Exploring the Health Beliefs of Older African Americans in a Faith-Based Education Program

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Abstract: Medical mistrust among African Americans is rooted in a history of abuse by unethical researchers and personal and community experiences of discrimination in healthcare. This study explored the relationship between spirituality and health, and health care attitudes of older African Americans in a faith-based health education program in the northeastern United States. The Health Beliefs survey includes combined items from the Spiritual Locus of Control Scale and the Group-Based Medical Mistrust Scale. We collected data over four years of a faith-based dementia caregiver support program from new participants (N=56) in an annual 12-week Healthy Living program. Participants completed the survey during their first session in their first year of the program. This exploratory study analyzed survey responses using univariate statistics. Participants endorsed the importance of their relationship with God in staying healthy and reliance on God to remain in good health and showed more trust than distrust in the healthcare system. Discussion: Results indicate a cultural shift in this community of older African Americans resulting from repeated exposure to messaging on self-advocacy in healthcare settings, importance of preventive screenings, and decreasing health risks through positive health practices. Health education programs must be designed to provide repeated health messaging stressing the importance of personal responsibility for adopting positive health practices, self-advocacy in healthcare settings, and active participation in the patient-provider partnership.

Keywords: Medical Mistrust, Locus of Control, Spiritual, Black Churches, Caregiving

PURPOSE

Exploring Health Care Attitudes and Expectations in the African American Community

As recently as 2021, researchers have found that African American survey respondents reported higher levels of medical mistrust than other racial or ethnic groups (Thompson et al., 2021). It is common knowledge among researchers – because it is taught in research ethics training – that African American have reasons for race-based medical mistrust, rooted in governmental experimentation on this population without informed consent, such as the abuse perpetrated in the Tuskegee Airman study (CITI Program, 2022; Williamson, 2022). However, many African American' race-based medical mistrust is rooted in more recent events, such as first-hand experiences facing discrimination when seeking healthcare for themselves or a family member (Hammond, 2010) as well as vicarious experiences of healthcare-related racial discrimination through media sources (Williamson, 2022). Personal experiences of discrimination in healthcare were documented in the results of a 2020 Kaiser Family Foundation survey of 1700 adults that included nearly 800 African American adults in the US (Hamel et al., 2020). They reported that 45% of African American respondents reported at least 1 of 6 negative experiences with a health care professional in the past three years (e.g., the health care professional assumed something about them without asking, talked down to them or did not treat them with respect, or did not believe they were telling the truth). However, while 36% of African American adults reported believing at least once in recent years that they would have gotten better medical care if they belonged to a different race/ethnicity, only 18% of African Americans aged 65 or older reported this belief.

Seventy percent of African American adults in the Kaiser Family Foundation survey thought that the US health care system treated people unfairly based on racial or ethnic background, compared to only half of African American adults surveyed in 1999, whereas Hispanic (43% in 2020 vs 51% in 1999) and Caucasian (41% in 2020 vs 46% in 1999) adults were less likely to believe this in 2020 (Hamel et al., 2020). Twenty percent of African American respondents reported encountering discrimination while getting healthcare for themselves or a family member in 2019 or 2020. Younger adults were more likely to report this (28% of age 30-49), than were older adults (14% of age 50-64 and 11% of age 65+).

These negative experiences were not limited to African American adults, however, about one in four

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African American and Caucasian adults reported health care providers making assumptions about them without asking or talking down to them or treating them without respect (Hamel et al., 2020). These findings support the notion that mistrust is associated with perceptions of past injustices and present-day experiences. At the same time, African American adults aged 65 and older were more likely to trust doctors (74%) and the health care system (56%), and not all African American adults who encountered mistreatment in medical settings thought race was a motivating factor; almost one third (27%) said it was from some reason other than race (Hamel et al., 2020).

