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The Relationship Between Religiosity & Selected Health Behaviors of
African Americans of the Pentecostal Faith

By

Caprice Jones-Agunbiade

A Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Science

In

Community Health Education

Minnesota State University, Mankato

Mankato, Minnesota

May 2012

The Relationship Between Religiosity & Selected Health Behaviors of African Americans (Pentecostal Faith)

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This thesis has been examined and approved by the following members of the thesis committee.

Professor Judith K. Luebke
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Abstract

THE RELATIONSHIP BETWEEN RELIGIOSITY & SELECTED HEALTH BEHAVIORS OF AFRICAN AMERICANS OF THE PENTECOSTAL FAITH

Caprice Jones-Agunbiade, M.S. Minnesota State University, Mankato, May 2012.

The purpose of this study was to assess the relationship between religiosity and selected health behaviors of African Americans in the Pentecostal faith. A 43 question printed survey was administered to 300 adult attendees from selected Pentecostal churches. The purposive sample was obtained from the Holy Christian Church of Mankato, Brooklyn Park, and St. Paul. The printed survey focused on information about demographics such as age, gender, ethnicity, marital status, education, fellowship, membership, and also health behaviors, perceived weight, weight goals, health classes desired, utilization of a community health educator and religiosity. The findings of the study indicated that high religiosity had a minimal effect on the overall selected behaviors for adult respondents. The results showed that the respondents in the study lack exercise and do not engage in healthy eating behaviors.

Recommendations for further study included conducting the study with other church denominations as well as a more diverse population. This would allow for more statistical analyses to be carried out with respect to the

relationship between religiosity and healthy lifestyles of African American church attendees.

Finally, there is great potential for further research to examine how health educators and church leaders can collaborate together in educating African American church attendees on the need for healthy lifestyles. Identifying the most efficient and effective ways of this collaboration provide additional research opportunities in this area.

Acknowledgements

I would first and foremost like to give God all the honor, thanks, and glory for giving me the ability to achieve this goal of receiving my Master's Degree. I would be nothing without the Lord on my side. I dedicate this degree back to the Father, Son, and Holy Spirit, Amen.

I would like also like to give thanks to my committee members Dr. Judith K. Luebke, Dr. Amy Hedman, and Elder C. Maxille Moultrie for all their support and encouragement through this crucial but yet rewarding process. I want to give a special thanks to Dr. Luebke for motivating me during the rough times. I truly appreciate everything you do, and may God continue to bless you!

I want to thank Bishop Wayne R. Felton of the Communion of Holy Christian Churches and all the attendees that helped to support my study. I pray that God will continue to shine upon the lives of every member of the ministry of the Holy Christian Church of Mankato, Brooklyn Park, and St. Paul, Minnesota.

I want to take this moment to thank my mother Linda M. Jones for showing me that hard work pays off. She taught me to be a strong woman and to never give up no matter what obstacles I may have to face. Thank you mom for believing in me.

I would like to also thank my daughters Samone and Ceira Stewart for allowing me the time to focus on my research without interruption. Although it was not easy for you all to move to another state, you adjusted to the best of your ability for me. So, I just want to celebrate you both for being the best

daughters a mother could ever have. I love you with all my heart, and I know my work will not go in vain. I have broken the poverty curse so that you can make it too, with God's help.

I would especially like to thank my husband Elder Victor O. Agunbiade for all his support during my academic endeavors. You were there through the tears and frustration, but you always found the right scriptures to calm my spirit. And today, I bless the Lord for your life. Thank you so much for all your love, prayers, and moral support.

I love you all dearly.

Philippians 4:13 "I can do all things through Christ that strengthens me".

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Chapter One: Introduction

According to the Advisory Council on Church and Society (2007), religiosity is an influence on the lives of many African Americans. Religion and religious institutions have a profound impact on individuals including African American communities. This influence is documented in the historical experiences of African Americans within American society, as well as the role of religion and African American churches in the development of independent institutions and communities (Lincoln & Mamiya, 1990; Nelsen & Nelsen, 1975).

African American religious institutions are cohesive spiritual and social communities that foster the religious and social wellbeing and integration of individual and families (Taylor, Chatters, Levin, & Lincoln, 2004). According to Meyers, Kagaw-singer, Kumanyika, Lex and Markides (1995) religiosity or some religious doctrine has continually played an important role in the lives of African Americans and their health by educating them to avoid premarital sex (thus avoiding sexually transmitted diseases) and abstain from alcohol and drug use. Religious doctrine can also promote good eating habits (avoiding gluttony) and adequate exercise (avoiding obesity).

Statistics from the Centers for Disease Control and Prevention (CDC) (2009) show that African Americans' have the highest number of health concerns in the United States. The health of the African American community has been an issue of public health and viability (Airhihenbuwa et al., 2006). Having this basic understanding about the state of health of the African Americans, the essential

question one can ask is, “what is the impact of the religious messages and teachings addressing the health needs of African Americans?”

Statement of the Problem

According to Taylor, Mattis, and Chatters (1999), it has been well established by research that religion plays an important role in the lives of many African Americans. But, the teachings from the pulpit have not transcended beyond church activities. A survey by Pew Research Center's Forum on Religion & Public Life (2009) showed that in addition to churches, bars have predominantly occupied African American neighborhoods. Also, there is high level of drug activity and significant increase in sexual activity among single African Americans. According to the Centers for Disease Control and Prevention (2009), unhealthy eating, lack of exercise, and risky sexual behaviors are responsible for the high mortality rate among African Americans.

According to the United States Department of Health and Human Services [USDHHS] (2010), African Americans live, on average, 5.3 fewer years than their white counterparts. In 2003, the most recent year for which there is official data, the highest life expectancy was observed for white females, who will live, on average, 80.5 years. The life expectancies for black females and white males are quite similar to each other 76.1 years and 75.3 years, with black females having the slight advantage over white males. Of the four race-sex groups considered, black males have the shortest average longevity 69.0 years (UDHHS, 2010). African Americans health problems are directly related to

unhealthy lifestyle, and it is predicted to become an uncontrollable issue if nothing is done to arrest the alarming morbidity rate.

Significance of the Problem

This study will address the possible relationship between religiosity and selected health behaviors of African Americans of the Pentecostal faith. This study is important to the community, society, and health educators because it helps examine the effect of religiosity in reducing the morbidity rate in the African American community through the teachings of healthy lifestyle from the church. The focus of this study was to determine the impact Christianity teaching has on the health behaviors of African Americans. The importance of this study is to measure current practices through religion (Christianity) as a way to address or educate the health concerns of the African Americans thus reducing morbidity rates. There is also a need to identify possible channels for health education to reach a population through religious communities.

Purpose of the Study

The purpose of this study was to assess the relationship between religiosity and selected health behaviors of African Americans in the Pentecostal faith. Previous studies have focused on the religiosity of African Americans and unhealthy behaviors. This study assessed the relationship of religion among African Americans in the Pentecostal faith and their health behaviors. Consequently, this study can provide such knowledge that could help to reduce

the morbidity rates by shedding some insight into developing faith based health promotion programs for African Americans.

The Social Cognitive Theory (SCT) was used in this study to explain how people, environment, and behavioral factors constantly interact and influence healthy lifestyles. Social cognitive theory provides a framework for understanding, predicting, and changing human behavior. The theory identifies human behavior as an interaction of personal factors, behavior, and the environment (Bandura, 2003).

Research Questions

This study addressed the following research questions:

1. What is the relationship between the selected reported health behaviors and religiosity among a sample of African American Pentecostal church attendees?
2. Is there a significant difference in religiosity based on the frequency of church attendance among fellowship of African American Pentecostal church attendees?
3. Is there a significant difference in selected reported health behaviors based on the fellowship of the frequency of church attendance among African American church attendees?
4. What health education services do the African American Pentecostal church attendees desire?

