christian spiritual growth impact in the lives of the African American women participants was also evaluated. The researcher-designed post-intervention survey had 19 questions that accessed the health benefit and outcomes of the VHB program as well as any impact to the spiritual growth of the African American women who participated.

Questions 1-5 gathered basic demographic information; questions 6-10 addressed the health disparity portion of RQ1; questions 13-16 addressed the spiritual growth aspect of RQ1. In addition to the online survey, qualitative data was gathered in the form of individual interviews with eight African American women that completed the VHB 16-week program. Each woman responded to six questions to describe their personal experiences and expound on the survey in order to answer RQ1 and RQ2.

Post-Intervention VHB Participant One on One Interview Questions:

1. What motivated you to join the Village HeartBEAT (VHB), 16-week Health Promotion program?
2. What were the reasons you decided to improve your health?
3. How did the VHB program impact your spiritual growth?
4. What were the challenges you faced in completing the VHB 16-week Health Promotion program?
5. Did the VHB program make an impact in your congregation? If so how?
6. How did VHB make an impact on your health behavior and habits?

Research Question #2

What challenges has the Village Heart B.E.A.T (VHB) 16-week health promotion program faced in addressing the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

The assumption was that as with any new program there may have been challenges. It was important to learn what those were for the African American women that participated in the 16-week program. Moreover, since this is a Christian context, it

was imperative to evaluate the spiritual challenges the women experienced. In the same survey as delineated above; questions 11-14 addressed RQ2. In the individual interviews with the eight African American women that completed the VHB program, specific questions were also asked regarding the challenges and hurdles they may have encountered. Due to the COVID-19 pandemic all the individual interviews were conducted via Zoom video or telephone and were recorded.

Research Question #3

What practices might help improve the Village Heart B.E.A.T (VHB) 16-week health promotion program in effectively addressing the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

After gathering the mix-method qualitative and quantitative data from the instruments utilized above, a focus group of pastors and lay leaders in VHB churches was created. Question #18 of the survey was also used to gather data about pastor and church participation in VHB. The assumption was that there might be a level of church leadership commitment to the VHB program and community focus goals. Pastors and lay leaders may interact with participants on a regular basis through pastoral care and church activities. The focus group was composed of pastors and lay leaders of churches that competed in the 16-week health promotion program and committed to preaching sermons on the topic. A series of seven questions were asked of the pastors and lay-leaders. Due to the COVID-19 pandemic, the focus group met in a controlled online Zoom video call environment. The focus group Zoom video call was recorded.

VHB Church Pastor Impact Focus Group Questions:

1. What motivated African American women in your church to join the VHB 16-Week Health Promotion Program?

2. Why did you commit as a leader to partner with VHB and Health Community partners?

3. Did you witness a spiritual formation change in the faith walk of African American women that participated in VHB? If so, what?

4. What impact did VHB have in the lives of African American women in your congregation?

5. What challenges did African American women who joined VHB face in completing the program?

Ministry Context

The ministry context for Mecklenburg County, NC and the city of Charlotte is a complex one. The two governments are intertwined and share one school system, Charlotte-Mecklenburg Schools. Charlotte, NC is one of the fastest growing cities in the US. According to Nicole and Hunt, Charlotte has the following impressive characteristics:

> Mecklenburg County, which Charlotte sprawls across, is home to 13% of all the private establishments in North Carolina and 16% of the state's private sector jobs. The gross regional product of the greater metro area (over $131 billion in 2014) is 30% of the equivalent North Carolina gross product. Per capita personal income in Mecklenburg is 125% of that of the state; and is the 4th highest, after the affluent Triangle area (Orange, Wake and Chatham counties) in North Carolina. Its job growth and relative wealth have attracted new residents at a prolific pace. One of the fastest growing large cities in the country, the number of people who call Charlotte

> home increased by 10% between 2010 and 2014, more than twice the statewide average.5 Charlotte is the 17th largest city in the United States by population. Mecklenburg County crossed the million-person mark in 2014 and contains over 10% of North Carolina's total population. (Nicole et al, 5).

The amazing growth and wealth of Charlotte, NC (Mecklenburg County), has an unfortunate side. In such a booming city, African American s continue suffering from poverty. In the Charlotte Opportunity Initiative 2020 Report, Economist, Raj Chetty expressed great concern about a lack of economic mobility in the area (3). There are other difficult issues in the area such as racial disparity, segregation in neighborhoods based on economic status, segregation of education, labor polarization, and lack of access to healthcare, insurance, and health education (Chalekian et al, 9; Nicole & Hunt, 15).

Thus, Village Heart B.E.A.T. is born as a vision of Cheryl Emanuel, both a Presbyterian lay leader and the Manager of Community Engagement in the Mecklenburg County Health Department. Her work in community engagement and health disparities in Mecklenburg County spans over 30 years. As a Christian woman herself and a public servant, she saw the need of intentionally engaging African American and Latinx pastors, leaders, and churches as partners in ministry to tackle the Mecklenburg County Health priority areas. The Mecklenburg County Health Department has priority health areas which include access to health care, chronic disease prevention, environmental health, healthy pregnancy, HIV & other STD's, injury, mental health, substance use disorder, violence and communicable diseases (2019 Mecklenburg County Community Health Assessment, 9).

The VHB was developed to partner with local African American and Latinx churches in Charlotte, NC (Mecklenburg County). The 2-year goal was as follow:

Ambassadors will demonstrate improvements in biometric measures (weight, BMI, blood pressure, and Hgb A1c). Additionally, ambassadors within the 60 participating FBOs will create sustainable changes in policy and local programs that model healthy behaviors in the domains of tobacco use, healthy diet and activity for their congregants and surrounding community members. Subsequently, over 30,000 (24,000 parishioners and 6,000 community members exposed to programs) people within the priority area will experience behavioral changes that will be measured through BRFSS derived survey data collected at the community-level (by phone survey) and at the individual level by all participants.

Thus, the main contextual reality sought to be addressed by the partnerships between FBOs, health care institutions, and the Mecklenburg County Health Department is focused on addressing priority areas. The priority areas that VHB focuses on are access to health care, chronic disease prevention and environmental health, meaning where people play, eat and live (2019 Mecklenburg County Community Health Assessment, 3).

Participants

Criteria for Selection

The criteria for selection for this study were as follow:

1. African American women that reside in Mecklenburg, County.
2. African American women ages 18-65 years old.
3. African American women that participated and completed the VHB 16-week health promotion program.
4. African American women that are members of participating VHB congregations.

The criterion-based survey link was emailed to VHB participants with the goal of reaching 75 women participants that met the criteria delineated above. An online survey tool called QuestionPro was used to gather the survey results. The survey was made up of 21 questions. Sensing encourages researchers to focus on a continuum. At times qualitative work requires "action and formative research," which at times can be "indistinguishable" (Sensing, 200). The survey was used to gain a sense of the macro impact of the VHB program on the physical and spiritual health of the women. In D.Min. projects action is imperative, and the researcher seeks to understand the impact and the implementation of the ministry program.

The second tool administered was in-depth, one-on-one interviews with fifteen women that met the criteria above. Sensing suggests that researchers use what he calls, "tools of the trade" (79). These tools may include interviews that provide direct quotations where participants can share their experiences about the activities, they have engaged in. The women that were part of the one-on-one interviews fulfilled the special criteria that distinguished them because they completed the program in its entirety. According to Creswell, one to ten interviews are acceptable for qualitative research. This sample also fulfilled the quantitative research aspect as it inquired about personal experience. Thus, this is a mix-method study design (10).

Third, a focus group was created with five pastors whose members participated in the VHB 16-week health promotion program. It is well known that pastors in Black churches often know the determinants of health of their congregants. Many times, they have insight on the particular health challenges their members may have and advocate for their health needs (Story et al, 81). According to Levin, "Pastoral influence extends into the surrounding community. The Black pastor is often the spokesperson for the church within the community at large, ensuring that community issues affecting his/her parishioners are

taken into account" (Story et al, 82). Since Black pastors are considered social pillar in their communities, they are the best suited participants to evaluate the impact of the VHB faith-based program.

Finally, the focus group was utilized to examine the impact on health and spiritual formation that the program had in the lives of the women who participated. Other VHB requirements included a commitment of participation and "buy in" from the pastors or lay leaders of the church. Other aspects of the program included completing a sermon series or Bible studies on health and engaging in community advocacy and health activities and events. The focus group with pastors and lay leaders provided a space for leaders to reflect on the various levels of impact VHB had on the women lives, the congregation, and the community.

Description of Participants

The focus group participants for this study were African American women between 18 and 65 years of age. These women identified as Christian and as members of a church participating in the VHB health promotion. Their level of education was not applicable. The description above also applies to the fifteen women that participated in the one-on-one interviews. Finally, the last group that was selected was a group of eight African American pastors, three female and four males, to have gender balance. These pastors and lay leaders were leaders whose churches committed and participated in the VHB program.

Ethical Considerations

All the data collected for this study was kept confidential. The researcher and authorized members that work with the researcher are the only people that know where each

piece of the data originated from. No person's original names were used in this study. All of the information of the ethics and confidentiality of this study was explained to all the participants in advance. Trochim, indicates the importance of putting in place all protocols and protective efforts that comply with ethical expectations of the research project (20). This process does not only include the ways in which participant information is protected, it also includes developing correct survey administration methods. If in a physical location, gathered data must be stored in a locked drawer, or if it is electronic, it must have a database-protected password (Hall et al., 4).

Instrumentation

The instrumentation was a mix-method study design. Creswell and Wisdom indicate that mix methods is a research methodology that mixes quantitative and qualitative data within one single investigation (Creswell, 111). Creswell assert that "the premise of this methodology is that such integration permits a more complete and synergistic utilization of data than do separate quantitative and qualitative data collection and analysis" (225). These instruments will allow a complete synergy of the data that could provide meaningful contributions of best practices in ministry.

The first researcher-designed, eighteen-question survey was called the Post-Intervention VHB Survey. This was the quantitative portion of the mix-study design data collection on participant impact and wellness results after completing the VHB 16-week friendly church competition. The second researcher-designed individual interview set of questions was called the Post-Intervention VHB Spiritual Growth and Health Impact Interview. This was the qualitative part of the mix-study design data collection, which focused on recording the individual experiences of the participants. Collecting this

important information allowed the researcher to record the lived experience they had within the VHB program without bias and in a confidential space.

The third researcher-designed instrument was a focus group called the VHB Impact Focus Group. This data collection tool was used after the themes of RQs #1 and #2 were developed. This group was made of pastors and lay leaders of churches that had groups of 10-14 competitors within their congregations participating in the VHB 16-week friendly competition. This instrument was used to identify patterns, themes, and experiences that they saw on the impact of the program on the African American women who participated, their spiritual formation, and the overall impact on the life of the congregation.

Expert Review

Using the Tim Sensing notions, the researcher developed several instruments to strengthen the mix-method approach (196). He generated a survey with series-scale choices and open-ended questions. The second instrument was post-intervention VHB-impact one-on-one interviews. This instrument was meant to evaluate the impact the VHB through a series of questions to learn from the experiences and impact of the 16-week health promotion program in participants' lives. There is an art to asking questions, and it is not an easy art to master. This was used in drafting the interview questions for the one-on-one interviews and the focus group. The questions were unstructured to provide flexibility, exploration, and conversation with the participants. First was an opening question to set the tone. According to Sensing, "In-depth, open-ended interviews…. yield direct quotations from people about their experiences, opinions, feelings, and knowledge (198).