The Relationship Between Faith and Health in African American Communities

The African American church remains the cornerstone of the African American community. In recent years, the pastor's role has expanded to health advocacy and addressing health disparities, despite a lack of specialized training (Baruth et al., 2015). Studies indicate that addressing health disparities in African American communities has proven challenging due to the widespread distrust of the medical system, as well as health literacy problems, being uninsured and underinsured, perceived lack of cultural relevance, and religious beliefs in God as the only healer (Williams, 2019). Pastors can impact congregant health by encouraging health promotion and modeling positive health behaviors from the pulpit (Williams & Cousin, 2021).The influence of these various factors has resulted in faith communities and pastors becoming increasingly important partners in targeting various health conditions that disproportionately impact African Americans and other minority groups (Baskin et al., 2001).

In recent years faith-based health education programs have partnered with pastors to reach at-risk African American communities using culturally appropriate health promotion messaging to address various health issues including breast health, prostate health, HIV, diabetes, and cardiovascular health (Best et al., 2016; Brown & Cowart, 2018; Cowart et al.; Cowart et al., 2004; Francis & Liverpool, 2009; Hou & Cao, 2018; Newlin et al., 2012; Tettey et al., 2017). Faith-based health education programs include critical elements that can address the factors that contribute to health illiteracy, mistrust in the healthcare system, and perceived lack of cultural relevance in traditional health education. These elements include the involvement of community nurses, faith leaders, culturally appropriate messaging, community support, and an emphasis on self-efficacy (Blankinship et al., 2021). The importance of the African American pastor's influence on health behaviors is crucial to eliminating health disparities in underserved communities (Lumpkins et al., 2013; Taylor et al., 2000). One example of a health education program that relies on pastors' influence in African American faith-based communities was the African American Dementia Caregiver Support Program, a program of the Genesis Health Project Network.

The Genesis Health Project Network

The Genesis Health Project Network (GHPN) is an established multi-year (beginning in 2004), community designed, faith-based, culturally sensitive, health education initiative. This initiative is designed to reduce health disparities and promote healthy lifestyles among African Americans in the local community. GHPN aims to address chronic diseases associated with health disparities, reach African Americans and people of color who are at higher risk for chronic diseases and health problems. The key goal in all GHPN health education programs is to reduce health disparities by empowering at-risk minorities to understand their health risks, adopt healthier lifestyles, and engage in self-advocacy in healthcare settings. Each year the program covers a specific disease entity. Previous topics included obesity, diabetes prevention and management, prostate cancer, and breast cancer (Brown & Cowart, 2018; Cowart et al., 2010; Cowart et al., 2004). During the educational seminars, health messaging consistently stresses the importance of self-advocacy, annual physicals, patient-provider communication, and preventive screenings.

GHPN began as the Prostate Cancer Education Council of Central New York (PCEC), established to provide culturally relevant information about prostate cancer to men of color in inner-city African American barbershops (Cowart et al., 2004). GHPN partners with African American pastors from fourteen inner-city churches and other community organizations. GHPN infrastructure consists of the Pastor's Health Council of Central New York and a group of church representatives called Lay Health Advocates. The Pastor's Health Council provides pastoral leadership, guidance, and advises GHPN in developing culturally appropriate health interventions to improve the health and health status of the church community. Lay Health Advocates receive training on each topic and provide ongoing health education and support for congregants.

African American Dementia Caregiver Support Project

The GHPN developed, implemented, and evaluated the African American Dementia Caregiver Support program (AADCS) to reduce stress and increase knowledge about and access to community-based resources among African American dementia caregivers in a mid-sized city in the northeastern United States. The AADCS was a five-year program (2016-2020) funded by the state health department. GHPN partnered with African American churches, community-based collaborators, and the University to reach African American dementia caregivers. We provided education about dementia to congregations and residents in public housing programs and referrals to dementia and caregiving resources in the local community.