Limitations

A number of limitations apply to this study. These limitations include:

1. The research sample was not randomly selected and may not fully represent the lifestyle of religious African Americans in the study area.
2. The preachers or priests might not be willing to disseminate teachings about healthy behaviors from their pulpit for doctrinal reasons.
3. Limitation of time to collect the data due to graduate study deadlines.
4. Lack of published research on religiosity and health behaviors of African Americans for the past few decades.

Delimitations

This research study is delimited to the geographic location of three selected Pentecostal churches in Ramsey, Anoka, and Blue Earth counties in Minnesota. Selection criteria for participants in this study included: 1) African American ethnicity, and 2) attendees of the Holy Christian Church. Data collection was completed March 18, 2012 to March 20, 2012.

Assumptions

1. It was assumed that the participants in the study were Christians, African Americans and members of the Pentecostal church.
2. It was assumed that the participants were able to read and understand the survey instrument and answer the questions in an open and honest manner.

Definitions of Terms

For the use of this research a variation of terms were used. These terms are defined as follows:

Christianity. Christianity according to *the American Heritage Dictionary* (2011) is defined as the religion based on the life and teachings of Jesus Christ. Christians is used within the research as reference to followers of Christ and the belief in Jesus as the messiah and also in His ministry.

Church. Church according to *the Holy Bible, People's Parallel Edition* (2005) is defined as a public worship of God or a religious service in such a building: to attend church regularly.

Glossolalia. Glossolalia according to Nickell (1993) glossolalia is language-like because the speaker unconsciously wants it to be language-like. Yet in spite of superficial similarities, glossolalia fundamentally is not language for the purpose of this study glossolalia is the ability to speak in other tongues that is not of the speaker's native language.

Healthy behavior. Health Behavior according to *the Mosby Medical Dictionary* (2011) is defined as an action taken by the person to maintain, attain, or regain good health and to prevent illness. Health behavior reflects a person's health beliefs. Some common health behaviors are exercising regularly, eating a balanced diet, and obtaining necessary inoculations.

Pentecostalism. Pentecostalism is unique to this research because it utilizes the scriptural meaning of the bible, therefore, connecting all terms and

associating them to the biblical teachings. Considering the history of the church, its teaching as gathered from the bible, and its equivalence to Pentecostalism, the researcher chose to remain focused on the motivating factors such doing the messages from the bible that would help believers to live a holy life according to the bible. The Pentecostal church is governed by the instructions from the bible.

Pulpit. Pulpit according to the *American Heritage Dictionary* (2011) is defined as an elevated platform, lectern, or stand used in preaching or conducting a religious service.

Religiosity. Religiosity according to the *American Heritage Dictionary* (2011) is defined as the quality of being religious; excessive or affected piety. For the purpose of this study religiosity refers to the numerous aspects of religious activity, dedication, and belief (religious doctrine).

Chapter Two: Review of the Literature

Introduction

The purpose of this study was to determine the relationship between religiosity, specifically the Pentecostal faith, and the health behaviors of African Americans. In identifying literature pertinent to this study, peer-reviewed publications were reviewed that reported research related to religiosity, healthy behaviors, African American health, the history of the Pentecostal faith, and the teachings of the Pentecostal faith. This review of the literature is separated into sections that pertain to the relationship between religiosity and selected health behaviors of African Americans in the Pentecostal faith. The first section describes religiosity and presents a review of literature regarding the relationship of religiosity to health and healthy behaviors. The second section describes current health issues of African Americans. The third section investigates teachings of the Pentecostal faith. The last section describes the Social Cognitive Theory (SCT) and published research using the SCT to help assess African Americans' health behaviors and their relationship to religiosity in the Pentecostal Faith.

Religiosity and Healthy Behaviors

The term religiosity is defined by Louis (1999) as excessively, sentimentally, or affectedly pious. Religiosity emphasizes the practice, belief, and operation of an individual's actions and devotion (Marzal & Ritzer, 2007). According to Marzal and Ritzer (2007), devotion is less intellectual and measured

more by one's faith. Religiosity plays a vital role in organizing society through moral values as a guideline for human behavior (Capps & Cole, 2000; Hardy & Carlo, 2005; Sorensen, Lienard, & Feeny, 2006). Religiosity varies in the day-to-day life of individuals. For example, Frederick (2002) stated that believers see religion as an assistance to find positive meaning both in ordinary daily events and in major life challenges. For non-believers, however, religion may be seen as a weakness and inability to make decision. Reiss (2002), however, stated that the reliance upon God is not related to a psychological weakness.

According to Walters and Brown (1979) researchers have attempted to explicate the relationship between religious activities and health. For example, religious beliefs and values offer a framework or worldview of life for interpreting events and experiences (Walters & Brown, 1979). Further, religious beliefs often promote healthy lifestyles such as those pertaining to the abstinence or moderate use of alcohol and tobacco (Levin & Schiller, 1991). Because an extrinsic orientation reflects less of a commitment to religion in general, including teachings regarding the body and health, one can expect that religiosity would not be associated with healthier behavior.

Mullen, Williams and Hunt (1996) reviewed 25 studies to examine the relationship between religiosity and health behaviors such as smoking, exercise, taking responsibility for one's health, nutrition, and stress management. A vast majority of studies reported an inverse relationship between religiousness and substance use or abuse. A similar pattern was presented with cigarette smoking.

In all but one study analyzed (96%, n = 24), reported less smoking by the more religious respondents. The remaining study the 24 studies found no association between smoking status and religion affiliation in Western Scotland (Mullen et al., 1996).

Similarly, other researchers from the health and medical professions such as psychiatry, social epidemiology, and clinical medicine, in particular, often define religious activities with respect to behavioral measures of church attendance or denominational affiliation. This practice is particularly the case in studies investigating the independent effects of church attendance on mental health outcomes such as depression, anxiety, suicide, drug and alcohol abuse, and psychiatric care utilization (Gartner, Larson, & Allen, 1991). According to Gartner and associates (1991), results from this study have helped researchers identify how to reduce mental health disorders through Christian counseling.

Several published studies have identified religious differences in a wide range of physical health outcomes and have examined the effects of religiousness on health status indicators and measures of disease states (Jarvis & Northcott, 1997; Koenig, McCullough, & Larson, 2001; Levin & Schiller, 1987). According to Taylor and associates (2004) results from these studies have presented a fairly consistent pattern. These studies, for the most part, show a salutary relationship between religious activities and health status. This is expressed in two ways:

First, observable difference is in rates of morbidity and overall, the causes –specific mortality exist across major categories of religious affiliations, with lower rates typically found among members of religions or denominations that make strict behavioral demands; for example Seventh-day Adventists and Latter-day Saints. Second, higher levels of active religious participation or observance are associated, on average, with less illness and with better health across a variety of scales or indices (Taylor et al. 2004, p.74).

Until recently, however, most of the studies in the literature reviewed were not designed solely and explicitly to investigate health issues. Coupled with the paucity of true experimental evidence, no one study was ideally designed to “prove” that religion exerts a positive influence on health (Levin, Chatters, & Taylor, 1995).

According to Taylor, Thornton, and Chatters (1997) the program of research on African Americans points to the pervasive and generally positive influence of religion on the welfare of African American. Researchers have shown that African Americans describe the church as having a generally beneficial impact on their lives (Taylor et al., 1997). Very few African Americans, even those reporting no current religious preference and no religious attendance since entering adulthood, exhibit a complete absence of overt religious involvement (Taylor, 1988a, 1988b).

Religious individuals may be less likely to use alcohol and other substances (Heath et al., 1999; Luczak, Shea, Carr, Li, & Wall, 2002; Stewart, 2001). Even among those who use alcohol and drugs, religiously involved individuals are more likely to use them moderately, not heavily (Gorsuch & Butler

1976; Miller, 1998). Fear of violating religious principles and doctrines can have a powerful effect. Further, spiritual leaders may play a role in educating people about the dangers of alcohol and drugs (Stylianou, 2004). Religious involvement and the accompanying positive external ties may keep people occupied and prevent idleness and boredom that can lead to substance abuse. Additionally, there may be peer pressure from other members of the church to remain abstinent and an absence of peer pressure to try alcohol and other substances. Moreover, religious involvement could be the effect rather than the cause. Substance abuse may prevent religious involvement. As noted by Larson and Wilson (1980) alcoholics compared to nonalcoholic subjects had less involvement in religious practices, less exposure to religious teachings, and fewer religious experiences.