All three instruments were submitted to three experts for review:

- Rev. Dr. Tori Butler, Lead Pastor, D. Min project, “The Power of Mourning: Creating Spaces of Vulnerability for Black Clergywoman to Lament and Holler”
- Rev. Dr. Karen Georgia Thompson, Associate General Minister for Wider Church Ministries at the United Church of Christ (UCC)
- Dr. Milton Lowe, D.Min. Associate Director and Academic Coach, Asbury Theological Seminary

All four of them received documentation in an email with a short description of the project, purpose statement, research questions, definition of terms, and the three instruments Detailed evaluation forms were included for each tool for them to express their opinions and offer suggestions (see Appendix A). The experts were given one week to complete the review and return them for review and implementation. Their feedback was insightful and helpful. The feedback from two experts identified areas to strengthen in the survey instrument. Since the survey included several questions that were the same as or similar to some of the questions on the interview instrument, the interviews were eliminated.

Eliminating the one-on-one interviews created an opportunity to reach more participants with the same questions on the survey. This may have created more volume in responses, thereby generating data based on volume without losing the personal touch. The instruments could also be reduced in order to avoid redundancy. The third instrument was the focus group and that one was affirmed by all the expert reviewers and thus remained the same. The changes were discussed with the dissertation mentor and coach, Dr. Milton Lowe.

Reliability and Validity of Project Design

The validity and reliability of this project design is based on evaluating the VHB 16-week Health Promotion program. Important components of the VHB program may be measured and improved through this study. A post-intervention project provides a unique opportunity to evaluate a program that impacts a large group of people. Village HeartBEAT program had more than 3,000 African American participants in the 16-week health promotion friendly completion without including additional African American women from congregations that committed to the VHB program. Therefore, the validity of the instruments was solidified by the experts who evaluated the instruments and the potential of impact on future ministry designs.

Data Collection

The Village HeartBEAT (VHB) Health Promotion friendly competition program occurred during a period of sixteen weeks beginning January 18, 2020. A Post-Intervention VHB survey was conducted using an online tool called Question Pro. The survey link was emailed to 75 women identified as having completed the VHB 16-week friendly completion. The email included an introduction that explained the purpose of the survey and its goal of strengthening future ministry programs, best practices, and ministry design. The survey included questions that evaluated Village HeartBEAT activities, performance indicators, and the current program results. Gajda and Jewiss, indicated that in order to evaluate program performance, survey questions needed to indicate qualities of a given program's outcome, the activities needed to accomplish the outcome and any indicators of progress towards a given program's intended purpose (7).

A consistent and standardized survey was emailed to each participant with a number that identified each survey. This assured that the identity that each participant was kept confidential. The email explained in detail the procedure to respond to the survey questions electronically. The survey included a section in which participants click in a box to acknowledge that they understand that their personal and physical data was protected to comply with the ethics of this research project. All the data was stored using password-protected electronic files that were only accessed by the researcher and authorized research team members. The instructions further indicated that the actual survey took no more than 30 minutes to complete. There were three automatic reminders sent for the survey to participants that had not completed it. The participants had a period of ten days to complete the survey online. The survey was used as a quantitative study method to gain data to respond to RQs #1 and #2 of the project.

The second instrument that was used to collect qualitative data was the VHB Experience Interview questions with fifteen African American women that met the criteria described above. The study design created a space for the women to reflect on the impact of VHB in their lives and within their church community context. The study format was selected to examine the collective perception of the program, while creating a confidential space for women to share their experiences freely. In addition to the physical health and any behavioral or habit changes, it was important to access if there was a spiritual formation element that impacted their faith and walk with Christ. The individual interviews were conducted using Zoom video chat. At the beginning of each interview, the woman was welcomed, and the researcher explained the ethical considerations for the interview and indicated that their name, physical data, and personal information would be protected.

Although the interview would be recorded, responses were transcribed with anonymous names that would keep their identity confidential. Before the interview, they received an online consent form that they signed electronically in order to participate in the Zoom interview. Once the interviews were completed, the responses were transcribed to find themes and patterns to analyze the data.

Third, in order to collect another set of critical qualitative data for this study, a focus group was employed. The focus group participants were 6 pastors and lay leaders from churches that participated in Village HeartBEAT. Each individual pastor received a phone call to invite them to participate in the focus group. The focus group was conducted via Zoom video chat because of the inability to meet in person because of the COVID-19 pandemic. The researcher explained the ethical considerations and protocols of confidentiality that all the members of the focus group should abide by. Each member of the focus group was invited to sign a confidentiality agreement that was emailed prior to the focus group interview. The focus group interview used probing questions to gather additional information while following the proper protocols. The Zoom video calls were recorded. The responses from the interview were transcribed to identify themes and patterns for more in-depth data analysis.

Finally, the main areas of attention in the focus group were first to understand the impact of the pillars of the program. The researcher sought to understand how the education the Village HeartBeat African American women received impacted their spiritual formation and faith walk with Christ. The second point was based on the impact of the VHB partnership on the entire congregation and their sermon themes. Third, it was important to

determine what best practices and challenges they identified from their observation of the participants. Below are the steps the researcher took to collect the data.

Post-Intervention VHB Surveys

1. Contacted Cheryl Emanuel, the Manager of VHB, to ask her permission to conduct the study.
2. Requested names, email, and phone numbers of participants within VHB that met the designated criteria.
3. Called each potential participant to extend the invitation to take the survey and explain the purpose of the project.
4. Explained the confidentiality and ethical considerations of the survey.
5. Sent a consent form at the beginning of the survey, which allowed participants to continue to take the survey. If they did not give consent, then they could exit the survey.
6. Emailed the survey the second week of January.
7. Emailed several reminders to survey participants.
8. Sent a thank you email the day after the survey deadline.

Post-Intervention VHB Interviews

1. Attended a VHB Captain's meeting to introduce this study.
2. Invited 8 VHB participants that met the criteria to volunteer to conduct the one-on-one interviews. These eight women were randomly selected for the one-on-one interviews after they signed the consent form.
3. Contacted the women via phone and email to extend the invitations for the interviews and explain the purpose.

4. Sent consent forms that participants had to sign and return before the interviews could be scheduled.
5. Scheduled a Zoom video call to conduct the interview.
6. Gave each participants a heartfelt thank you after the interview was completed.
7. Recorded the Zoom video or telephone call in order to transcribe it.

Post-Intervention VHB Focus Group

1. Contacted Cheryl Emanuel, Manager of VHB, and asked permission to contact pastors and lay leaders from churches of the African American women that participated in VHB.
2. Called and invited participants from the list of pastors and lay leaders until a list of five was populated.
3. Explained the confidentiality and ethical considerations for the focus group.
4. Asked the participants to sign the consent form.
5. Emailed a Doodle poll to arrange the best time for a Zoom focus group call for all the participants after receiving the consent forms.
6. Sent a thank you email the date after the focus group meeting.

Data Analysis

The Post-Intervention VHB survey was used as the quantitative tool to analyze data. After receiving the survey from the subset group of African American women, a descriptive method and a cross-sectional design was used to analyze the data. The data was carefully organized using Microsoft Excel (2019). and a T-test was used to compare the themes and patterns. A descriptive statistical method was used to examine and

describe the sample and summarize information about the subset group of African American that returned the survey.

Second, a phenomenological design was used for the quantitative data analysis of the VHB Experience Interview and the VHB Focus group. The design was used to explore the in-depth experiences of African American women with VHB regarding their health and spirituality. There are several leading voices in the field of phenomenological design including John Creswell and Tammy Moerer-Urdahl. This analysis method is designed to allow insight into understanding the phenomenon of African American and African American pastors and lay leaders in relation to VHB and their spiritual formation development (Creswell et al, 8). After carefully collecting themes and patterns from the interview questions and focus group, the researcher analyzed the contextual realities and the essence of African American women's experience with Village HeartBEAT program in their local church and community.

CHAPTER 4

EVIDENCE FOR THE PROJECT

Overview of the Chapter

This chapter presents data analysis for the project. It describes the study's actual participants and contains results from the qualitative and quantitative research methods: the Post-Intervention VHB Survey, Post-Intervention VHB Individual Interviews, and the Post-Intervention VHB Focus Group.

The purpose of this study was to evaluate the effectiveness and challenges of the Village Heart B.E.A.T (VHB) 16-week health promotion program in addressing the health care disparities and spiritual formation among African American women in Mecklenburg County.

Participants

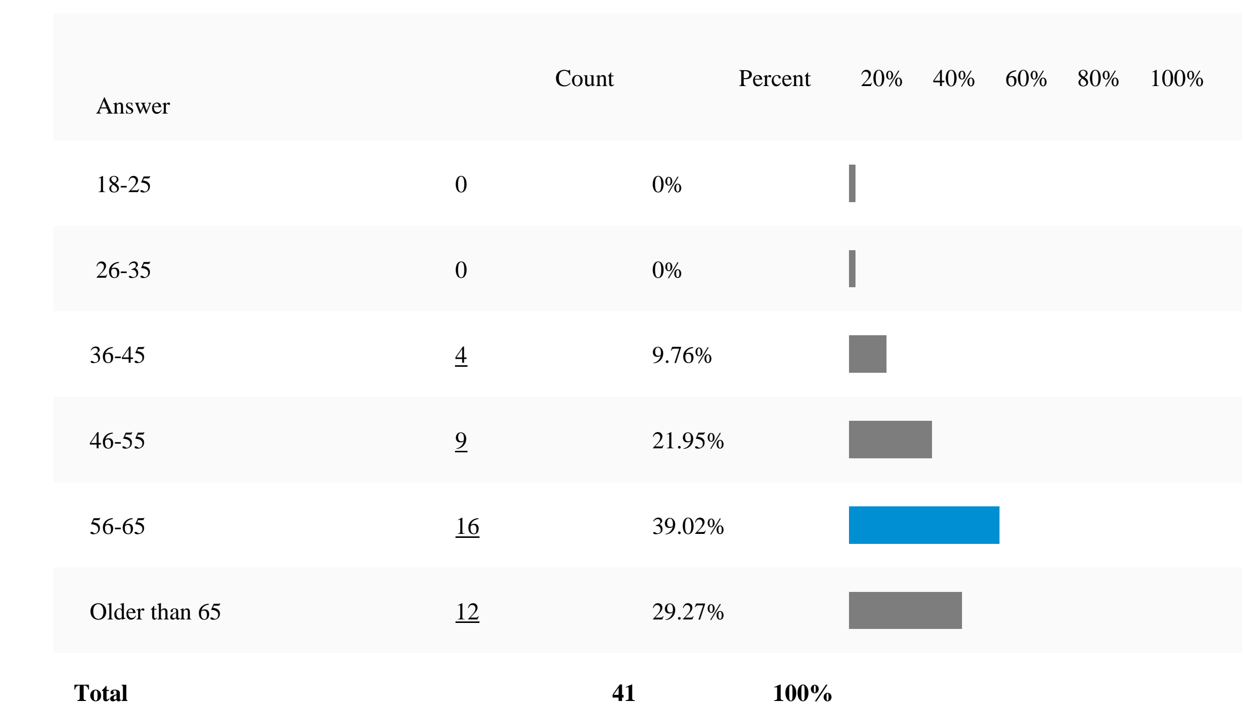
The online Post-Intervention VHB Survey was shared with up to 75 participants and 41 completed it. Forty (40) of the responses were considered valid based on the following criteria for the participants: (1) African American women that reside in Mecklenburg County, NC, (2) African American women ages 18-70 years old, (3) African American women that participated and completed the VHB 16-week health promotion program, and (4) African American women that are members of participating VHB congregations. The responses in Figure 1.1 indicate that 97.56% of the respondents completed the health promotion program. Forty samples were valid and completed. From the 40 samples, 8 women volunteered to complete the one-on-one interviews to gather the qualitative data.