The AADCS included three programmatic components from the traditional GHPN model: a pastor's educational seminar and quarterly meetings with the GHPN Pastors' Health Council and Lay Health Advocates, church-based dementia education seminars, and an annual 12-week Healthy Living program. The Healthy Living program was designed so that each year's content included basic information and specific educational content, so that participants could attend any one or more years. Basic information included topics such as Ten Warning Signs of Alzheimer's and Ten Healthy Habits for Your Brain. Unique content included topics like Dementia Conversations and Effective Communication Strategies. Other presenters included nutritionists, exercise physiologists, representatives from local agencies serving older adults, and law students from the University elder law clinic.

Additionally, AADCS staff facilitated a caregiver support group and hosted lunch-and-learn dementia education sessions in public housing, community outreach events and health fairs at local senior programs, caregiver social support programs, and joint enrichment programs for people with dementia and their caregivers. AADCS used pastoral health messaging and culturally appropriate strategies (e.g., storytelling) to heighten awareness about dementia and dementia caregiving, increase awareness of the importance of early diagnosis, promote the use of community-based resources, reduce caregiver stress, and encourage the adoption of healthier behaviors to reduce health disparities. Throughout the program, we stressed the importance of caregivers advocating for themselves and the person with dementia in health care settings. The current study explored the relationship between spirituality and health, and health care beliefs and attitudes, among older African American participants in AADCS.

METHOD

Data Collection

We collected Health Beliefs data in person using paper surveys during the first sessions of the Healthy Living program in years one through four of the AADCS project. Participants were administered informed consent documents, the Health Beliefs survey, and the pre-Healthy Living survey during the first session and the post-Healthy Living survey during the twelfth session. Clinical measures were taken during the first and twelfth sessions. Participants were administered the Health Beliefs survey to collect data on beliefs about spirituality and health and attitudes towards health care providers. The Health Beliefs survey was collected in each year's Healthy Living sessions only from participants who were new to the program that year and attending their first session, resulting in a single survey from every participant over the four-year period. Data were not collected in year five, as all in-person programming was suspended in 2020 due to the Coronavirus Pandemic.

Our Health Beliefs survey was a combination of the Spiritual Health Locus of Control Scale (SHLC) (Holt et al., 2003) and the Group-Based Medical Mistrust Scale (GBMM) (Thompson et al., 2021; Thompson et al., 2004). The SHLC contained ten items representing four dimensions of health locus of control: internality, externality, active spirituality, and passive spirituality. The GBMM contained twelve items representing three subscales: suspicion, group disparities in health care, and lack of support from health care providers. We combined items from these two validated instruments based on, and consistent with, health literacy principles (Osborne, 2022). The items included were those we believed were most relevant to the local African American faith-based community and would fit comfortably on a one-sided page with larger, more accessible print.

Table 1 displays the items included in the Health Beliefs survey and the dimension or subscale they represented. From the SHLC we used both Passive Spirituality items and one Active Spirituality item (under Spirituality and Health in Table 1). From the GBMM we used all three items from the lack of support subscale, three of six from the suspicion subscale, and two of three from the group disparities subscale (under Health Care in Table 1). Response options ranged from 1=strongly disagree to 5=strongly agree, with higher values indicating stronger agreement. Results from the three positively worded items (e.g., doctors have the best interests of people of my ethnic group in mind) were reverse coded so that higher values indicated stronger disagreement. The resulting instrument was adequately reliable, with a Cronbach' alpha of .71 for the three items from the SHLC and a Cronbach's alpha of .81 for the combined GBMM items. Health Beliefs survey data were collected by paper survey from all new participants during their first session attending the 12-week Healthy Living Program, in years one through four of the AADCS project. Each participant submitted the survey only once. Informed consent and data collection protocols were approved by the Syracuse University Institutional Review Board.

Analysis Plan

This exploratory study aimed to better understand the health beliefs of older African Americans participating in a faith-based public health education program. Responses to the Health Beliefs survey were analyzed using univariate (frequency distributions, means and percentages) and bivariate (correlations with Kendall rank coefficients) statistical functions in SPSS.