Similarly, a study by Larson and Wilson (1980) examined the association between religiosity and cigarette smoking in a representative sample of ($n = 266$) non-institutional African American women ages 18-44 who were living in Norfolk, Virginia. Pentecostals were significantly less likely to smoke cigarettes 16 percent less than Baptist, of whom 40 percent reported smoking cigarettes.

Religion may play a role in preventing risky sexual behavior. In a study of African American adolescent females, religiosity correlated with more frank discussions about the risks of sexual activity and avoidance of unsafe sexual situations (McCree, Wingood, DiClemente, Davies, & Harrington, 2003). Miller

and Gur's study (2002) of more than 3,000 adolescent girls found positive associations between personal devotion and fewer sexual partners outside a romantic relationship, religious event attendance and proper birth control use, and a better understanding of human immunodeficiency virus (HIV) and pregnancy risks from unprotected intercourse. But these findings are not universal. Some researchers have found no relationship between religiosity and sexual practices (Dunne, Edwards, Lucke, Donald, & Raphael, 1994; McCormick, Izzo, & Folcik, 1985). In fact, religious traditions or environments may actually suppress open discussion of sexuality and contraception. For example, Lefkowitz, Boone, Au, and Sigman (2003) found that adolescents who discussed safe sex with their mothers tended to be less religious.

Diet can be heavily influenced by religious affiliation, particularly when religious groups have rules about the types of food that members are allowed to eat. Those dietary prescriptions and proscriptions can often be traced back to sacred religious texts (Koenig et al., 2001). A study by Oman and Reed (1998) surveyed 1931 participants over the age of 55 from Marin County, California. They found that participants who attended religious services weekly or more often were more likely to be overweight but less likely to be depressed than less frequent attendees which were significantly less likely to die during the five year follow-up.

Some studies reviewed have looked at how religion and spirituality can promote exercise. Among Utah residents, Merrill and Thygeson (2001) found that persons who attended church weekly were more likely to regularly exercise. However, differences in smoking and general health status seemed to account for this effect (Merrill & Thygeson, 2001). Further, a study by McLane, Lox, Butki, and Stern (2003) suggested that incorporating faith-based practices in to exercise programs might be attractive to certain people and improve participation in physical activity.

Health of African Americans

According to *Health United States* (2001), current epidemiological evidence indicates a persistent disparity in health status, morbidity, and mortality among racial and ethnic minorities relative to non-Hispanic Whites, including African Americans, especially those who are poor. Current evidence indicates that African Americans fare poorly on health status, such that African Americans have higher rates of stroke, diabetes, and certain cancers than whites (CDC, 2005). The greater burden of health disparities is also evident with respect to health risk behaviors of African Americans including diet, obesity, physical inactivity, the use of substances, and high-risk sexual behaviors (Meyers, Anderson, & Strickland, 1996).

According to the American Cancer Society (2008) there is substantial evidence linking diets, especially high-fat, high calorie, high sodium, low calcium, and low-potassium diets to obesity and a host of chronic medical conditions.

These include hypertension, heart disease, stroke, diabetes, hypercholesterolemia, breast and prostate cancer, as well as poor overall health. As noted by Airhihenbuwa and associates (2006) there are both cultural and socioeconomic reasons African Americans' diets are typically poor.

African Americans are disproportionately overrepresented in morbidity rates, especially women and youth (CDC, 2002). In 2000, African Americans accounted for 47 percent of all new AIDS cases, 63 percent of new cases among women, and 65 percent of new pediatric and adolescent AIDS cases (CDC, 2002). A disproportionate burden of morbidity has been linked to a greater clustering of risk factors among African Americans that are directly or indirectly shaped by the attitudes, beliefs, and practices of the family, including unhealthy diets, obesity, sedentary lifestyle, smoking, abuse of alcohol and illicit drugs, unprotected sex, and exposure to chronic and debilitating stress. For example, 46 percent of African American men have high cholesterol while 42 percent of African American women have high cholesterol. Further for both African American genders, 23 percent smoke, 65.4 percent are at risk for health problems because they are obese, and 66.8 percent are at high risk because of lack of physical activity (CDC, 2002; Flegal, Carroll, Ogden, & Johnson, 2000; National Center for Health Statistics, 2001).

African Americans are also overrepresented among those affected by the abuse of alcohol and illicit drugs, as well as by violence and involvement in the criminal justice system. Jones-Webb (1998) reported that 53 percent of African

American men in a sample of 150 reported alcohol use. African American men had higher rates of heavy drinking than their white counterparts (15 percent and 12 percent, respectively), and were more likely to die of alcohol-related illnesses and injuries, such as cirrhosis and automobile accidents (Jones-Webb, 1998). Rates of illicit drug use among African Americans were also comparatively high, with 7.4 percent reporting illicit drug use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2002). Drug offenses accounted for 27 percent of the total growth among black prison inmates (United States Department of Justice, 2002).

Hence, spiritual strategies have been identified to increase a number of health-promoting behaviors in African American women that include increasing exercise, decreasing dietary fat and sodium intake, and helping African American women in recovery from substance abuse to maintain their sobriety (Banks-Wallace & Parks, 2004; Yanek, Becker, Moy, Gittlesohn, & Koffman, 2001). Although several studies reviewed have found a positive relationship between religious activities and physical and mental health (Levin & Schiller, 1991; Roberts, 1990) few studies of religious variables have focused on males (or even gender differences), and even fewer have included black male respondents.

A study by Larson and Wilson (1980) found that religious commitment, more so than church attendance, was related to lower systolic and diastolic blood pressure levels in males, 55 years of age and older. However, Levin and Vanderpool, (1987) found mixed results in their analyses of the effect of religious

variables on several health outcomes including high blood pressure and alcohol use in a sample of 23 males. Neither study, however, specifically included African American males. In one of the few studies of religious factors and physical health that did include black males, Livingston, Levin, and Moore (1991) found that being affiliated with a church was related to lower systolic and diastolic blood pressure.

Pentecostal Teachings

Researchers note that in Acts 2:4 (King James Version), the term Pentecostal refers to the first Christians, and disciples who received the Holy Spirit “on the day of Pentecost”, (Anderson, 2005; Livingstone, 2006; McGee, 1999). This is the day on which believers of Jesus Christ accepted the comforter, also called the Holy Spirit (John 14:16, King James Version). Pentecostals believe in the receipt of the Holy Spirit, and their foundation rests upon accepting Jesus as their Savior. Pentecost also is significant because it is a festival of celebration in remembrance of the coming of the Holy Spirit after Christ’s ascension and anticipation toward the unifying of the body of Christ, and the church 1 Corinthians 12:13 (King James Version) (Browning, 1997) Pentecostal Christians are commanded by the Bible to practice being led by the Holy Spirit so that they may demonstrate “love, joy, peace, long-suffering, gentleness, goodness, faith, meekness, and temperance” (Galatians 5:23, King James Version) to all persons so as not to be motivated to fulfill the sinful nature not of the ‘Spirit of God’ (Galatians 5:16, King James Version).

The strength of the Holy Spirit is the way by which Pentecostal attendees believe they are able to live according to God's will for their life. The purpose of the Holy Spirit is to help believers to refrain from practices such as "adultery, fornication, sexual impurity, sexual excess, idolatry, witchcraft (sorcery), hatred, variance (strife or discord), emulations which are jealousy, wrath, strife (selfish ambition), seditions (dissensions), heresies (permanent organized divisions or cliques), envying, murders, drunkenness, reveling, and the like" (Galatians 5:19-21, King James Version). These teachings instill the foundation of a solid marriage and prepare Pentecost believers for the sanctimony of marriage. The faith gospel is noteworthy, not only because of the scale of its success, but because of its distinctive teaching related to divinely blessed 'health and wealth' which has enjoyed considerable acceptance in different parts of the world (Hunt, 2007).