Figure 1.1 Did you complete the 16-week VHB Health Promotion Program?

Answer	Frequency	Percentage
Yes	40	97.56%
No	1	2.44%
Total	**41**	**100%**

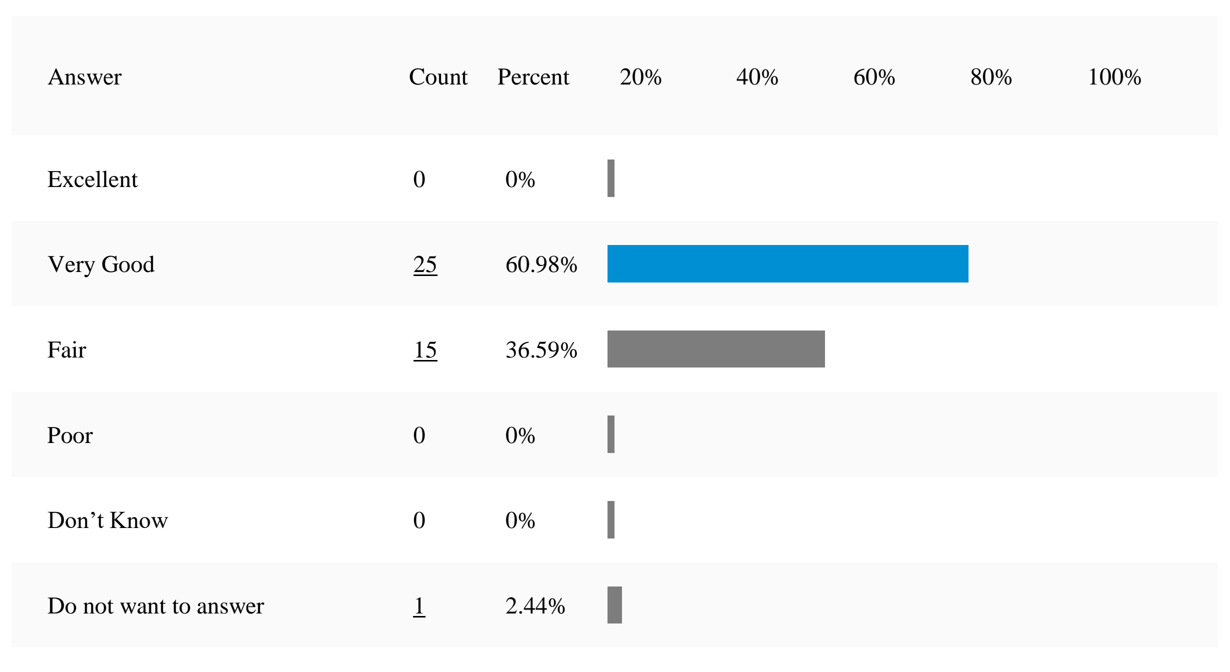
Only a few relevant questions were gathered in regard to demographics. The main age ranges of the VHB participants were 56-65 years of age (39.02%), 46-55 (21.95%), older than 65 (29.27%), and 36-45 (9.76%) (See Table 1.2). In general, 60.98% of participants considered that their health was very good, and 36.59% considered their health to be fair. Only one person opted not to answer. The next question had to do with health care insurance coverage. All 40 participants (100%) indicated that they had some kind of health care insurance coverage (See Table 1.4). Finally, the majority of those surveyed had attended their churches for more than two years. Thus, were established the members of the FBO that participated in the VHB program.

Table 1.2: What is your age range?



Answer	Count	Percent	20% 40% 60% 80% 100%
18-25	0	0%	
26-35	0	0%	
36-45	4	9.76%	
46-55	9	21.95%	
56-65	16	39.02%	
Older than 65	12	29.27%	
Total	**41**	**100%**	

Table 1.3: Would you say, in general, your health is...



Answer	Count	Percent	20% 40% 60% 80% 100%
Excellent	0	0%	
Very Good	25	60.98%	
Fair	15	36.59%	
Poor	0	0%	
Don't Know	0	0%	
Do not want to answer	1	2.44%	
Total	**41**	**100%**	

Table 1.4: Are you covered by any kind of health insurance or any health care plan?

Answer	Count	Percent	20% 40% 60% 80% 100%
Yes	41	100%	
No	0	0%	
Don’t Know	0	0%	
Don’t want to answer	0	0%	
Total	**41**	**100%**	

Research Question #1: Description of Evidence

In what ways has the Village Heart B.E.A.T (VHB) 16-week health promotion program effectively addressed the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

Responses of Participants

The survey contained four survey questions that answered the first part of RQ1 (categorized as Q1a) regarding the effectiveness of the VHB 16-week health promotion program. Second, two survey questions answered the second part of RQ1 (categorized as Q1b), regarding how effectively the VHB program addressed the spiritual growth needs of African American women.

The question on the level of satisfaction with the activities and programs offered by the VHB program demonstrated a high level of satisfaction (satisfied to very satisfied)

with an average score of 1.71 (see table 2.1). The consistent scores throughout each pragmatic category indicated that the VHB program offerings were effective and made a positive difference for African American women participants. There is consistency of satisfaction among the responses in all the categories of question 7.

Second, the series of individual questions suggests a consistent trend in high satisfaction levels on each VHB health program activity evaluated. The top 6 activities were:

- Ability to find meaningful fellowship: 60.98% were very satisfied (VS), 29.27% satisfied (S), 2.44% Very Dissatisfied (VD), and 2.44% Dissatisfied (D).
- Community partnership activities: 57.50% VS, 32.50% S, and 10% Neutral (N).
- Exercise programs: 52.50% VS; 42.50% S, and 5% N.
- VHB Martin Luther King Jr. walks: 75% VS, 17.50 S, and 7.50% N.
- Biometric measurement events: 60.53% VS and 31.58% S.
- YMCA VHB partnership (VHB participants could use the YMCA facilities free of charge): 50% VS, 35% S, 2.50% D, and 12.50 N.

The lowest category of the VS category was with the VHB point system and even then, it scored well (37.50 % VS, 42.50% S). A high level of satisfaction remained steady with the diabetes education (47.37% VS, 15.79% S), however 12 participants remained neutral (34.21%). The same observation is made with the cooking classes with 32.43% VS, 32.43% S and 32.43% neutral. On the one hand, the neutral responses may indicate that the sample did not participate in those particular activities. On the other hand, a neutrality if they had both positive and negative experiences with the activity. The individual interviews may provide further insight into further understanding the neutral

responses. However, overall, survey responses clearly indicate a strong sense of satisfaction with the program provisions. It also indicates that the activities the participants engaged in were effective in transforming the health and wellness of the African American women that participated.

Figure 2.1: How would you rate your satisfaction with the VHB 16-week health program on these parameters:

Question	Count	Score	Very Satisfied	satisfied	Dissatisfied	Very Dissatisfied
Ability to find meaningful fellowship	41	1.56				
Community partnership activities	40	1.52				
Exercise programs	40	1.52				
VHB physical activities	39	1.72				
VHB nutrition program	40	1.7				
VHB MLK Walk	40	1.32				
VHB Advocacy days	39	1.87				
YMCA VHB Partnership	40	1.68				
Johnson C. Smith Partnership	37	1.95				
VHB Capitan meetings	40	1.73				
VHB point system	40	1.88				
Class on reading labels on food products	38	1.87				
Cooking Classes	37	2.05				
Diabetes Education	38	1.92				
Biometric Measurement events	38	1.5				
VHB walking program	39	1.69				
	Average	**1.71**				

Third, question 8 of Q1a provided insight on the impact of the VHB program, services, activities and church affiliation and participation. The overall category scores were favorable and suggest that most participants agreed or strongly agreed with the statement with an overall consistent score of 4.33. The majority of responses on question eight indicated they "strongly agreed" that they were highly satisfied with the VHB 16-week health program (see Table 3.1: 63.41% Strongly Agreed (SA), 24.39% Agreed (A), and only 9.76% disagreed). The question about care indicated that the majority of the women felt cared for by the VHB program leadership (72.50% SA, 20% A, and 7.50 SD). Another insightful statistic suggests that the African American women believed that their health was impacted in a positive way as a result of the VHB 16-week health promotion program (58.54% SA, 34.15% A, 4.88% SD, and 2.44% N). Participants also indicated that they understood the program premises and thus were comfortable with the VHB 16-week rules of the program (62.50% SA and 32.50% A). The question about positive impact to physical health also indicated a high level of satisfaction with 58.54% SA and 34.15% A.

Another important aspect that was evaluated in the survey (Q1a), was the effectiveness of the VHB community partnerships with the local church that participated. There was also a high level of agreement with 50% indicating "strongly agree" and 35% "agree" when it came to the effectiveness of VHB/Church community partnerships. The next table also supports a high level of satisfaction on the response of the church in welcoming partners (See Table 3.8: 58.97% SA and 23.82% A). Five participants did remain neutral suggesting that they may not have enough information on the given topic. Finally, in this

category (Q1a) it is imperative to highlight Table 3.11 as it indicates that there was a positive change in health habits and behaviors (51.22% SA, 39.02% A and only 2 participants (4.88%) SD).

Table 3.1: Overall, I am satisfied with participating in the VHB 16-week challenge.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly disagree	4	9.76%	
Disagree	0	0%	
Neutral	1	2.44%	
Agree	10	24.39%	
Strongly agree	26	63.41%	
Total	**41**	**100%**	

Table 3.8: The Church was welcoming of community partners.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly disagree	1	2.56%	
Disagree	1	2.56%	
Neutral	5	12.82%	
Agree	9	23.08%	
Strongly agree	23	58.97%	
Total	**39**	**100%**	

Table 3.11: VHB programs motivated me to change negative health habits and behaviors.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly disagree	2	4.88%	
Disagree	1	2.44%	
Neutral	1	2.44%	
Agree	16	39.02%	
Strongly agree	21	51.22%	
Total	**41**	**100%**	

Finally, the fill in question 8 (Q1b) in the survey showcased greater insight on what exactly the VHB participants found satisfactory and transformational to their health. There were three that stood out.

Nutrition Education. Many participants concurred that one of the strengths of the VHB 16-week health promotion program was the nutrition education that was offered.

Participant #39211178- "I found the nutrition classes most helpful for me."

#38888136- "Reading labels and healthy cooking classes."

#38858501- "The nutrition classes that focused on reading labels. Also, the classes that encouraged us to try different spices instead of salt."

Exercise Programs and Group Workouts. Many of the participants agreed that the exercise programs that VHB created impacted their health in positive ways. Many agreed that particularly, the group workouts were of great impact.

Participant #38820090- "Having motivated team workouts and having access to the YMCA."

#38759389- "Before COVID-19, I enjoyed the ability to go to other facilities to work out."

#38746274- "I found the workouts most helpful because I was able to find a routine that worked best for me. Working out gave me more energy and strength."

The "Village" Provided Accountability: There was a constant repetition on the impact of the sense of family and accountability. This project also explored the opportunities of fellowship that the program created to build relationships and how this impacted spiritual growth in a positive way.

Participant #38993317- "Weekly encouragement from team members."

#38732226- “Having others to workout with.”

#38693778- “Accountability.”

#38727890- “Fellowship and competition with my team.”