RESULTS

To keep the Health Beliefs surveys anonymous, surveys were isolated from other data collected during the AADCS project. Table 2 displays participant demographics for each year of AADCS, collected through a pretest survey administered each year of Healthy Living. In each year, the number of pretest responses differed from the number of Health Beliefs surveys because: 1) they responded to the Health Be-

Table 1. Health Beliefs Instrument Responses, Healthy Living Participants, 2016-2020

Caregiving	**Mean**	**Std Dev**	**Range**
Have you ever taken care of someone with dementia? (n=57)	0.35		0=no, 1=yes
How long did you take care of them? (n=19)	1.24	2.635	Number of years
Do you still care for them? (n=19)	.42		0=no, 1=yes
Spirituality and Health (n=57)	**Mean**	**Std Dev**	**Range**
Through my faith in God, I can stay healthy. (passive)	4.51	.069	1 (Strongly Disagree) - 5 (Strongly Agree)
If I stay healthy, it's because I am right with God. (active)	3.46	1.29	1 (Strongly Disagree) - 5 (Strongly Agree)
I rely on God to keep me in good health. (passive)	3.90	1.14	1 (Strongly Disagree) - 5 (Strongly Agree)
Health Care (n=57)	**Mean**	**Std Dev**	**Range**
Doctors and health care workers sometimes hide information from patients who belong to my ethnic group. (lack of support subscale)	2.89	1.02	1 (Strongly Disagree) - 5 (Strongly Agree)
Doctors have the best interests of people of my ethnic group in mind. (lack of support subscale)	3.45	0.88	1 (Strongly Disagree) - 5 (Strongly Agree)
People of my ethnic group should not confide in doctors and health care workers because it will be used against them. (suspicion subscale)	2.11	0.82	1 (Strongly Disagree) - 5 (Strongly Agree)
People of my ethnic group cannot trust doctors and health care workers. (suspicion subscale)	2.25	0.97	1 (Strongly Disagree) - 5 (Strongly Agree)
People of my ethnic group receive the same medical care from doctors and health care workers as people from other groups. (group disparities subscale)	3.15	0.89	1 (Strongly Disagree) - 5 (Strongly Agree)
Doctors and health care workers do not take the medical complaints of people of my ethnic group seriously. (suspicion subscale)	2.66	1.12	1 (Strongly Disagree) - 5 (Strongly Agree)
People of my ethnic group are treated the same as people of other groups by doctors and health care workers. (group disparities subscale)	3.04	0.95	1 (Strongly Disagree) - 5 (Strongly Agree)
I have personally been treated poorly or unfairly by doctors or health care workers because of my ethnicity. (lack of support subscale)	2.27	0.94	1 (Strongly Disagree) - 5 (Strongly Agree)

liefs survey in their first year but not the pre-test, and 2) they took the pretest every year and the majority of participants came to more than one year of programming. Most participants were African American and female, more than half had at least some college education, and the average age ranged from 64.7 to 67.7 years of age.

Of the Healthy Living participants in 2016 through 2019 who completed the survey (n=56), 35% reported having cared for someone with dementia (see Table 1). On average, they were caregivers for 1.24 years, and of those who reported providing care, 42% were still caring for that person at time of survey. Most Healthy Living participants (not displayed) attended the program for more than one year of AADCS (57% of participants in 2016; 60% in 2017; 52% in 2018; 65% in 2019), and about one third had more than five years of exposure since 2004 to GHPN Healthy Living programs prior to AADCS.

Table 3 displays Health Beliefs survey items, mean scores, standard deviations, and correlations. In terms of the SHLC items (1-3), on average participants strongly agreed with the passive statements "through my faith in God, I can stay healthy (M 4.51, SD 0.69)" and "I rely on God to keep me in good health (M 3.90, SD 1.14)." However, they were more neutral on the active statement "if I stay healthy, it's because I am right with God (M 3.46, SD 1.29)." As expected, there was positive correlation among SHLC items 1-3. In terms of the GBMM items (4-11), on average, participants were