The major commonality between persons of Pentecostal faith is their belief and reliance on their personal relationship with God through seeking "moral perfection – or holiness" with the help of the Holy Spirit (Anderson, 2005). Similarly, Charette (2006) believed that "it would be incorrect to describe glossolalia as the essence of Pentecostalism; nevertheless this spiritual gift has distinguished the movement from the beginning" (p. 189).

In order to avoid pre-marital sex, Pentecostal faith upholds guidelines and expectations for those choosing to marry within the Church. However, marriage within the Pentecostal Church is sanctioned by five covenants.

First is the covenant of belief, which is a belief in the Pentecostal church that God wants Christians to be married to fellow Christians, so there must be evidence that couples have accepted Jesus Christ as their personal savior. Second is the covenant of purity, which mandates that one abstain from sexual relations until after the wedding has taken place. This covenant comes from the belief that sexual relations between men and women are intended only for the bonds of marriage. Thirdly is the need for the couple to live separately until the marriage has taken place. This is another term of the covenant of purity, as the Pentecostal church sees cohabitation before marriage as compromising to Christian witness. Fourth, the couple must enter the covenant of faithfulness by agreeing to keep Christ as a central focus throughout their marriage. This includes a life based on true faith and continued participation in His church. Finally, the couple must realize that the minister selected to marry the couple reserves the right to deny services if the minister feels that the obligations to this covenant have not been met (Apostolou, 2007, p. 403).

Using the Social Cognitive Model as Theoretical Framework to Understand African Americans' Health Behaviors

Bandura's (1997) social cognitive theory (SCT) explains how people acquire and maintain certain behavioral patterns, while also providing the basis for intervention strategies (Bandura, 1997). Evaluating behavioral change depends on the environment, people and behavior. SCT provides a framework for designing, implementing and evaluating programs.

Environment and situation provide the framework for understanding behavior (Parraga, 1990). Environment refers to the factors that can affect a person's behavior. There are social and physical environments. Social environments include family members, friends and colleagues. Examples of physical environment include the size of a room, the ambient temperature or the availability of certain foods. The situation refers to the cognitive or mental

representations of the environment that may affect a person's behavior. The situation is a person's perception of the place, time, physical features and activity (Glanz, Rimer, & Viswanath, 2008).

The factors of environment, people and behavior constantly influence each other. Behavior is not simply the result of the environment and the person, just as the environment is not simply the result of the person and behavior (Glanz et al., 2008). The environment provides models for behavior. Observational learning occurs when a person watches the actions of another person and the reinforcements that the person receives (Bandura, 1997). Behavioral capability means that if a person is to perform a behavior he or she must know what the behavior is and have the skills to perform it. The SCT focuses on four primary learning processes, which are: 1) attention, 2) retention, 3) reproduction in behavior, and 4) motivation.

The Social Cognitive Theory Model is appropriate for my study because it focuses on the influence of both the environmental factors, such as the availability of suitable behavioral models and by intra-individual factors. Also, the four primary learning processes of SCT are relevant to understanding religiosity and health behaviors of African Americans.

The Social Cognitive Theory Model has been used with a cross-sectional correlation study of the Spiritual Models Inventory of Life Environment (SMILE) (Oman & Reed, 2008). The model showed that most spiritual and religious practices may be largely transmitted through the four primary learning process

identified in SCT, that is, attention, retention, reproduction in behavior and motivation (Oman & Reed, 2008). The four primary learning processes were used to measure the perceptions of spiritual models, defined as prominent people who functioned for respondents as exemplars of spiritual qualities, such as compassion, self-control, or faith. The study sample consisted of 1010 college students from California, Connecticut, and Tennessee from geographical and ethnical diverse students drawn from both religious and state supported public universities. According to Oman and Reed (2008), the spiritual modeling framework offers an approach to religion and spirituality that can promote more effective ways of learning and enacting spiritual attitudes, beliefs, and actions in daily life. The study also concluded that incorporating the (SMILE) model will help foster overall health and well being, and could reduce a range of negative or harmful attitudes, beliefs and behaviors (Oman & Reed, 2008).

Summary

There is much published research about religiosity and health among religious groups such as Muslims, Jews, and Baptists but there is a lack of information about religiosity and health behaviors of African Americans in the Pentecostal faith. From the earliest days of America's history, a deep-rooted spirituality has been one of the hallmarks of the African American population in the United States of America. Despite the conceptual significance of one's relationship with God, there is surprisingly little empirical data on its possible role in the religiosity and health link (Koenig et al., 2001).

According to Charette (2006) little research on religiosity of the African American population has been conducted. Most of the studies reviewed provide evidence of perception or belief that by living a holy life, according to God's commandments as clearly written in the Bible, that it is possible for one to live a healthy lifestyle. But none of the research reviewed specifically identified how these beliefs may be able to transform the lifestyles of the African Americans to help reduce the high morbidity rates observed in this community as a result of unhealthy behaviors.

Also, there is a benefit to using the social cognitive theory to understand the health behaviors of African American attendees in relationship with religiosity. According to Jones- Webb (1998) "the fact that behavior varies from situation to situation may not necessarily mean that behavior is controlled by situations but rather that the person is construing the situations differently and thus the same set of stimuli may provoke different responses from different people or from the same person at different times" (p. 262).

Chapter Three: Methodology

Introduction

The purpose of this study was to assess African American Pentecostal adult attendees relationship between religiosity and selected health behaviors. This was done to help determine if religiosity plays a significant role in the lives of the African Americans concerning the selected health behaviors. Findings of this study can ultimately contribute to new educational interventions aimed at living healthy lives. Description of this research design how data were collected, processed and analyzed are included in this chapter.

Described in this chapter are the methods used in this study to answer the following research questions:

1. What is the relationship between the selected reported health behaviors and religiosity among a sample of African American Pentecostal church attendees?
2. Is there a significant difference in religiosity based on the frequency of church attendance among fellowship of African American Pentecostal church attendees?
3. Is there a significant difference in selected reported health behaviors based on the fellowship of the frequency of church attendance among African American church attendees?
4. What health education services do the African American Pentecostal church attendees desire?

Description of Research Design

A structured print survey (see Appendix A) was used to gather information about participants' health behaviors including diet, exercise, alcohol use, tobacco use, pre-marital sex, perception of health, perceived weight, weight goals, and religiosity based on the social cognitive theory (SCT). The research data were gathered from a print survey of the selected Pentecostal Churches adult attendees.

Before the survey was disseminated and data was collected, permission was acquired from the Minnesota State University, Mankato Institutional Review Board (IRB) (see Appendix B). Similarly, permission from selected churches for data collection was acquired as well (see Appendix C). Informed consent information (see Appendix D) was distributed to all respondents prior to survey dissemination. Completion of the survey was interpreted as their informed consent to participate, as well as the confirmation that the participants met all the study requirements.

Instrumentation

This quantitative, descriptive study was designed to identify the relationship between religiosity and selected health behaviors of African Americans of the Pentecostal faith. A 43 question printed survey was administered to 300 adult attendees from selected Pentecostal churches. The printed survey collected information about: 1) demographics including age, gender, ethnicity, marital status, education, fellowship, membership; 2) health behaviors, 3) perceived

weight, 4) weight goals, 5) health classes desired, 6) utilization of a community health educators, and 7) religiosity.

Reliability and Validity of the Religiosity Scale

To establish validity an expert panel reviewed the survey. A copy of the selected survey questions was provided to five religious African Americans clergy members of the selected churches in Minnesota. The surveys were distributed in person after bible study class. The expert panel had ten minutes to complete survey review. The panel members were given seven questions to help guide their review of the survey instrument. These questions were:

- 1) Do the survey questions reflect the content of the research?
- 2) Do the survey questions reflect the purpose of the research?
- 3) Are the survey questions clear?
- 4) Is the terminology used appropriate?
- 5) Are the instructions on the survey clear?
- 6) Any suggestions for additions or deletions of questions?
- 7) Any other suggestions?