Pastors Participation and Spiritual Growth

The survey questions 12 through 17 regarding the pastors’ participation and the impact to participant’s spiritual growth are categorized as Q1b. The questions evaluating the pastors’ engagement and support of the African American women suggest agreement and strong agreement. Table 4.2 indicates that 43.24% Agree (A) and 35.14% Strongly Agree (SA) that the pastors created meaningful fellowship utilizing VHB tools and resources. In this same category, there may be opportunity for improvement in this category since 16.22% disagree (D). Pastors also preached sermons on health issues on a regular basis (See Table 4.3: 40% SA, 40% A, 14.29% D, and 5.71% SD). The African American women also strongly agreed and agreed that the pastors’ or lay leaders’ sermons were effective and made an impact in their spiritual growth (See Table 4.4: 45.45% SA and 45.45% A). Table 4.4 also indicates that a significant number of pastors or lay leaders conducted Bible studies on health topics (48.39: 22.58% A). This statistic also suggests that there is an opportunity for even more Bible studies on health (19.35% D, 9.68% SD). The data also suggests agreement that the congregation members benefited from the VHB programs (See Table 4.7). Lastly, the participants “agreed” at 54.29% and “strongly agreed” (34.29%) that the pastor empowered or motivated them during the 16-week health promotion program.

Second, the survey indicated a consistent trend of “strongly agree” and “agree” regarding the impact to the spiritual growth of African American women. The women

confirmed that the VHB impacted their faith walk with Jesus Christ (See Table 4.10: 55.88% SA, 35.29% A, and 8.82% D). On a similar question on whether the VHB program strengthened their spiritual formation or spiritual growth, 55.88% strongly agreed and 38.24% agreed. This outcome is almost identical to the question about impact on the women's faith walk with Jesus Christ.

Table 4.2- My pastor created meaningful fellowship opportunities using the VHB tool.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly Agree	13	35.14%	
Agree	16	43.24%	
Disagree	6	16.22%	
Strongly Disagree	2	5.41%	
Total	**37**	**100%**	

Table 4.3-My pastor or lay leader preached sermons on health issues.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly Agree	14	40%	
Agree	14	40%	
Disagree	5	14.29%	
Strongly Disagree	2	5.71%	
Total	**35**	**100%**	

Table 4.4-The pastor or lay leader's sermons were effective.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly Agree	15	45.45%	
Agree	14	42.42%	
Disagree	3	9.09%	
Strongly Disagree	1	3.03%	
Total	**33**	**100%**	

Table 4.7- The pastor or lay leader participated in VHB advocacy days.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly Agree	9	29.03%	
Agree	11	35.48%	
Disagree	8	25.81%	
Strongly Disagree	3	9.68%	
Total	**31**	**100%**	

Table 4.9- There were policy changes as a result of the VHB program, i.e., cease smoking on the campus, additional wellness programs, etc.

Answer	Count	Percent	20% 40% 60% 80% 100%
Strongly Agree	15	42.86%	
Agree	16	45.71%	
Disagree	2	5.71%	
Strongly Disagree	2	5.71%	
Total	**35**	**100%**	

Third, many of the women provided consistent feedback on the positive impact of VHB to their spiritual growth in the fill in questions. These served as testimonials. The fill in question, “In what ways did the VHB 16-week health promotion program impact your spiritual growth?” had several responses:

Participant #39211178- “It helped me place more emphasis on my temple and be more mindful of taking care of it.”

#39022460- “An opportunity to further need for healthy servants of God shared within the congregation.”

#39004459- “We instituted water Wednesday and that is also the day we have corporate prayer, so the health recognition led to a deeper God consciousness on Wednesdays when the practice are coupled. Much like fasting.”

#38992361- “Have the faith to believe in yourself and trust the process.”

#38963198- “Kept me praying for compassion and peace. I thanked God for my health and the internal Holy Spirit in me that wants to live life abundantly.”

#38858501- “During the 16-weeks, I read more Scriptures and prayed more for God’s guidance and for will power with junk food.”

#38761138- “Leaned on God and my faith to make necessary changes.”

#37857656- “It helped me understand how faith and health goes hand in hand (faith without works is dead). It is not easy to work out and get better health, but VHB participants encourage one another, not only in our health journey, but personal lives as well. Praying for one another and supporting each other. “

#38729696- “I practiced acknowledgement that my body is God’s temple by being more aware of my lifestyle decisions and making better choices.”

#38703115- "I felt better so that helped me feel closer to God. I also felt that God cared about my body and that my spirituality was connected to my body."

#38698339- "My walk is my quiet time. I spend that time with God listening to his word, I've listened to the Bible at least 3 times from old to new, sometimes I get a better understanding, or a door opens up and I see what is being said in a verse."

#39211178- "It helped me increase my faith in that I was reminded that I must have faith in everything I do."

Qualitative Data

A total of eight women volunteered to participate in the one-on-one interviews. These interviews took place at different times via Zoom or telephone. The first two questions addressed the health disparity part of RQ1. The third question addressed the second part of RQ1. The samples shared their lived experience resulting from their participation in the VHB 16-week health promotion program. The responses are congruent with the quantitative data gathered. The following subheadings surfaced as repeated themes from their responses.

African American women were motivated by the prospects of improving their health, learning about nutrition, and changing negative outcomes of family health issues.

All the women spoke about the importance for them to improve their overall health. They were eager to engage in nutrition education. It was also critical to address detrimental family health determinants of health. Several participants alluded to the historic aspect of health disparities as African American women and because of their

gender. One woman shared that she had “a lot of health challenges” in her family. There was a sense of determination to change the outcome of their story:

> “I have a lot of health challenges within my family. Both my mom & dad have health challenges. My mom has a gallon size zip lock bag full of medicine. I was determined that I wasn’t going to be that girl. So, when I was approached 8 years ago to be a part of VHB, I said yes. I like what VHB stands for – our health, our priority, our community” (Interview A).

Interview G, poignantly shared about her husband’s death and the challenges she experienced as a result. Interview C also confirmed what G and others shared. Interview H also mentioned her family history as the main factor motivating her to get healthier as both of her parents died young (in his 50s) and had lost siblings to health conditions as well. There was a commitment to dismantle health issues like diabetes and high blood pressure:

> “After my husband passed away, I tried to keep my weight down and watch my health. I wasn’t taking any kid of medicine initially, but when my husband passed away, I started taking blood pressure medicine (due to stress) and then started having issues with my cholesterol. I decided to join VHB to help me keep my health intact. My team members were able to help me along the way” (Interview G).
>
> “I was striving to improve my overall health and decrease my blood sugar numbers. Diabetes and High Blood Pressure that runs in my family (IM). I want to live healthier and do my part to have that accountability so that I can reduce my numbers (Interview C)”

Interview F indicated the "need" to place a greater focus on her health. By way of that process a person's spiritual growth and faith can be impacted:

> "There was a need for me to focus on my health. I have no health issues and I am on no medications, but I am obese. I was overweight so I thought the program would help me to focus my on how I can become healthier and that was through the exercises, knowing your numbers, and nutrition, how to read food labels, how to prepare your foods" (Interview F).
>
> "In the church we are brothers and sisters in Christ, and everybody is on the same accord. All [VHB Participants] are of the same mind to help each other overcome high blood pressure or diabetes… or how just how to become healthy" (Interview F).

All the women interviewed mentioned the important theme of accountability to self and to each other as a source of motivation.

The quantitative data is almost identical to this important theme throughout. The church provided participants with a space to be accountable and hold Christian siblings accountable in their health journey. Interview D mentioned the importance of invitation into the program. Another woman (interview B) was motivated by her pastor in the church. This was the source of creating accountability.

> "Leader 1 was trying to form a church team and asked me to join" (Interview D).
>
> "I like what VHB stands for – our health, our priority, our community. It's a wonderful idea. The village concept that there's someone there holding you accountable was it for me" (Interview A).

> "A pastor introduced the program to me. I've been in it for 3 years now. It was a combination of my pastor and how deeply rooted I am in my faith. It made sense to support the pastor's vision and continue the exercise regimen that I already developed" (Interview B).

Question 2 answers of the one-on-one interviews are parallel to responses in question 1 and show continuation of the survey themes. The main themes found here were concerns for their health and the desire to be healthier; the need to change negative family health outcomes; the desire to connect with community partners and VHB team members, and the goal of ultimately getting healthier in a Christian environment. The desire to live for her family were the main reasons H cited as her reason to improve her health:

> "I wanted to live, I have four grandkids and because of my family history…I did not think I would make it this long, so I am grateful to see 62 and I am hoping that I will be able to see great grands now. You know, I am grateful by the grace of God and VHB that I am able to be as strong as I am" (Interview H).
>
> "Because I saw that my health was starting to fail, I decided to improve it. Joining "VHB was an opportunity for me to get and stay healthy" (Interview G).
>
> I wanted to minimize my risk for long-term use of medication for chronic diseases. I don't want to be on insulin" (Interview C).

Third, question three answered part 2 of RQ1 related to the impact to the women's spiritual growth. This qualitative data strongly supports responses from the survey and fill-in questions. The main themes mentioned that resulted in their spiritual growth were building relationships through fellowship, meeting "like minded" people in

their VHB teams and congregations, practicing their faith and strengthening their faith as they worked on their health, increasing their faith as they saw positive results, holding each other and "self" accountable, and opportunities to pray together and have increased communion with God. Woman E mentioned a raised awareness that her body was the temple of the Holy Spirit. D talked about the encouragement she encountered during her walks, and A described the spiritual growth found via VHB as a "blessing:"

> "Just knowing that our body is a temple of God and that we must focus on taking care of our bodies, we can't serve others or love others or emulate God or try to emulate Jesus in the way he walked this earth; share his love. If I am not taking care of myself, I cannot very well take care of others and do what God would have me to do" (Interview E).
>
> "When I walked, I listened to gospel music to encourage my spirit; help me stay in tune. Since there are other churches that joined VHB, I was able to build relationships with other believers outside of my team members. (D)
>
> I feel twice as blessed having to have found VHB. I found a wonderful group of friends who was like-mind. They were into their faith. My friends helped me by being faithful together. They were instrumental in increasing my faith. In the village, we hold each other accountable" (Interview A)

There was a positive correlation between the VHB activities, unity, and caring for the temple as part of the women's Christian journey.

Several women like C highlighted that VHB activities allowed them to practice their faith openly and do things like pray and read Scripture. One woman believed the VHB teams were "led by God to walk this walk." This idea was coupled with the

importance of unity in community. H believes she has grown in “faith and strength,” especially during the COVID-19 pandemic. She said, “Just thinking about everything that we have been through this year, my husband has been out of work just about all year. In November (2020), he had open heart surgery, he had a triple by-pass surgery, in December my brother died, so the village was there for me through all of that.” There was a commitment to unity in community that provided spiritual growth and strength through trials and tribulations. Finally, many of the women talked about the unity between their faith and spiritual health. As they worked on their health, advocated for equity in their communities, and came together as teams their “spiritual health and wellbeing” was increased.

> It helped because we always put it [prayer] first in our meeting and events/activities. Taking time to give praise and thanks along with the opportunity to fellowship together within the program strengthens the relationship I have with God. Holding myself accountable in knowing that although I’m not perfect there are always opportunities to improve on myself. I like that we always start and finish our meetings/activities with prayer and fellowship; we’re like a family. (C)
>
> We could always find Scriptures that would correct you in how you need to take care of your body and how you need to be that servant. That is what we were trying to live in the community and our churches, our own families. You can’t share with them what you are not doing… being focused on God’s will and doing what the word tells us to do” (E).
>
> The leader of VHB always stressed that the churches involved in VHB is not an isolated team, but a family. I felt comfortable knowing there is unity among all

churches in the program. We as African American women have strong faith, and we know God has a purpose for our lives. When we try to walk in that purpose and participate in initiatives such as VHB we feel comfortable in knowing everyone is on one accord. We all are striving for something positive. We are led by God to walk this walk. This process has expanded my awareness of the churches involved within the community. I was able to see how God has led them to develop their health ministries. It's just another way that God is saying, "I got you" (C).