Table 2. Demographic Characteristics, Healthy Living Participants, 2016-2020

Characteristic	**2016 (N=18)**	**2017 (N=25)**	**2018 (N=19)**	**2019 (N=28)**
Age (M,SD)	64.7, 10.4	65.8, 9.3	67.7, 11.7	66.9, 9.2
Range	47-82	47-83	33-90	47-87
African American (%)	92.9%	96.0%	92.1%	93.1%
Female (%)	89.3%	92.0%	82.8%	89.7%
Education (%)				
High School Diploma or Less	42.9%	48.0%	48.3%	46.4%
Some College to Undergraduate Degree	35.7%	40.0%	44.8%	39.3%
Graduate Degree	17.9%	12.0%	3.4%	14.3%
Participated in Health Beliefs Survey	34	9	5	8

more likely to trust the healthcare system than to distrust it. Participants disagreed with negatively oriented statements that doctors and health care workers hide information from people in their ethnic group (M 2.89, SD 1.02), that people of their ethnic group should not confide (M 2.11, SD 0.82) or cannot trust (M 2.25, SD 0.97) doctors and health care workers, that doctors and health care workers do not take the medical complaints of people in their ethnic group seriously (M 2.66, SD 1.12), and that they personally had been treated poorly or unfairly by doctors or health care workers because of their ethnicity (M 2.27, SD 0.94). They agreed with the positively oriented statements that doctors have the best interests of people in their ethnic group in mind (M 3.45, SD 0.88), that people in their ethnic group received the same medical care from doctors and health care workers (M 3.15, SD 0.89), and that people of their ethnic group were treated the same as people of other groups by doctors and health care workers (M 3.04, SD 0.95). The SHLC items were positively correlated with two of the three positive GBMM items 5 (with items 2 and 3) and 10 (with items 1 and 3). There was no correlation between SHLC and any of the negative GBMM items.

DISCUSSION

Our participants reported greater spiritual health locus of control, strongly endorsed passive spirituality statements, and were more neutral in reaction to statements of active spirituality, than was the sample with which the Spiritual Locus of Control Scale was originally validated. By comparison, Holt and colleagues found that their participants were neutral on all passive spiritual locus of control items (Holt et al., 2003): "through my faith in God, I can stay healthy (M 3.24, SD 0.76)" and "I rely on God to keep me in good health (M 3.30, 0.74), and tended to disagree with the active spirituality item "if I stay healthy, it's because I am right with God (M 2.61, SD 0.89)." In the current study Healthy Living participants had higher average scores on these measures (see Table 1).

Our participants ranked the health care attitudes items more positively on average than the sample with which Thompson and colleagues originally validated the Group-Based Medical Mistrust scale (Thompson et al., 2004). As a group, our participants (see Table 1) were more likely to agree with the positive statements (doctors have the best interests of people of my ethnic group in mind, people of my ethnic group receive the same medical care…, and people of my ethnic group are treated the same…) and more likely to be neutral on negative statements (doctors and healthcare workers sometimes hide information…, do not take the medical complaints seriously) and about personally being treated poorly or unfairly by doctors or health care workers because of their ethnicity. Further, they were less likely to strongly disagree with statements about not confiding in doctors and health care workers and not trusting doctors and health care workers. Finally, participant responses to two of the positive statements ("doctors have the best interests…" and "people of my ethnic group are treated the same…") were correlated with their responses to the spiritual health locus of control statements, indicating their faith and positive attitudes toward health care workers were related. Notably, we found no correlation between spiritual health locus of control and whether participants believed people from their ethnic group received the same medical care as people from other groups. This finding reinforces reports from the Kaiser Family Foundation indicating that while African American adults reported bad healthcare experiences, and over one third believed not all ethnicities received the same medical care, older African American adults were less likely to report this belief (Hamel et al., 2020).