The selected clergy members reviewed each survey question and verified that the questions reflected the content and purpose of the research. Comments and suggestions were also made by the expert panel to keep the premarital question in the survey because it is a very important factor in the particular religious faith. The three thesis committee members also reviewed the questions

for content validity. There was no other suggestion for any other changes to the survey by the panel or committee members.

Cronbach's alpha analysis was used to evaluate each Likert scale question constructed for this research. This analysis evaluated the internal consistency of the constructed scales. Each scale was constructed by summing the scores of each of the items included in the scale and dividing the sum by the number of items that were in the scale. The results of the Cronbach's alpha analyses are presented with the mean scores and standard deviations for each type of the scales. The reliability results of the Cronbach's alpha analyses was 0.43 from the original data consist of a 17 item religiosity scale, and the M (SD) 24.6 (3.6) which might be due to an error of misspecification. After retesting the reliability with a 13 item religiosity scale results increased to 0.66 Cronbach's alpha with a mean and standard deviation, M (SD) 16.6 (3.1). Caution should be made when making the assumption with respect to the reliability of the religiosity scale in this study due to its low Cronbach's alpha score.

Data Collection

Data collection for this study was conducted in March 2012. Permission to administer the survey was obtained from the Minnesota State University, Mankato Institutional Review Board in March 2012. Letters were mailed to each church that was selected to be a part of this study because attendees of these ministries met the study criteria for participation. The letter stated the purpose of the study and the time frame of the study. A week after mailing the solicitation

letters and invitation flyer (see Appendix E), the priests or pastors was contacted through telephone and electronic mail to verify receipt of the letters. Participant consent forms specified how and where the data collected would be maintained, who has access to that information and that the access will only be to the survey instrument data itself and not to any identifying information to protect respondents' privacy and anonymity. In addition to privacy, the consent forms contained information about the intent of the study, potential risks and benefits to the participant and also his or her rights regarding participation. Finally, the consent form informed participants about what data would be collected and how findings would be used.

The clergy at each of the selected churches in Minnesota were asked to distribute questionnaires to adult attendees and members. The questionnaires contained a cover letter briefly explaining the purpose of the study and why they were chosen. Before completing the questionnaire the participant was instructed to read the informed consent in order to participate in this study. Once the participants were done with the questionnaires they were told to place them in a sealed box in the church where the documents were collected by the researcher.

Data Processing and Analysis

Data for this study were collected from March 13, 2012 to March 18, 2012. After the survey collection period was completed, the researcher entered the gathered

information into SPSS spreadsheet for quantitative analysis. Descriptive statistics were used to analyze relevant trends in the study.

Summary

This chapter described the methodology used in a non-experimental, cross-sectional survey to assess the relationship between religiosity and the selected health behaviors of African Americans in the Pentecostal faith. The next chapter will review the study findings related to the research questions.

Chapter 4: Findings and Discussion

Introduction

The purpose of this research was to study the relationship between religiosity and selected health behaviors of African American Pentecostal church attendees. A 43-item survey was developed and administered to collect data regarding African American adult attendees' health behaviors, perception of health, perceived weight, weight goals, religiosity, health education and screening desires; as well as demographic information. Findings from the quantitative analysis of each research question and procedural discussion is presented in this chapter.

After IRB approval was obtained, 500 printed surveys were distributed to adult attendees of at the Holy Christian churches in Mankato, St. Paul, and Brooklyn Center, Minnesota. After a week of data collection, 300 completed surveys respondents were gathered. After the researcher cleaned up the data, 289 surveys analyzed. Findings were reported with descriptive research analysis. The research questions were answered using descriptive statistics test analysis.

Response Rate of Adult Attendees

Data were collected from March 13, 2012 to March 18, 2012 at the Holy Christian Church, Mankato, the Holy Christian Church, St. Paul, and the Holy Christian Church, Brooklyn Center. A total of 500 structured questionnaires were distributed and 300 responses were received. There were 11 adult respondents

who did not meet the selection criteria of African American ethnicity therefore a total of 57.8% (n = 289) questionnaires were included in analysis.

Respondents' Demographics

Demographic data collected from respondents included age, gender, race, marital status, education, fellowship, and ordination. The key findings from the demographic data collected revealed that 42.2% (n = 122) were males and 57.8% (n = 167) were females with 56% respondents reported being under the age of 32. A total of 100% (n = 289) respondents were African Americans. A total of 56.4% (n = 163) respondents were single, and 33.9% (n = 98) completed some college. There were a total of 90.3% (n=260) of the respondents attended every service and 85.1% (n = 246) were not ordained ministers. Table 4.1 displays these descriptive data.

Table 4.1

Demographics

Characteristic	Frequency	Percentage
Age	289	
18-22 years old	53	18.3
23-27 years old	43	14.9
28-32 years old	69	23.9
33-37 years old	31	10.7
38-42 years old	38	13.2
43-47 years old	11	3.8
48-52 years old	15	5.2
53-58 years old	16	5.5
59 years or older	13	4.5
Gender		
Male	122	42.2
Female	167	57.8
Ethnicity	300	
Black/ African American	289	96.3
White/ Caucasian	8	2.7
Asian American	1	0.3
Hispanic	2	0.7
Marital Status	289	
Single	163	56.4
Single and engaged	33	11.4
Married	83	28.7
Divorced	6	2.1
Widowed	3	1.0
Separated	1	0.3
Education	289	
High School Graduate/GED	83	28.7
Some College	98	33.9
Associate Degree	42	14.5
Bachelor's Degree	42	14.5
Master's Degree	19	6.6
Doctorate	5	1.7
Fellowship	288	
Do not attend	1	0.3
Every other service	26	9.0
Attend every service	260	90.3
Other	1	0.3
Membership	281	
Ordained	35	12.5
Member	246	87.5

Perceived Health and Weight Management Results

The findings from the data collected for perceived health were 36.6% ($n = 106$) respondents reported associating their weight with obesity. Table 4.2 displays the descriptive data for respondents' perceived health responses.

Table 4.2

Reported Weight by Adult Attendees Responses

Weight	Frequency	Percentage
Reported Weight	289	
Very Underweight	4	1.4
Slightly underweight	9	3.1
About the right weight	170	58.8
Slightly overweight	79	27.3
Very overweight	27	9.3

Survey question number 15 asked if respondents were trying to do anything about their weight. From the data collected, 45.3% ($n = 131$) respondents reported a desire to stay the same weight while 42.2% ($n = 122$) respondents reported a desire to lose weight (see Table 4. 3).

Table 4.3

Reported Weight Management by Adult Attendees Responses

Weight Management	Frequency	Percentage
Reported Weight	289	
No response	1	0.3
Gain weight	10	3.5
I am not trying to do anything	25	8.7
Stay the same weight	131	45.3
Lose weight	122	42.2

Health Education, Screening, and Community Health Education

From the collected data, 92.4% ($n = 266$) respondents reported that their churches did not offer any health education classes. Similarly, 99.3% ($n = 285$) respondents reported that their church does not offer any health screenings. Also, of the 289 respondents 93.4% ($n = 268$) reported that a community health educator (CHE) could be utilized in their church, and 66.4% ($n = 188$) respondents reported desire to have a CHE every month to educate on preferred topics (see Table 4.4).

Table 4.4

Health Education Classes Desired by Adult Attendees Responses

Desired Class	Frequency	Percentage
Nutrition	66	22.0
Diabetes	51	17.0
High Blood Pressure	40	13.0
Exercise	25	8.0
Practical Living	24	8.0
Weight Management	20	7.0
Mental Health	15	5.0
No Response	13	4.5
Cancer	10	3.0
Any Health Topics	9	3.0
HIV/AIDS	6	2.0
Women's Health	5	2.0
None	3	1.0
Proper Hygiene	2	1.0
Healthy Relationships	1	0.1
Spiritual Health	1	0.1
Sexual Transmitted Diseases	1	0.1
Total	289	100.0

Research Questions and Findings

The following section provides statistical analysis as well as data interpretation for each of the research questions investigated in this study.