"My spiritual growth and faith in God have always been above anything else (a priority). VHB has helped increase my spiritual health and well-being. It's a good program to be a part of" (G).

Research Question #2

What challenges has the Village Heart B.E.A.T (VHB) 16-week health promotion program faced in addressing the spiritual growth and health care disparities of African American women in Mecklenburg County, NC?

Questions 9 and 11 (Q1c) were part of the quantitative method to gather testimonial data. First, #9 was a direct, open-ended question that allowed the participants to fill in their own answers. Many valuable themes surfaced from the VHB participants The top three themes are described here.

1**. The COVID-19 pandemic:**

The COVID-19 pandemic created many challenges to this current class. Several of the African American women named isolation as one of the most difficult challenges to deal with. Others mentioned the isolation they experienced because they could no

longer engage in the healthy activities the program facilitated or even go to church physically.

Participant #38698339- "The second challenge came with COVID-19, having several members that were either sick or had family that were sick. To me they did a wonderful job during that time, but I felt VHB could have been more supportive. I wanted to ask for help but didn't know what question to ask.

#39116725- "The way we had to do things during COVID."

#38756154- "Staying on the program during the long break."

#38858501- "Being consistent with my exercises during COVID. Once the Aquatic Center closed. I was in water aerobics 2-3 times a week and beginner yoga class. I stared walking 3 times a week for 1 hour and working out with Mitch weekly."

2. Accountability:

The theme of accountability was the strongest of this session. Many of the women expressed how important remaining accountable to self and others was to them. However, they also expressed how difficult it was at times. The sense was that they were accountable to God for their commitment, and they were accountable to their team members and their church. The issue of accountability showed up in many ways such as staying motivated to exercise and complete workouts, sticking to nutritional changes, showing up to classes, following the point system, staying accountable to the team for their weight loss or routines, doing what they said they were going to do, and being consistent with their water intake and healthy eating habits.

Participant # 39004459- “Getting to classes…looking forward to participating again and actually taking classes.”

#38965700- “Water intake, consistent eating and exercising.”

#38891698- “The aspect I found most challenging was finding time to participate in all the available programming due to competing responsibilities and options.”

#38820090- “Staying motivated to do the same workout at the church every week.”

#38796184- “The challenge was to eat healthy and increate my intake of healthy foods and resisting the urge to snack on unhealthy foods (Chips, candy, etc.).”

#38746274- “Nutrition was challenging for me because I have a weakness for carbs and that has caused my A1C to be off.”

#38732226- “Being able to attend meetings.”

#38687524- “It was difficult for our team members to coordinate schedules to do team workouts.”

3. Challenges recording daily data and meeting daily targets:

Several of the participants highlighted challenges in recording the daily data sheet that is required. This process was a part of the rules that VHB required for participants to keep track of their daily routines, calorie intake, food choices, water intake, exercise, and workouts. The purpose of this was to record the progress of the participant at the end of the 16 weeks. Most important, it was a part of the point system that each VHB church team had to keep track of in the friendly competition. It was an honor system based on the participants’ personal commitment and the accountability to the team. It was also challenging for some of the women to meet the daily targets as expressed below.

Participant #38757656- “Getting team members data submitted with ease.”

#38729696- “Getting team members to record weekly activity reports.”

#38705215- “Recording daily meals.”

#3877907- “Rule changes making a simple program more complicated.”

As far as the spiritual growth part of the question neither question 9 or 11 (Q1c), provided any significant data on the challenges to their spiritual growth. The fill-in question response tended to focus more on the programmatic challenges that participants may have encountered. However, the one-on-one interviews may provide insight on this question.

Quantitative Data Analysis

The one-on-one interviews generated very similar responses that concurred with the survey results and the fill-in question responses. The main four challenges repeated over and over were: (1) Negative impacts of the COVID-19 pandemic on their VHB routines, (2) Changing unhealthy eating and nutritional habits, (3) Remaining accountable to oneself and to the VHB team members, and (4) Remaining accountable to the process and the schedule challenges to attend workouts and meetings.

Interview G was honest about her own struggles with keeping up with new health and eating habits. She said, “Changing my eating habits was a challenge. Some of the things I was eating wasn’t good for me. I enjoyed eating it, but knew I had to change my diet.”

The Global COVID-19 pandemic affected the moral and activities of the Village HeartBEAT participants:

> "One of the challenges included the global pandemic and how things had to be shut down. Not being able to leave the house and take part in activities (Facility use/group work-out). There was a lack of mobility when working from home. I spent more hours in front of a computer. I have to make sure that I'm self-motivated because I have so many competing responsibilities that it's easy to say I'll exercise later, but later never comes then it's bedtime" (Interview C).

> Being a co-captain for a team, I stayed in touch with team members to encourage them while they are in their house. VHB has offered online exercise classes which is instructor led. I encouraged my team not to stop what they are doing because it will get us through the pandemic mentally and physically" (Interview G).

The theme of remaining accountable was present in the interviews. One woman mentioned her inability to "stick to what she said, she would do." Another woman used the word "roadblock" to describe her challenges with the pandemic. She said, "this year the roadblocks were not going to the gym because of the pandemic." Some other comments made by the women were as follow:

> I wasn't able to attend the classes due to other personal commitments. The only challenge I had was sticking to what I say I'm going to do; being accountable" (Interview D).

> "I have been several years on no medications, but I knew that my weight was not what it was supposed to be. I am down but I know I can do more. It is not only the exercise, is also what you put into your body. So, I am just watching more carefully, and it is a challenge, and it is a lifestyle change, and it is for a lifetime. Not only for the 16 weeks, but for a lifetime" (Interview D).

> "Willing to set aside time and then willing to eat properly. Preparation was really the Key. In your shopping, thinking of your meals and how to prepare them" (Interview E).

> "This past year, the pandemic made it very challenging for us. It was the challenge of trying to stay motivated while still trying to do my part by myself. I took back to running, which was something I could do on my own…. I miss the fellowship with others. Being that I'm a widow, I really look forward to being around others; working out, learning how to eat right, etc. I really miss the workouts, line dancing and weighing-in as a group. I will be glad when this pandemic is over" (Interview A).

Research Question #3

What practices might help improve the Village Heart B.E.A.T (VHB) 16-week health promotion program in effectively addressing the spiritual growth and health care disparities among African American women in Mecklenburg County, NC?

In order to answer this important question, the researcher conducted a focus group of five pastors whose churches participated in the VHB program. These pastors also had spiritual oversight of the African American women that participated. Furthermore, each pastor has been a long-standing member of the VHB program within their local churches. This information addressed the perspective of the church leadership. The focus group was conducted in order to deepen the evaluation in areas that the quantitative data could not facilitate. The focus group interview also provided an important perspective of how the church leaders experienced the impact of the VHB 16-week program on their African

American female members and on the congregation as a whole. Most importantly, the pastors provided insight on RQ3.

Pastors generally agreed on the theme of accountability and the challenges some of the women faced in completing the VHB program or staying committed. Pastor A mentioned the time challenges that many African American women may face. She said, "It was great to have PM classes, but not everyone can join classes at that scheduled time. VHB can benefit from creating more scheduled times that ma\y give more options to participants to choose from on a weekly basis." Pastor B added the factor of transportation to time, and Pastor A specifically named, "transportation for seniors." Thus, a practice that may help improve the VHB program is creating more avenues of transportation for senior African American women. Pastor C mentioned the factor of time as well and "including families." Pastor C shared the following observation that concurred with other pastors:

> **Pastor C:** "The friendship amongst the participants seems to have grown by being part of the VHB program; relationships got richer. Their regard for one another grew, which was exciting to see."
>
> **Pastor A:** "I had a senior to partake of the challenge. Her participating encouraged other seniors to get involved." "The other thing was transportation for some of the seniors, getting to the different events, but I think that was taken care of by the fellowship of their teammates."
>
> **Pastor D:** "VHB created a sense of community; women exercised together (they had fun). The program helps build fellowship and made the team more aware of

their own health struggles. The team loved the accountability and competitiveness of the program."

Another important theme that is witnessed throughout the data analysis was the positive aspects of accountability and the challenges with remaining accountable. Pastor D and E brought up the challenges some of the women had with commitment, being accountable to make the necessary changes to eating habits, church culture, and breaking the stigma of weighing in. VHB may develop new models that address the church cultures around topics of food, healthy eating, and nutrition. Also, the challenges of COVID-19 provided an opportunity to help women with remaining accountable. Pastor A mentioned that COVID-19 opened more use of platforms like YouTube. In the same way Interview B saw the pandemic as an opportunity to develop new methods for the changing times. She said, "I didn't find any challenges even with being in a pandemic… VHB has offered online exercise classes which is instructor led." Therefore, VHB is encouraged to create new effective social media and online platforms that will empower African American women to be accountable to each other even while at home. Other comments by the pastors provide insight on practices that may continue to benefit VHB such as fellowship, accountability, and community building.

Pastor B: "Women of the church understood they have a health problem. They decided to work together as a family to help one another; encourage each other through the VHB competition journey."

Pastor A: "I would say that one of the challenges was weighing themselves, the scale to weigh. I know last time we weight ourselves more often. The teams were making sure that we had scales."

VHB should also continue developing programs that include opportunities to grow in faith because the impact to women's spiritual growth is evident by pastors.

> **Pastor A:** "Some of my team members weren't saved initially. They stared coming to church and meeting team members from their teams as well as other teams. They pray together, send group texts to encourage each other. I watched them grow. The members witnessed healing as well as experience healing for themselves."
>
> **Pastor C:** "I have a 93-year-old participant who loves chair aerobics. I've seen her faith increase and her sense of happiness/joy increase by being in the program."
>
> **Pastor D:** "Participants learned that they could control their diabetes, weight, etc., with this program. I love witnessing the fellowship amongst the team members; it was key to us. I saw growth within the team. Participants were happy to be on the team."

Finally, Perhaps VHB, can duplicate happiness and joy by creating capacity and utilizing the health ambassadors to create more than one group to compete per church. This was also suggested by a survey participant who encouraged VHB to open more opportunities of recruitment and participation. Sample 39863198 wrote, "Getting full participation from my own church. Participants are chosen instead of creating an open option for those that really wanted to improve their health. VHB itself was amazing." With these new potential tracks finding creative ways to keep VHB participants motivated during the challenging times of COVID-19 is possible.

Summary of Major Findings

The data analysis that was conducted revealed important major findings. These findings that emerged are listed below and will be broadened in Chapter 5:

1. An effective faith-based program that builds Christian *Koinonia* is important for African American women in Mecklenburg County, NC.
2. An effective faith-based program that addresses health equity issues for African American women is critical to close the health disparity gap in Mecklenburg County.
3. COVID-19 challenged the VHB program in unprecedented ways; however, the pandemic presents unique opportunities for new VHB, church, and community partnerships to emerge to build the Kingdom of God.
4. Healthy, happy wholehearted spaces are needed to help African American s thrive.
5. Local churches have a unique opportunity to duplicate efforts by using innovative programs such as efforts of missional outreach to young adults, other racial and ethnic groups, and other churches in Mecklenburg County.

CHAPTER 5

LEARNING REPORT FOR THE PROJECT

Major Findings

This research project was post-intervention, and it sought to evaluate the VHB 16-week health promotion program through the lens of African American women of faith in Mecklenburg County. NC. It used three instruments to gather data, which included a post-intervention survey, one-on-one interviews, and a clergy focus group. The project evaluates both the health impact and the spiritual impact on African American women that participated through their local churches. The results of the data suggest the following findings.