Because the Genesis Health Project is a faith-based health education program the majority, if

Table 3. Health Beliefs Instrument, Descriptive Statistics and Correlations, Healthy Living Participants, 2016-2020

Variable	n	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Through my faith in God, I can stay healthy.	57	4.51	0.69	-										
2. If I stay healthy, it's because I am right with God.	57	3.46	1.29	21	-									
3. I rely on God to keep me in good health.	57	3.9	1.14	.49**	.58**	-								
4. Doctors and health care workers sometimes hide information from patients who belong to my ethnic group.	57	2.89	1.02	.05	.23	.051	-							
5. Doctors have the best interests of people of my ethnic group in mind.	57	3.45	0.88	.24	.31*	.31*	-.12	-						
6. People of my ethnic group should not confide in doctors and health care workers because it will be used against them.	57	2.11	0.82	.11	.15	.05	.29*	-.22	-					
7. People of my ethnic group cannot trust doctors and health care workers.	57	2.25	0.97	.24	.17	.16	.34*	.15	.59**	-				
8. People of my ethnic group receive the same medical care from doctors and health care workers as people from other groups.	57	3.15	0.89	.24	.13	.20	-.31**	.45**	.18	.18	-			
9. Doctors and health care workers do not take the medical complaints of people of my ethnic group seriously.	57	2.66	1.12	.13	.18	.19	.40*	-.14	.44**	.49**	-.15	-		
10. People of my ethnic group are treated the same as people of other groups by doctors and health care workers.	57	3.04	0.95	.27*	.21	.31**	-.25*	.51**	*23	-.12	.65**	-.17	-	
11. I have personally been treated poorly or unfairly by doctors or health care workers because of my ethnicity.	57	2.27	0.94	-.08	-.02	-.09	.41**	-.40**	-.41*	.38**	-.27*	52**	-.44**	-

*<.05, **<.01.

not all, of our participants were regular attendees in their congregations and were believers of God's ability to heal. Their relatively high average scores on the passive spirituality items may be the result of high involvement in the African American faith community of the individuals who participated in the Healthy Living Program, and the importance of the African American church as a cornerstone of the African American community. However, we believe the more neutral scores on the active spirituality item may reflect the work of Dr. Cowart and the GHP Pastoral Health Council since 2004 to cultivate a cultural shift within the local faith community. This cultural shift would be to move away from reliance solely on "God as healer" without regard to the need to adopt and practice disease preventative measures. The new perspective is one of relying on God as healer in partnership with one's healthcare provider and recognizing the importance of self-advocacy and personal responsibility for one's health.

This cultural shift is necessary to overcome a history in African American faith communities of relying solely on faith in God alone to keep oneself healthy, or of some community members using faith as a substitute for taking care of one's health (Bolger et al., 2018). Some faith leaders believe this historical approach to health in African American faith communities has contributed to high rates of chronic conditions in the African American community in general, such as obesity, diabetes, and hypertension. To achieve this cultural shift, the Healthy Living Program offers information from community experts on nutrition and physical fitness approaches to reducing risk of chronic disease conditions and educates participants on the critical importance of preventive screenings, self-advocacy, and open communication with health care providers.

It is possible that, although medical distrust persists among African Americans (Pew Research Center, 2024; Webb Hooper et al., 2022; Webb Hooper et al., 2019), our sample skewed toward positive health care attitudes because their long-term involvement (2004-2015) with the Healthy Living Program had succeeded in initiating this cultural shift among our participants. While the Health Beliefs survey did not directly address self-advocacy, we believe repeated messaging on self-advocacy over multiple years may be resulting in better communications and more positive interactions with healthcare providers, which in turn has a positive impact on participants' trust in providers. Most Healthy Living participants had repeated exposure to the health messaging offered by trusted members of the faith community during earlier iterations of the Healthy Living Program as early as 2004. For many participants, Dr. Cowart has been and continues to be a trusted member of the healthcare and faith communities, and her leadership of the Genesis Health Project Network and the Healthy Living Program may be a principal reason they have more trust in healthcare providers. As a result, repeat participants who had attended multiple years of the Healthy Living program may have a more proactive relationship with their healthcare providers than they otherwise would. Another influence on participants' healthcare attitudes may have been leadership of the Lay Health Advocates (LHAs) in Genesis programming, who modeled positive healthcare attitudes and proactive involvement in their own healthcare. Finally, the level of trust indicated by Healthy Living participants could be a function of their age (64.7 to 67.7 on average across four program years). Surveys show that older African American adults – although more likely than older Whites to report discrimination in health care settings and be dissatisfied with their care – were less likely to feel disrespected than other patients, and reported having more trust than younger African American adults in healthcare providers, the healthcare system, and medical researchers (Pew Research Center, 2022; Doty et al., 2022; Hamel et al., 2020; Mundy et al., 2025).