Research question 1: What is the relationship between the selected reported health behaviors and religiosity among a sample of African American Pentecostal church attendees? The selected health behaviors were examined by 10 questions from the survey that the respondent self reported. The selected health behaviors included alcohol use, cigarette smoking, pre-marital sex, healthy eating, and exercise. From the descriptive statistics none of the respondents reported consuming alcohol or cigarettes, which reveals that religion might have played a significant influence in their decisions because this is contrary to the lifestyle of African American respondents (Pew Research Center's Forum on Religion & Public Life, 2009). From the data collected no respondents reported the usage of alcohol or cigarettes. Regarding sexual health behaviors, 84.8% ($n = 245$) reported engaging in pre-marital sex at some point in their lives. They might have been engaged in pre-marital sex before they became church attendees. It is difficult to actually predict if there is any positive relationship between religiosity and pre-marital sex, as the survey did not ask if they engaged in pre-marital sex after coming to the Christian faith. Table 4.5 displays the reported selected health behaviors of respondents.

Table 4.5

Reported Selected Health behaviors by Adult Attendees Responses

Selected Health Behaviors	n	%
Alcohol	0	100.0
Non- Alcohol	289	100.0
Smoke	0	100.0
Non- Smoker	289	100.0
Pre-marital Sex	245	86.0
No pre-marital sex	39	13.7

Also, the survey findings show that one fourth of the respondents were not involved in physical exercise at least once a week. This clearly shows that there was no pattern predicting a relationship between the religion and physical exercises. Of the total survey of 289 respondents, 25.6% ($n = 74$) respondents reported zero days per week of moderate-intensity cardio or aerobic exercise (MPA) for at least 30 minutes (see Table 4.6).

Table 4.6

Reported Selected Exercise Behaviors by Respondents

Moderate-Intensity Cardio	Frequency	Percentage
0 days per week	74	25.6
1 day per week	62	21.5
2 days per week	53	18.3
3 days per week	51	17.6
4 days per week	25	8.7
5 days per week	19	6.6
6 days per week	4	1.4
7 days per week	1	0.3
Total	289	100.0

This findings were also similar to responses regarding Vigorous intensity cardio with 38.8% ($n = 112$) respondents out of 289 reported zero days of vigorous-intensity cardio or aerobic exercise (VPA) for at least 20 minutes (see Table 4.8), 48.6% ($n = 140$) respondents reported 0 days per week strength training exercises (STE) for 8-12 repetitions each (see Table 4.6) 22.2% ($n = 64$) respondents. Nearly half reported no strength training which is an important activity in building muscle mass. Table 4.7 and 4.8 displays the descriptive data for respondents reported exercise.

Table 4.7

Reported Selected Exercise Behaviors by Respondents

Vigorous-Intensity Cardio	Frequency	Percentage
0 days per week	112	18.8
1 day per week	71	24.6
2 days per week	54	18.7
3 days per week	29	10.0
4 days per week	11	3.8
5 days per week	10	3.5
6 days per week	2	0.7
7 days per week	0	0.0
Total	289	100.0

Table 4.8

Reported Selected Exercise Behaviors by Respondents

Strength Training Exercise	Frequency	Percentage
0 days per week	140	48.6
1 day per week	64	22.2
2 days per week	40	13.9
3 days per week	27	9.4
4 days per week	8	2.8
5 days per week	9	3.1
6 days per week	0	0.0
7 days per week	0	0.0
Total	289	100.0

The survey findings also indicate that there was no positive relationship between religiosity and the eating habits of the church attendees. Although many (61.1%, $n=176$) reported cooking fried food at least once a week in their home (see Table 4.9).

Table 4.9

Reported Cooking Fried Food in the Home by Adult Respondents

Fried Food	Frequency	Percentage
Never cook fried food	128	44.3
1 time per week	80	27.7
2 times per week	46	15.9
3 times per week	26	9.0
4 times per week	8	2.8
5 times per week	1	0.3
Total	289	100.0

From the data collected, 36.0 % of respondents reported eating 3-4 servings of fruits and vegetables per day (see Table 4.10) and 61.1% ($n = 176$) respondents eat fast food at a restaurant at least once a week (see Table 4.11).

Table 4.10

Reported Eating Behaviors by Adult Attendees Respondents

Fruits & Vegetables	Frequency	Percentage
0 servings per day	5	1.8
1-2 servings per day	87	31.1
3-4 servings per day	104	37.1
5 or more servings per day	84	30.0
Total	289	100.0

Table 4.11

Reported Eating Fast Food at the Restaurant by Adult Respondents

Fast Food	Frequency	Percentage
Never eat at a fast food restaurant	112	38.9
1 time per week	67	23.3
2 times per week	52	18.1
3 times per week	37	12.8
4 times per week	15	5.2
5 times per week	5	1.7
Total	289	100.0

Research question 2: Is there a significant difference in religiosity based on the frequency of church attendance among fellowship of African American Pentecostal church attendees? Given that the majority of the adult

attendees reported to be highly religious it was not appropriate to statistically analyze the data related to this research question.

Research question 3: Is there a significant difference in selected reported health behaviors based on the fellowship of the frequency of church attendance among African American church attendees? Given that the majority of the adult attendees reported a high frequency of church attendance it was not appropriate to statistically analyze the data related to this research question.

Research Question 4: What health education services do the African American Pentecostal church attendees desire? Table 4.12 shows the various health education classes desired by study respondents. The table shows that the most desired health education are desired in a nutritional class 22% (n = 66), diabetes class 17% (n= 51) and high blood pressure class 13% (= 40). The least desired classes are, healthy relationships, spiritual health, and sexually transmitted diseases 0.1% (n = 1) among the respondents.

Table 4.12

Health Education Classes Desired by Adult Attendees Responses

Desired Class	Frequency	Percentage
Nutrition	66	22 .0
Diabetes	51	17.0
High Blood Pressure	40	13.0
Exercise	25	8.0
Practical Living	24	8.0
Weight Management	20	7.0
Mental Health	15	5.0
No Response	13	4.5
Cancer	10	3.0
Any Health Topics	9	3.0
HIV/AIDS	6	2.0
Women's Health	5	2.0
None	3	1.0
Proper Hygiene	2	1.0
Healthy Relationship	1	0.1
Spiritual Health	1	0.1
Sexual T.D	1	0.1
Total	289	100.0

Interpretation

Findings from the study in relation to the Social Cognitive Theory showed that the African American respondents faith environment has an influence on their lives in respect to drinking alcohol and smoking cigarettes. Therefore, it appears that observational learning occurred among this population and the four primary learning processes were activated. Perhaps, because of the messages from the pastor or priest of the selected churches about alcohol and smoking, the attendees all reported not engaging in those behaviors. Healthy eating and physical activity behaviors, however, are not common, however, among this group of regular church attendees. It is possible that the pastor or priest may have not focused the messages about healthy eating and physically activity behaviors as much as alcohol and smoking which may account for the low response rate in this healthy behavior area.

Summary

Although there was no statistical significance between religiosity, selected reported health behaviors and frequency of church attendance of the African American Pentecostal church attendees, findings indicated that none of the attendees reported to drinking or smoking behaviors. However, they lack healthy eating and exercise.

Chapter Five: Summary, Discussion, and Recommendations

Introduction

The purpose of this research was to study the relationship between religiosity and selected health behaviors of African American Pentecostal church attendees using the Holy Christian Church of Mankato, St. Paul and Brooklyn Center as the study population. This study explored the health lifestyle of these church attendees to identify ways to help control and reduce the morbidity and mortality rate for many chronic diseases due to unhealthy behaviors of African Americans. Because of central role of religion in the lives of many African Americans this study attempt to determine the possible relationship between religiosity and selected health behaviors. Specifically, this study examined alcohol consumption, smoking habits, eating habits, physical exercise and pre-marital sexual activity of the African Americans in the selected sample. This study may add to the body of research regarding religiosity and healthy living of African Americans in the Pentecostal faith.