An Effective Faith-Based Health Program that Builds Christian *Koinonia* is Important for African American Women to Thrive in Mecklenburg County

As a pastor whose church participated early on in the VHB program years before entering the D. Min program, the researcher observed its effectiveness in creating a special kind of community for African American women. There was a sense of excitement and renewal when African American women could openly join their physical health to their faith and break societal taboos about Black bodies. The program gave a spark to the women and the sense of fellowship seemed to become more vibrant. It created authentic Christian fellowship among the body of believers.

This this kind of faith-based health program also created longevity in participation. It seemed to create a community of accountability founded in Christian love, kindness, and care. African American women created it among themselves in organic ways that were judgment-free zones. The faith-based health program went

beyond getting physically healthy to impacting spiritual growth. It touched the very core of Christian community because it creates it in authentic ways.

In essence, it was not the idea of community, it was what Dr. King called the beloved community because the practices were rooted in Christian faith. Dietrick Bonhoeffer asserts, “The person who loves their dream of community will destroy it, but the person who loves those around them will create community” (26). A well-planned, structured program, supported by community partnerships within the context of church life, can create *Koinonia*. One participant indicated that the program helped her “by keeping the faith.” Another indicated that it created for her, “fellowship, leadership, love for God, prayer, kindness and compassion.”

The findings in the study were supported by the literature review in multiple ways. First, Jesus’ healing ministry mostly happened in the context of community. Jesus also took care to heal many that were physically ill (John 4.43-54; Matt. 8.14.; Matt. 9:27-31). Most importantly, for the purpose of this study, Jesus had a preferential treatment for women who were marginalized. Healing for Jesus meant realizing true community by restoring the opportunity for the sick to be back in fellowship.

Second, the literature review concurs with the study finding as it suggests that Church folk must work toward restoring the “devalued other” (Joynes, 497). African American women have had a long history in the South of being the devalued other in Mecklenburg County. The statistics presented in the literature review are concerning and attest to the institutional and dehumanizing violence that Black women have endured. The 224th PCUSA GA report indicates that the church must aid in the deconstruction of the “multidimensional (physical, mental, emotional and spiritual) violence” against Black

womanhood and in the many forms of "theo-political sanctioned and socially accepted practices of disenfranchising" (224th General Assembly). Thus, faith-based health programs like VHB return the power to the stakeholders by taking a ground-up approach in the community to empower Black women. Finally, the fullness of *Koinonia* is manifested as faith-based leaders are treated as allies and change agents together with the members of their congregations (Emanuel, 2020).

Third, the biblical foundation for this research projects also strengthen the findings and provide new insights on the theological idea of *Koinonia*. The Merriam Webster dictionary defines Koinonia as an "intimate spiritual communion and participative sharing in a common religious commitment and spiritual community ("Koinonia"). In other words, Koinonia is the spirit-filled fellowship of the body of believers. The main biblical narrative for the project was the woman with the issue of blood. As such, Jesus seems to restore the right of this unnamed woman to enter into community by taking a participatory action in her own physical and spiritual healing (Mark 5:25-34; Matt. 918-26; Luke 8:40-56). Thus, the woman may be representative of African American women, who are invited to participate in their own healing. They are accompanied by Jesus and empowered to do all that they can do when they encounter the great Healer. Therefore, through effective faith-based programs, African American women participate in their right to self-determination, which in turn gives them access to the Koinonia of Christ.

Finally, a faith-based health program that intentionally targets members of a historically marginalized group within the context of their faith tradition is effective. Christian faith is lived out both in prayer and in action because it empowers participants

to become health ambassadors. As the literature review asserts, faith-based programs can provide unique spaces of healing within the local church. Faith-based programs also can provide unique opportunities to dismantle toxic theological ideals that may perpetrate the inferiority of African American women in relation to men and societal hegemonies.

An Effective Faith-Based Program that Addresses Health Equity Issues for African American Women is Critical to Close the Health Disparity Gap in Mecklenburg County.

A consistent challenge that the researcher witnessed as a community leader and pastor in an African American congregation were the disparity gaps. Many church members often worried about having access to the health care they needed. Many African American women in the congregation struggled with challenges such as diabetes, obesity, and hypertension. There were no efforts in place to address these issues from the theological perspective or physical perspective. The VHB faith-based health program was potentially as way to improve these sensitive areas in the lives of a vulnerable demographic.

During the faith-based program, taboos such as obesity, health issues, and racial disparity topics could be addressed. These were addressed as church leaders and their members were invited to lobby and advocate for their rights in county town hall meetings. The act of walking in the Rev. Dr. Martin Luther King, Jr. observation event as church communities was a powerful witness. The goal was to understand how partnering with secular institutions could play out in the life of a congregation. Participants attested to the impact of this program in closing the health disparity gap.

For instance, one woman said, [The VHB program] “really makes you aware if you are not healthy you are limited in being able to help others when needed.” Other women talked about breaking the generational chronic disease pattern she found in her family line. She said, “Diabetes and high blood pressure that runs in my family. I want to live healthier and do my part to have that accountability so that I can reduce my numbers.” Thus, an organized, serious faith-based program that emphasized community engagement with African American women as the health ambassadors was fundamental to support long-term health equity. Closing health disparity gaps in communities involves the buy-in from the members affected by the discrepancy and the leaders of the institutions that serve these communities.

The literature review addressed the historic trauma that African American women faced in Mecklenburg County as a Southern city. Each African American woman has their own story and experience, so this study does not try to speak for all African American women in the South. Collins asserts that African American women confront specific sociological challenges in the US, especially when coming from different social economic statuses. The experience of institutional racism, micro-, and macro-aggressions affects all African American women one way or another. Therefore, the literature review provides concrete data that explain exactly how African American women continue to be systematically impacted by avoidable health differences and a host of diseases (Beadle et al, 3; Healthy People 2020).

These challenges are complicated by the further inequity in gender gaps in Mecklenburg County and the high rates of poverty that African American women encounter in this city. African American women have higher risks to issues of

reproductive health, mental health, food insecurity, and access to healthy spaces (Semuels, 4; AHRQ, 2013; Collins, 1999; Smedley et a., 6, 2003, Walker, 2018; ODPHP, 2020; IOM, 2002; Owens, 2012). Thus, the urgency to create health equity for African American women is a matter of life and death. Faith-based health programs have led the banner of health equity for a long time. VHB is one of the most successful models that has produced data-focused results in Mecklenburg County for African American women within FBOs.

As delineated in the literature review, VHB has done this while creating practices that are deeply rooted in community inclusion and mobilization. The program utilizes a Christ-centered approach of accountability, unity, and ecumenical collaboration. The founder Emanuel asserts, “the team reduces barriers by collaboratively working across organizational cultures, including the public health organization (MCHD), healthcare service providers, and FBOs in high-risk communities” (2020). The strategy of the VHB model contributes to closing the health disparity gap by investing, training, listening to servant leaders, and eliminating the barriers to the self-empowerment of the women in high-risk zip codes. Churches are empowered to fulfill the Kingdom mandate to go and do the work of harvesting the fields (John 4:35; Mark 16:15).

From the biblical perspective, the woman with the issue of blood is an example of creating health equity. Luke 8:44, describes the health disparity situation the woman is facing, she “had spent every penny she had on doctors, but no one had been able to help her” (The Message Version). The economic distress led the unnamed woman to act on her last hope, which was her faith in action. The setting of the biblical series narratives, from the healing of the hemorrhage to the healing of Peter’s mother and the ruler’s

daughter, are all non-institutional. Since this is a non-institutional moment, it puts the power in the woman's hand and outside the patriarchal health system of the time.

Thus, in this instance, after depending solely in the health care system, she expanded her possibilities through her spiritual awareness and faith. The hemorrhaging woman displays courage, stands alone, stands empowered and initiates her own healing. African American women's involvement in faith-based health programs within their local churches is effective in closing the health disparity gap in the community. African American women become their own healers within their churches in special ways that sustain its longevity because Jesus acknowledges their place to do so, "woman your faith has made you well" (Mark 5:24-34). B. Ehrenreich sustains:

> Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were mid-wives, traveling from home to home and village to village. For centuries women were the doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. Medicine is part of our heritage as women, our history, our birthright. (Ehrenreich et al., 1)

Therefore, in good Matthean fashion, the biblical narrative places the ultimate faith and trust in Jesus. Jesus does not shy away from empowering the woman to participate in her own healing outside of an institution. In a certain way, he rebukes the males around him that question, "how can you ask who touched you" when the crowds

press against you. The touch Jesus felt was of a special woman who decided to be a healer with her faith as she partnered with the ultimate healer, Jesus. In the same way, historically marginalized African American women in at risk zip codes in Mecklenburg County are being called to close the health disparity gap, not only from within institution but outside of institutions via effective faith-based programs.

The COVID-19 Pandemic Presents Unique Opportunities to Increase Faith-Based Health Programs in Churches

The timing for completing the data collection of this project happened in the middle of the COVID-19 pandemic, December 2020 into the first few months of 2021. Many of the participants that responded to the VHB post-intervention survey, and the one-on-one interviews have been repeat participants of the program. These women could evaluate the great impact the pandemic had on the faith-based program and their own lives. The women were able to name the negative impact of COVID-19 on the African American community precisely because they had been participants in different seasons.

The COVID-19 crisis affected many lives in detrimental ways and halted many parts of life. However, it disproportionately affected African American s and other minorities in the US. According to Dr. Michelle Albert, “African American women are often at the intersection of the worst economic and health disparities” (Tata Health). This was a reality during COVID-19 as the virus affected African American communities in disproportionate ways. For instance, since African American women suffer at a higher rate from cardiovascular disease, studies show that the impact of the virus is often mortal compared to other groups. The virus has revealed the real impacts to African American s,

ethnic minorities, and lower socioeconomic communities. This race and ethnic discrepancy show the “disproportionate burden of illness and death” (Azar, et al., 1;).

The literature review initially did not consider the impacts of COVID-19, so this was a major finding in this study. The impacts of the historic burden of disparities in education, income, wealth, housing, and other social determinants of health make African American women more vulnerable to COVID-19 due to their underlying risk factors (Howerton et al, 2; Raine, 5). African American women are also more vulnerable due to the jobs they have which may expose them to this virus in significant ways. Dr. LaPincess Brewer states, “They are more likely to hold service sector jobs that increase their risk of exposure. They are. Also, the caregivers in their communities and are more likely to experience racial bias in all systemic areas of society from medical to housing and employment” (Williamson, 2). Usually, most African American women tend to seek health care last in their households or wait until the symptoms are worst.

The biblical traditions of lament speak directly to the disproportionate discrepancies African American women reckon with in COVID-19 times. All of this compounded what they have to overcome every day in all sectors of society and life. Psalm 13 is in place to sustain the biblical foundation of this project:

> **1** How long, Lord? Will you forget me forever?
>
> How long will you hide your face from me?
>
> **2** How long must I wrestle with my thoughts
>
> and day after day have sorrow in my heart?
>
> How long will my enemy triumph over me

[3] Look on me and answer, Lord my God.

Give light to my eyes, or I will sleep in death,

[4] and my enemy will say, “I have overcome him,”

and my foes will rejoice when I fall.

[5] But I trust in your unfailing love;

my heart rejoices in your salvation.

[6] I will sing the Lord’s praise,

for he has been good to me.