Limitations

These results, while promising in terms of the potential for healthcare attitudes to be positively influenced by repeated messaging from trusted community members, should be evaluated within certain limitations. These limitations include sample size; our sample was too small and homogeneous to allow for cross-group comparisons (e.g. differences in amount or intensity of religious participation), or to confirm if rankings of passive and active spirituality or healthcare attitudes were influenced by program participation, number of years with the same healthcare providers, messaging outside of the program, or unrelated public health education campaigns. Future research should include larger, more diverse samples of older adults, to allow for cross-group comparisons, and evaluate other potential explanations for healthcare attitudes among older African American adults in urban communities. This data is cross-sectional, which limits our ability to determine if correlation indicates causation between spiritual locus of control and health beliefs. Finally, while this program targeted African American caregivers of people with dementia, only 35% of participants in the Health Beliefs survey identified as caregivers at time of survey. The GHPN invites all community members to take part in our programming, having learned from experience that many people may not identify with a specific issue or disease process at the time we are addressing it, but may in the future. Community members also share what they are learning with other people in the community, and inclusivity helps ensure the information we provide reaches community members who need it. Furthermore, it is common for family members providing care to individuals in the earlier stages of cognitive impairment or dementia to engage in caregiving behaviors without developing a caregiver identity (Beatie et al., 2021).

Implications for Practice

These results highlight several key concepts that we believe improve the impact of health education programs with the African American commu-

nity. First, it is our experience that health messaging is more effective in inspiring the adoption of new health habits if it is repeated more than once; therefore, effective health education programs must be designed to provide repeated health messaging. Second, to change an individual's approach to improving their health, particularly in a culture that has historically externalized control over one's health, health messaging should stress the importance of personal responsibility for adopting positive health habits and practices. Third, self-advocacy is important and can stand alone as a goal in health education, but self-advocacy should be extended into developing a patient-provider partnership, where the patient and their provider discuss their healthcare options and both parties are engaged in decision-making (Anderson et al., 2020). Previous studies have documented racial disparities in the quality of provider-patient communication (White-Means & Osmani, 2017). To improve patient-provider relationships, patients need health education programs that directly and frequently address the importance of the patient provider partnership and providers need training on effective and culturally appropriate patient communication (Hansen et al., 2016; White-Means & Osmani, 2017). Finally, based on our experience, we recognize the importance of ensuring that some elements of program design focus on the importance of open and effective communication with participants about their role in patient-provider partnerships.

CONCLUSION

Participants in a five-year health education program supporting African American dementia caregivers responded to the Health Beliefs Survey, which included items from the Spiritual Locus of Control and Group-Based Medical Mistrust scales. We believe their responses to the spiritual locus of control items indicate that a cultural shift is happening in this community of participants away from solely relying on God for good health, towards a shared responsibility between themselves and God. Their responses to the GBMM items indicate higher than expected levels of trust in healthcare providers. We believe these shifts may be the result of repeated exposure to health messaging about personal responsibility, positive health behaviors, the importance of preventative screenings, and the benefits of self-advocacy and communication with healthcare providers. Further research should evaluate the efficacy of faith-based health education programs specific to changing health beliefs and attitudes after repeated exposure to these types of health messaging.

Declaration of Conflicting Interest

We have no conflicts of interest to disclose.

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