Study Summary

Respondents in this study included a sample of 289 church attendees of the Holy Christian Church of Mankato, St. Paul, and Brooklyn Center. To qualify for the study the participants had to be African American, and attend any of the three churches. Respondents included males and females over 18 years of age. The data collection instrument was a printed survey and the participants voluntarily completed the 43 questions in the survey. The questions in the survey

were structured to collect data about the demographic characteristics of the respondents, alcohol consumption, smoking habits, eating habits in relation to fried and fast food, cardiovascular or aerobic exercise, strength training, and pre-marital sex.

In this study it was found that religion might have played a significant influence in the decisions of the surveyed African Americans because 100% ($n = 289$) respondents reported no alcohol consumption, and 100% ($n = 289$) respondents reported to being non-smokers. The study also shows that the respondents did not engage in a physical exercise at least once a week.

The study findings indicate that it is difficult to actually predict if there is a positive relationship between religiosity and pre-marital sex as the survey did not ask if respondents engaged in pre-marital sex after coming to the Pentecostal faith. The study shows further that there is no positive relationship between religiosity and the eating habits of the church attendees with over 50% of the respondents reported eating fried food at home and fast food from a restaurant at least once a week. The study also shows that nutritional education class is most desired among the respondents.

Discussion

Findings of this study showed that 100% of the respondents did not use alcohol or smoke cigarettes which suggests that religious individuals of the Pentecostal faith may be less likely to use alcohol and other substances (Heath et al., 1999; Luczak et al., 2002; Stewart, 2001). This confirms the findings that

fear of violating religious principles and doctrines can have a powerful effect upon health behaviors (Jones-Webb, 1998). Further, these findings are congruent with the conclusion that spiritual leaders may play a role in educating people about the dangers of alcohol and drugs (Stylianou, 2004).

Findings regarding perceived weight revealed that respondents 27.3 % (n = 79) of respondents reported being slightly overweight, and 9.3% (n = 27) reported being very overweight. Also, the findings about self reported exercise concluded that 25.6 % (n = 74) of the respondents reported not engaging in moderate-intensity cardiovascular exercise. While 38.8% (n = 112) of respondents reported not engaging in vigorous intensity cardiovascular, and 48.4% (n = 140) respondents reported not engaging in strength training exercise for a minimum of 8-12 repetitions. Findings show that my study is comparable to the study by Centers for Disease Control and Prevention (2002). In that study, 65.4 percent of African Americans were at risk for health problems because they were obese, and 66.8 percent were at high risk because of lack of physical activity. Although several studies have found a positive relationship between religious activities and physical and mental health (Levin & Schiller, 1991; Roberts, 1990) more effort is needed to focus on this area to promote a healthy lifestyle.

However, caution should be noted in analyzing data, as there were insufficient data to test for significant differences in religiosity based on the frequency of church attendance of the African Americans in this study.

Limitations and Delimitations

The first limiting factor to this research was the time available for data collection. With more time for this study, a more articulated research design could have been developed. Other religious denominations could have been studied as well. Personal interviews may have been helpful to collect data not obtained through surveys. To better predict if there was any relationship between religiosity and pre-marital sex questions could have been rephrased. For example: "Have you ever engaged in pre-marital sex? If the answer was yes, at what age did you engage in pre-marital sex? Have you engaged in pre-marital sex after you became a member of the Holy Christian church?" Also, more time could have allowed the researcher to conduct several focus groups to obtain more information from the respondents.

Recommendations for Health Education

Findings of this research study suggest that there is need for health educators to provide services to the African American Pentecostal church attendees, especially in the areas of nutrition, healthy relationships, mental health, diabetes, practical living, weight management, cancer, high blood pressure, and cardio-aerobic exercises. Study findings show that more knowledge among African American communities is required in these areas if the overall objective of reducing the morbidity rate of African Americans through healthy lifestyle is to be achieved. It is recommended that health educators collaborate with church leaders of Pentecostal churches to provide these

educational services to African Americans at the church. Studies are needed that systematically examine current efforts by religious communities to promote health and detect diseases early in their course. Health education programs in churches could encourage members to stop smoking, exercise regularly, eat a balanced and healthy diet, and keep their weight under control. Additionally, churches may sponsor screenings for high blood pressure, cancer, blood sugar levels and high cholesterol. Where such programs are not in place research is needed to examine the clergy's interest in, and openness to, developing such programs. There is also great potential for further studies to examine how health educators and church leaders can collaborate together in educating African American church attendees on the need for healthy lifestyles. Identifying the most efficient and effective ways of this collaboration provide additional research opportunities in this area.

Recommendations for Further Research

Based on the findings of this research study, inclusion of respondents from other denominations in addition to Pentecostal faith could provide data to test for statistically significant differences in selected reported health behaviors based on the frequency of church attendance among African American church attendees. This would allow for more statistical analyses to be carried out with respect to the relationship between religiosity and healthy lifestyles of the African Americans church attendees with comparison to other religions.

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Appendix A

Religiosity & Health Behaviors

Instructions

The following questionnaire examines the relationship between religiosity and selected health behaviors of African Americans Pentecostal churches adult attendees.

To answer the questions, mark with (X) in the box that corresponds to your response or fill in the blank.

Select only one response unless instructed otherwise.

This survey is completely voluntary. You may choose not to participate or not answer any specific questions. You may skip any question you are not comfortable in answering.

Please make no marks of any kind on the survey which may identify you individually.

**Thank you for taking the time and
effort to complete this survey.
I appreciate your participation!**

Demographics

Please answer the following questions by selecting the response that best describes you.

1. How old are you? _____ Years

2. What is your gender?

_____ Male

_____ Female

_____ Other (please specify) _____

3. What is your race?

_____ Black/African American

_____ White/Caucasian

_____ Asian American

_____ Hispanic

_____ Latin American

_____ Caribbean American

_____ Other (please specify) _____

4. What is your marital status?

_____ Single

_____ Single and engaged

_____ Married

_____ Divorced

_____ Widowed

_____ Separated

5. What is your highest level of education completed?

_____ High School Graduate/GED

_____ Some College

_____ Associate Degree

_____ Bachelor's Degree

_____ Master's Degree

_____ Doctorate

6. How often do you attend a fellowship?

_____ Do not attend

_____ Attend every service

_____ Every other service/Biweekly

_____ Other (please specify)

7. What date did you become a member of the Holy Christian Church (Month/ Year)?

8. Are you ordained? Yes No

If Yes, what office? _____

9. How often do you drink Alcohol?

Non-drinker

Number of drinks per day _____

10. How often do you smoke?

Non-smoker

Number of Cigarettes per day _____

11. Have you ever engaged in pre-marital sex?

Yes _____ No _____

12. How would you describe your health?

Excellent

Very good

Good

Fair

Poor

Don't know

Exercise, Weight, and Nutrition,

13. How often do you engage in exercise such as the following:

a) Moderate-intensity cardio or aerobic exercise (caused a noticeable increase in heart rate, such as a brisk walk) for at least 30 minutes?

0 days per week

4 days per week

1 day per week

5 days per week

2 days per week

6 days per week

3 days per week

7 days per week

b) Vigorous-intensity cardio or aerobic exercise (caused large increase in breathing or heart rate, such as jogging) for at least 20 minutes?

0 days per week

4 days per week

1 day per week

5 days per week

- 2 days per week 6 days per week
 3 days per week 7 days per week

c) Strength training exercise (such as resistance weight machines) for 8-12 repetitions each?

- 0 days per week 4 days per week
 1 day per week 5 days per week
 2 days per week 6 days per week
 3 days per week 7 days per week

14. How do you describe your weight?

- Very underweight
 Slightly underweight
 About the right weight
 Slightly overweight
 Very overweight

15. Are you trying to do anything of the following about your weight?

- I am not trying to do anything about my weight
 Stay the same weight
 Lose weight
 Gain weight

16. How many servings of fruits and vegetables do you usually have per day? (1 serving= 1 medium piece of fruit; ½ cup fresh, frozen, or canned fruits/vegetables; ¾ cup fruit/vegetable juice; 1 cup salad greens; or ¼ cup dried fruit)

- 0 servings per day
 1-2 servings per day
 3-4 servings per day
 5 or more servings per day

17. How often do you cook fried food in your home? _____

18. How many times do you eat at a fast food restaurant in a week? _____

19. Do your church offers any health education classes?

Yes No

If yes, which health education classes? _____

If no, which health education classes would you like to have at your church?