COVID-19 revealed, not only the ever-increasing gaps of health disparities among African American women, but also the despair and circumstances that challenge faith. The theological concepts of trust, faith in action, and justice relate to the biblical and theological foundations of this project. For African American Christian women, the question of, “How long, Lord?” is very real and literal. It stands directly with the biblical witness and the contextual theological ideals mentioned in the literature review such as womanist, feminist, liberation, and black theologies. They point to the unique stories African American women have held in their defense of claiming their relationship to Jesus and the biblical cannon from their own lens. It points to the historic struggle to dismantle theological and societal notions such as the “strong black woman” or the “angry black woman.” It has created theological language for denominations like the PCUSA to address the injustices and disenfranchisement of African American and Afro-Caribbean women in the clergy and in broader society.

For indeed, the ultimate theological reality for many African American women in the US is and has been their full dependence on God. They recall the women of promise

in the Bible such as Hagar, Mary of Nazareth, Deborah the prophetess, and Esther the queen as evoked in the biblical foundation. Other women that speak to African American women and their quest to create happy, wholehearted spaces after going through pain are Zipporah, who utilized her wisdom and the mother of Moses Jochebed, who in the face of genocide put herself on the line as women of her time. Finally, the most prominent for this project is the woman with the issue of blood, who overcame deep despair and physical illness in a patriarchal and religious society that had counted her out. These are the elements of the biblical and theological foundations that inform the opportunity for African American churches to seize the times of COVID-19 as another opportunity to rise in urgency to gain health equity for such a vulnerable group.

Healthy, Happy, Wholehearted Spaces are Needed to Help African American s to Thrive

Many churches in the US create wellness programs. Wealthy churches even have entire work out facilities. However, what makes VHB unique is that it approaches churches with a structured program, in collaboration with health institutions and other health organization partners. The faith of the women who participated was impacted in a program connected with secular entities and was also impacted with a sense of joy and happiness. The data clearly showed the correlation between changes in health habits and changes in how the women felt.

For instance, one woman indicated how good it felt for her to receive the "village" support during a difficult time of loss in her family. Another woman indicated that the program "increased my health and it was because of my pastor's encouragement." Yet, another participant indicated, "I've always had a strong faith, but

the 16-week health program (VHB) has connected me with others who are of the same mindset. We work together to edify God through our commitment to exercise and eating right." The success in this faith-based health program for African American women within the context of Christ was healthy, happy, wholehearted spaces. The women could practice their faith openly and fully. They could go from despair to healing, like the woman with the issue of blood, as equitable participants in their healing efforts.

The literature review supports and points to the African idea of Sankofa as empowerment of wholehearted spaces for people of African descent. Sankofa is an African word from the Akan tribe in Ghana, which means "it is not taboo to fetch what is at risk of being left behind." The spirit of Sankofa is based on the ancient understanding of the past serving as a guide for planning the future. It is a concept used by many women of Pan-African decent to guide them in recalling their stories. Just like in the Christian tradition, they are called to remember and to stay in the movement of new learning. VHB serves as a modern-day space of Sankofa for African American women of faith. It creates happy spaces of health and wholeness for women to return to health and go toward the joy of the Lord. Spaces that create health allow African American women to return to their roots and gain the knowledge that has always been their birthright.

Therefore, the unique spaces build by faith-based health programs not only create space for the spirit of Koinonia in Christ, but also for the spirit of Joy. As Nehemiah 8:10 says, "The joy of the Lord is your strength." Elion sustains that the practice of Sankofa serves as "a form of holistic medicine in the repair of Black souls" (Elion, 480). As suggested in the literature review, "the partnership of FBOs is not a one-dimensional approach, but instead is one that may serve to strengthen the spiritual healing and

spiritual connection with Christ of participants that seek to empower themselves" (Literature Review, 59). In addition to the health benefits that occur as a result of being happy, which adds positive benefits to a person's health, the benefits for African American women rage from promoting a healthy lifestyle, combatting stress, boosting the immune system, protecting the heart, reducing pain, promote healthier diet, helping with sleep problems, promoting concentration, increasing productivity, and maintaining a healthy weight (Coyle, 3).

Brené Brown suggests that in cultivating "wholehearted living" one must let go of, "what people think, perfectionism, numbing and powerlessness, scarcity and fear of the dark, need for certainty, comparison, exhaustion as a status symbol and productivity as self-worth, anxiety as a lifestyle" (TEDxHouston). Brown suggests, cultivating "authenticity, self-compassion, a resilient spirit, gratitude & joy, intuition, trusting faith, creativity, rest & play, calm & stillness, meaningful work and laughter and dance" (TEDxHouston). Many of the latter things are missing in at high-risk zip codes for African American women as the determinants of health are not pointed in their favor. Thus, given these and many other facts expressed in the literature review, African American women can thrive with faith-based health programs that create happiness and wholehearted spaces.

From the biblical and theological perspectives, the concept of happiness or joy is presented as an imperative of spiritual life. "Many are the afflictions of the righteous, but God will deliver us from them all" says Psalm 34:19. Joy and delight are encouraged in the biblical narrative. The biblical foundation makes the point of that power of deliverance. For instance, when Peter was going under water, he cried, "Lord, save me!"

(Matthew 14:3). As indicated above, the deliverance of Peter was both spiritual and physical. Both acts are deeply intertwined. Jesus also pushes the boundaries of his time to heal a woman marginalized by physical suffering and sickness. What happens next after the deliverance is accomplished is joy, delight, and happiness. The Scripture tells us, "When one of them saw that he was healed, he came back. He praised God in a loud voice. He threw himself at Jesus' feet and thanked Him" (Luke 17:15). The joy of being delivered causes a response of pure happiness and wholeheartedness that serves the well-being of African American women in Mecklenburg County. These wholehearted spaces can be duplicated in many ways.

Local churches have a Unique Opportunity to Duplicate Efforts

Village HeartBEAT is a powerful grass-root movement that expands in new ways each year. The program leaders find innovative ways to increase church leader participation as well as African American women's commitment. The faith-based program takes a positive stance toward community strengths and valued local knowledge. Through valuing pastors as spokespersons of their community, the VHB can build transparency and lift community pride. This was the reason the researcher became one of the seven pilot pastors in the program almost a decade ago. As years passed the program continued to impact the lives of hundreds of African American women in Mecklenburg County, with strong data backing up the impact. VHB has developed a vibrant partnership with several Latinx churches that influence both the new immigrant community and the established Latinx community. However, the program faced struggles to become cross cultural beyond the African American community.

The study data demonstrated that faith-based health program models like VHB have a unique opportunity to duplicate outreach efforts to the community. According to the survey, most of the participants represented were between the ages of 36 and 65 years old. While it is to be celebrated that woman in this age range are getting healthy, the 18–35-year-old demographic was missing from the survey. Thus, young adult African American women need outreach within the churches and institutional partners participating. The program is also in the position to extend its outreach and missional goals into the broader Latinx community and within other ethnic groups in Mecklenburg County. For instance, Charlotte, NC (where most of the participant churches are located) is the sixth nationally for attracting young adults. The Latinx population accounts for 14% and the Asian for 6%, and there are many other ethnic groups that make Mecklenburg a growing diverse city. However, while growth is expansive and continued, as the 2020 Pulse Report indicates, it is “not everywhere and not for everyone” (39).

The literature review supports the finding that, while this study is focused on African American women in the US, the sin of slavery affected many ethnic groups. The project begins with the premise of the historic woundedness of people of African descent in the US, the peoples of the Caribbean, Latin America, and beyond. The literature review outlines that suffering is a human condition. Rev. Dr. Marjorie Lewis asserts, “Wounds are a source of suffering and can also be opportunities to reflect theologically about the nature of suffering” (Lewis, 546). Since suffering due to health disparities is part of the human condition, then other groups of people can also benefit from a model such as the VHB health promotion faith-based programs.

The Biblical perspective continues to evoke the story of the woman with the issue of blood as a catalyst and representation of all women in the world. This biblical story of faith, Jesus' healing power within the context of community, and the woman's bold approach are an example to all women of faith. Jesus would have been located within the health care system of his time. The type of healing being predicated of Jesus places him firmly within Israel's health care system as mediator and doctor of divine healing (Dube, 6). This healing experience and access is available to all who receive Jesus as their own.

Ministry Implications of the Findings

This study and its findings have important implications that inform the practice of ministry. The first one is an affirmation that both the positive witness of the Church universal and the good work and sacrifices that many African American women of faith engage in can contribute to the collective creation of health equity in Mecklenburg County. The book of Colossians indicates, "And whatever you do, in word or deed, do everything in the name of the Lord Jesus, giving thanks to God the Father through him." (3:17). Health equity creation that impacts the daily lives of this vulnerable group adds to the collective healing of African American women and other women of color through their participation within their faith-based health programs. This witness cannot be taken for granted given the historic struggles of the Black Church, the health disparities of African American women in the US, and the discrepancies in all sectors of society in regard to health care access, education, housing, and economic status. Most importantly, the effectiveness of transformations in their health and the growth in their journey with Jesus Christ strengthens the witness of the Church.

Second, the findings of this study may impact the practice of ministry by reinforcing the practice of effective partnerships between FBOs and community organizations, among them the Public Health Department. There is power in partnership through structured faith-based models like VHB that place African American women as the stakeholders. Through cross-agency collaboration churches can be united to attend to issues that affect the community at large. Churches, pastors, and the lay community may be able to build capacity by implementing evidence-based approaches. By implementing these kinds of models FBOs may be able to create supportive environments for vulnerable groups such as African American women in high-risk zip codes. Such faith-based models may enhance individual and collective self-efficacy by empowering people from the community to become health ambassadors. Most importantly, the church may be able to strengthen their God-given mandate of being an outward-focused place that encourages community engagement and awareness.

Third, there is a great opportunity for church leaders such as pastors and other church officials to take their proper place in community advocacy for equity and justice. The prophetic imperative of Amos 5:24, “but let justice roll down like waters,” can be manifested. Since church pastors are at the center of leadership within the VHB model, it may provide church leaders an opportunity to empower the action of their people. These formal partnerships are critical elements for community development and accomplishing county health goals for the population. In addition, it gives churches tools for assessments, trainings, resource access, and connecting their people in self-empowering ways.

Finally, an important implication for ministry is duplicating efforts in other at-risk ethnic group such as the Latinx community and young adults of color. By using faith-based tools of evangelism, outreach, and missional ministry development, the church may reach more siblings for Christ. By promoting health and well-being through shared values, churches may foster community engagement. If VHB and new church partners duplicate cross-sector collaborative partnerships, they may make a difference in the lives of more ethnic groups in Mecklenburg County. Expanding these efforts to improve health outcomes may benefit the community at large.

Limitations of the Study

This post-intervention study was focused only on African American women in Mecklenburg County that participated in the VHB 16-week health program. This study was also focused on the experiences of the African American women that completed the program in their churches that partnered with VHB. Therefore, this study may be generalized for women in other high-risk female ethnic groups. The focus group tool can be utilized with pastors and clergy people as well and contextualized accordingly. Churches and FBOs can use this study model to conduct research on other women's issues. However, the study may not be adequate to do the same with a male population.

One of the limitations of the study was conducting the study completely virtually due to the COVID-19 Pandemic. This limited the opportunity to observe human reactions and interact in a more organic way. The nature of virtual meetings and potential technical difficulties created a non-traditional way of conducting interviews and focus groups. It was also challenging to manage the flow of the conversations virtually. Nothing replaces face-to-face interaction with people.

Unexpected Observations

One unexpected observation was the level of ecumenical engagement that the VHB model created among churches of different communions. The ecumenical visions is one of unity in Jesus Christ, “that they all may be one” (John 17:21). The level of ecumenical collaboration was enormous. Churches that participated represented various Historic Black denominations, reformed traditions, and Pentecostal traditions. Woman 7117 said, “When we all realized that getting healthier takes a village began working together, motivating one another, because we want to live longer, healthier lives.”

A second unexpected observation was the level of engagement by the pastors or lay leaders within the faith-based program. Pastors lead very busy and sometimes hectic lives due to their level of responsibilities. It was encouraging to see that pastors kept an ongoing commitment to the participants of the program by encouraging them, preaching about health, and accompanying them. Woman 1698 asserts, “my pastor or lay leader empowered through promoting health and wellness during sermons, and educational programming and through active engagement and participation in activities offered.” Woman 3317 indicated that her pastor “consistently did her best to keep me motivated with my walking and drinking more water.” Another woman also said, “Our pastor had sermons on being healthy and also had speakers to come to the church.”

Recommendations

This post-intervention study sought to evaluate the VHB 16-week health promotion program and its impact on the lives of African American women in Mecklenburg County, NC. The researcher, as a clergy person, sought to understand how the participants’ faith and spiritual growth were impacted as a result of their participation

in the faith-based program. The study was fruitful; however, it is not exhaustive and can be strengthened in following ways:

1. It may be useful to conduct a study such as this one in post COVID-19 times in order to utilize a face-to-face approach. This may lead to greater richness in responses and observations.
2. This study can be used to contribute to the better understanding and support of African American women. Their example may be of inspiration to other ethnic groups in Mecklenburg County who face similar challenges.
3. This study model may be useful in evaluating other faith-based programs that relate to the local church in high-risk zip codes.
4. On every opportunity available it may be of great benefit to study the spiritual impact of a program since, for followers of Christ, actions can be connected to faith. These types of findings may yield greater theological understanding in the praxis of ministry.
5. Future areas of research should include the impact of faith-based health models on African American men. The study could also benefit from inquiry into the spiritual growth of African American men.
6. The local church can use this study model to explore its practice of partnerships with secular organizations and what they mean for the building of God's Kingdom on earth.

Postscript

At the beginning of this journey in 2015, Dr. Verna Lowe told our cohort that this journey was not about winning a game. Instead, it was about winning the championship.

In order to win a championship, each player had to do their part by being disciplined, dedicated, and committed. Along the journey, I lost my way from the Doctorate in Ministry a few times as the things of life happened to me: situations and circumstances like the loss of a job, challenges in ministry, giving birth to a beautiful baby girl, and the global COVID-19 pandemic. Thus, I understood what Dr. Lowe, meant! I had to change my mindset in order to complete this doctoral degree. Along the way, my community of support were my cheerleaders reminding me of the worth of this project.

At each juncture of the way Jesus' words to us are, "I have told you these things so that in me you may have peace. You will have suffering in this world. Be courageous! I have conquered the world" (John 16:33). We are more than conquerors through him that loved us. Indeed, this project has taught me that the Christian way is about finding peace and joy in the midst of the trials and tribulations of life. Even though this journey took me longer than anticipated, it was completed precisely at the right time. The subject matter became ever so real to me as a woman of Afro-Puerto Rican descent in times of COVID-19. The recent occurrences and "being Black" in America made this project critical in the hope of strengthening ministry now and in the future. This project taught me that my contributions matter and my voice matters. I learned the value of loving self and seeing the plight of the other. The Holy Spirit met me many times in my quiet place, and I learned lifelong skills that have transformed my life for the better.

The journey was not only writing the dissertation; it was also completing rigorous courses and various residencies. Those moments of fellowship and communion with God and other siblings were important to our spiritual formation. The partnerships with the Village HeartBEAT program and the support of Cheryl Emanuel and the pastors was

heartfelt. As the great African proverb says, “I am because you are.” This journey was a true “*Sankofa*.” It taught me the power of sacrifice and hard work, together with the love and support of community. It also taught me the power of sacrifice and overcoming the disappointments and hardships of ministry. Most importantly, I gave myself permission to lament and grieve the realities that Black women face on a day-to-day basis. The journey for us ahead is long, but our ancestors and the power of the Holy Spirit continue to guide us toward God’s vision in Jesus Christ. I look forward to the opportunities and doors of ministry that the learnings of this project will create for me and others. My hope is that this project will be a blessing to the Church, the community, and the world in healing African American and Pan-African women as we search for justice, equity, and peace. Thanks be to God!

APPENDIXES

A. Survey/Interview Schedule and questions

Post Intervention Village HeartBEAT (VHB) Survey

Hello:

You are invited to be in a research study being done by Rev. Everdith Landrau a doctoral student from Asbury Theological Seminary. You are invited because *you meet the criterions for this study as a self-identified African American or Black American female that have participated in the Village HeartBEAT 16-week friendly competition and have successfully completed it.*

If you agree to be in the study, you will be asked to fill an online survey questionnaire that will be emailed to you.

We will also ask you to complete a short demographic survey; this will help to describe the group and will not be used to identify you personally. The study poses no risk to your health. The only risks are that of disclosure of the personal information you have given us. I will attempt to minimize these risks, and such a disclosure is unlikely. All results will be de-identified prior to their release.

This survey may or may not improve the health status of the community, in the short or long term. The information gained from your participation may result in an improvement of activities and programing provided by VHB and the local church, and it may benefit similar efforts of future ministry design.

There is no alternative to participation; the only alternative is not to participate.

If something makes you feel uncomfortable in any way while you are Completing this survey, please tell *Rev. Everdith Landrau who* can be reached at everdith.y.landrau@asburyseminary.edu You can refuse to respond to any or all of the questions, and you will be able to withdraw from the process at any time without penalty.

Survey Questions:

1. Did you complete the 16-week VHB Health Promotion Program?

   Yes

   No

2. What is your age range?
   18-25
   26-35
   36-45
   46-55
   56-65
   Older than 65

3. Would you say, in general, your health is...?

   Excellent

   Very Good

   Fair

   Poor

   Don't Know

   Do not want to answer

4. How would you rate your satisfaction with the VHB 16-week health program on these parameters:

	Very dissatisfied	Not satisfied		Satisfied	Very satisfied
Ability to find meaningful fellowship					
Community partnership activities					
VHB Exercise programs specific to your local church					
VHB nutrition program					
VHB MLK Walk					
VHB Advocacy days					
YMCA VHB Partnership					
Johnson C. Smith Partnership					
VHB Capitan meetings					
VHB point system					
Class on reading labels on food products					
Diabetes Education					
Biometric Measurement events					
VHB walking program					
Cooking Classes					

5. Are you covered by any kind of health insurance or some kind of health care plan?

   Yes

   No

   Don’t Know

Don’t want to answer

6. How long have you been attending the Church you represented for VHB?
   0-6 months
   7-12 months
   Since the last 2 years
   More than 2 years

*Overall, I am satisfied with participating in the VHB 16-week challenge

	Strongly Agree	Agree	Disagree	Strongly disagree
*The VHB cares about its participants				
*I receive timely updates about events in VHB				
*I received timely updates about my progress in VHB				
*My health was impacted in positive ways during the 16-week health promotion program				
*I understood the rules of the VHB 16-week health promotion program				
*The VHB community partnerships with my church were effective				
*The Church was welcoming of community partners				
*It was easy to understand the VHB information materials				
*Workout routines facilitated by VHB health ambassadors or coaches				
*VHB programs motivated me to change negative health habits and behaviors				

9. Is there any other feedback you would like to give the VHB health promotion organizers?
Yes (If yes, please explain)
No

10. What aspects of the VHB 16-week health promotion program did you find most helpful?

11. What aspects of the VHB 16-week health promotion program did you find challenging?

12. Please give 3-5 changes you made to your habits and or health behaviors as a result of the 16-week VHB health promotion program

13. Did your pastor participate in VHB activities and events?

Yes

No

Sometimes

14. Please agree or disagree with the statements below on your pastor or lay leaders' participation with the VHB program based on the following parameters

	Strongly Agree	Disagree	Strongly Disagree
*My pastor created meaningful fellowship opportunities using VHB tools			
*My pastor or lay leader preached sermons on health issues			
*The pastor or lay leaders' sermons were effective			
*The pastor or lay leader conducted Bible Studies on health			
*The pastor or lay leader participated in VHB events			
*The pastor or lay leader participated in VHB advocacy days			
*The congregation benefited from the VHB programs			
*There were policy changes as a result of the VHB program, i.e., cease smoking on the campus, additional wellness programs, etc.			
*My pastor or lay leader empowered or motivated me during the 16-week health promotion program			
*The VHB program impacted my faith walk with Christ			
*The VHB program strengthened my spiritual formation			

15. In what ways did the VHB 16-week health promotion program impact your spiritual growth?

16. In what ways did the 16-week health promotion program affect your faith in Christ?

17. Do you believe that the VHB program impacted your faith, if so, how?

18. My pastor or lay leader empowered or motivated me during the 16-week health promotion program?

19. Did the VHB program made an impact in your congregation? If so how (i.e., sermons on health, policy changes, prayer practices, fellowship with others)?

20. What feedback do you have for your pastor or lay leader the VHB program in your church?

VHB Church Pastor & Lay Leader Impact Focus Group Questions:

1. What motivated African American women in your church to join the VHB 16-Week Health Promotion Program?
2. Why did you commit as a leader to partner with VHB & Health Community partners?
3. Did you witness a spiritual formation change in the faith walk of African American women that participated in VHB? If so, what?
4. How did VHB make an impact your behavior and spiritual formation?
5. What impact did VHB have in the lives of African American women in your congregation?
6. What challenges did African American women who joined VHB face in completing the program?

B. Informed Consent Letter

INFORMED CONSENT LETTER

Post-Intervention VHB Participant Impact

You are invited to be an Expert Reviewer in a research study being done by **Rev. Everdith Landrau a doctoral student** from Asbury Theological Seminary. You are invited because ***you meet the criterions for this study as a self-identified African American female that has participated in the Village HeartBEAT 16-week friendly competition and have successfully completed it.***

Please see below information for those considering participating in this study:

If you agree to be in the study, you will be asked to fill an online survey questionnaire that will be emailed to you. You may also be invited to a one-on-one interview, which will be conducted vis Zoom.com or the telephone. These will be scheduled individually with each participant.

I will audio record the discussion so that I can transcribe it and have a written record of what was talked about. With that said our discussions and their transcripts are confidential and will only be read and analyzed by members of the research team. Anything that is said the online video chat room should not be discussed with others once you have logged off. All identifying information will be stripped from the transcript.

The study poses no risk to your health. The only risks are that of disclosure of the personal information you have given us. I will attempt to minimize these risks, and such a disclosure is unlikely. All results will be de-identified prior to their release.

This study may or may not improve the health status of the community, in the short or long term. The information gained from your participation may result in an improvement of activities and programing provided by VHB and the local church, and it may benefit similar efforts of future ministry design.
There is no alternative to participation; the only alternative is not to participate.
All discussion will be audio recorded and later transcribed. During transcription we will be taking out any names or other identifying information that is in the recording to assure there is no breach of confidentiality on the data. Once the data has been transcribed and verified, it will be printed and placed in a binder in the researchers locked filing cabinet, and under the supervision of a researcher or team member at all times. The audio recording will be destroyed.

If something makes you feel uncomfortable in any way while you are in the study, please

tell ***Rev. Everdith Landrau*** who can be reached at
everdith.y.landrau@asburyseminary.edu
You can refuse to respond to any or all of the questions, and you will be able to withdraw from the process at any time without penalty.

If you have any questions about the research study, please contact **Rev. Everdith Landrau** at everdith.y.landrau@asburyseminary.edu**.**

____
Signature of Person Agreeing to be in the Study   Date Signed

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