20. Do your church offers any health screening programs?

Yes No

If yes, which health screening programs do your church offers?

If no, which health screening programs do would you like to have offered at your church?

21. What health topic do you desire to be address at your church?

22. Do you think a Community Health Educator could be utilized in your church?
(Community Health Educators are advocates, coordinators, teachers and communicators who empower people to take control of their health to improve their lives and well-being.)

Yes No

23. If you have a Community Health Educator in your church, how often would you like to have health education programs and health screenings?

Weekly

Every Month

Every Other Month

Every Six Months

Annually

Never

Please answer the following questions about religiosity using the scale below. Indicate the level of agreement (or disagreement) for each statement by placing a check in the box.

24. My religious faith is extremely important to me.

strongly agree agree neutral disagree strongly disagree

25. I pray daily.

strongly agree agree neutral disagree strongly disagree

26. I try to live according to values of the bible, rather than those of the world.

strongly agree agree neutral disagree strongly disagree

27. I look to my faith as providing meaning and purpose in my life.

strongly agree agree neutral disagree strongly disagree

28. I am not active in my faith or church.

strongly agree agree neutral disagree strongly disagree

29. My faith is an important part of who I am as a person.

strongly agree agree neutral disagree strongly disagree

30. My relationship with God is not important to me.

strongly agree agree neutral disagree strongly disagree

31. I enjoy being around others who share my faith.

strongly agree agree neutral disagree strongly disagree

32. My faith does not influence exercising or eat healthy.

strongly agree agree neutral disagree strongly disagree

33. My faith impacts many of my decisions.

strongly agree agree neutral disagree strongly disagree

34. My Priest/Pastor encourages the members to not live a healthy lifestyle by drinking and smoking themselves.

strongly agree agree neutral disagree strongly disagree

35. I seek counseling from my spiritual leader.

strongly agree agree neutral disagree strongly disagree

36. My Priest/Pastor minister about living a drug/alcoholism free live in his sermon.

strongly agree agree neutral disagree strongly disagree

37. I believe that living with a man or women that is not my spouse is acceptable in my faith.

strongly agree agree neutral disagree strongly disagree

38. I do not believe that God can heal me when I am sick.

strongly agree agree neutral disagree strongly disagree

39. I enjoy reading/studying/ listening to the bible or other religious material

strongly agree agree neutral disagree strongly disagree

40. I avoid worldly vices

strongly agree agree neutral disagree strongly disagree

THANK YOU FOR COMPLETING THIS SURVEY

Appendix B



March 1, 2012

Dear Judith K. Luebke:

Re: IRB Proposal entitled "[301549-2] Relationship Between Religiosity and Selected Health Behaviors of African Americans (Pentecostal Faith)"

Review Level: Level I

Your IRB Proposal has been approved as of March 1, 2012. On behalf of the Minnesota State University, I wish you success with your study. Remember that you must seek approval for any changes in your study, its design, funding source, consent process, or any part of the study that may affect participants in the study. Should any of the participants in your study suffer a research-related injury or other harmful outcome, you are required to report them to the IRB as soon as possible.

The approval of your study is for one calendar year from the approval date. When you complete your data collection or should you discontinue your study, you must notify the IRB. Please include your log number with any correspondence with the IRB.

This approval is considered final when the full IRB approves the monthly decisions and active log. The IRB reserves the right to review each study as part of its continuing review process. Continuing reviews are usually scheduled. However, under some conditions the IRB may choose not to announce a continuing review. If you have any questions, feel free to contact me at patricia.hargrove@mnsu.edu or 507-389-1415.

The Principal Investigator (PI) is responsible for maintaining consents in a secure location at MSU for 3 years. If the PI leaves MSU before the end of the 3-year timeline, he/she is responsible for following "Consent Form Maintenance" procedures posted online.

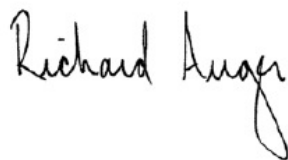
Sincerely,

A handwritten signature in black ink that reads "Patricia Hargrove".

Patricia Hargrove, Ph.D.
IRB Coordinator

A handwritten signature in black ink that reads "Mary Hadley".

Mary Hadley, Ph.D.
IRB Co-Chair

A handwritten signature in black ink that reads "Richard Auger". The signature is written in a cursive style with a large, looping 'A' at the end.

Richard Auger, Ph.D.
IRB Co-Chair

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Minnesota State University's records.

Appendix C



The Holy Christian Church International

125 Stevens Street St. Paul, MN 55107
(651) 789-4260 (office) (651) 789-4270 (fax)

February 19, 2012

Caprice Agunbiade:

In response to your request, *The Holy Christian Church* and her congregations agrees to participate in the research and all surveys appertaining thereof with reference to your thesis.

Attached is the signed consent form which you have supplied to us.

In His Holy Name,

A handwritten signature in black ink, appearing to read "Wayne R. Felton", with a small cross symbol to the left.

Bishop Wayne R. Felton
Presiding Bishop, *Communion Of Holy Christian Churches*
Senior Pastor, *The Holy Christian Cathedral*
(651) 789-4260, Office
(651) 789-4270, Fax
Bishop@thcci.org, Email
www.thcci.org, website

INVITATION LETTER TO PARTICIPANTS

Initial Letter to Churches

Greetings to the Bishop Wayne R. Felton and Potential Participants,

My name is Caprice Jones-Agunbiade, and I am a second year graduate student of Community Health Education at Minnesota State University, Mankato. I am conducting a research study to understand the relationship of religiosity and the selected health behaviors of African Americans among Pentecostal church adult attendees at three (3) local congregations of The Holy Christian Churches in the state of Minnesota.

1. The Holy Christian Church, Cathedral
2. The Holy Christian Church, Mankato
3. The Holy Christian Church, West

This study is grounded by the researcher's intent to understand the importance of religiosity in Pentecostal churches and the factors considered for living a healthy lifestyle from the teachings. Research in this area will enhance the knowledge of pastors and ministers as they counsel and advised members of the church.

The data collected will be used for my thesis. All data for this study, including any future presentations and publications, will be presented in a way that does not specifically identify any participants or their responses.

This letter is my attempt to make contact with and inform the Bishop of the churches targeted for this study. I am requesting a meeting or telephone conversation with you to solicit your assistance in using your Pentecostal churches within this study. I desire to speak with you in depth regarding this study and how the local church congregation may become involved. If you are interested in learning more about this opportunity and all that it entails, I am available to meet with you.

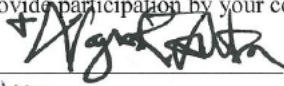
If you have any questions about this research or need to speak with me, I can be reached any time at (507) 491-2222 or by e-mail at caprice.jones-agunbiade@mnsu.edu. You may also contact my thesis committee chair, Dr. Judith K. Luebke at (507) 389-5938
Thank you.

Sincerely,

Caprice Jones-Agunbiade

Please sign below if you are willing to provide participation by your congregation in this thesis research study outline above.

Signature



Print name Bishop Wayne R. Felton

Title Sr. Pastor, The Holy Christian Church International

Date 2-13-12

Appendix D

Dear Participant,

This research is a survey of the relationship of religiosity and selected health behaviors of African Americans among the Pentecostal Faith. You will be asked questions about your personal religion belief and health status. All of your information will be kept private. Only authorized research committee members will be able to view the collected data. The survey takes about 20 minutes to complete.

I understand that I can contact the researcher Caprice Jones-Agunbiade at (507) 491-2222 or caprice.jones-agunbiade@mnsu.edu or Dr. Judith K. Luebke at (507)-389-5938 or judith.luebke@mnsu.edu about any concerns I have about this project. I understand that I also may contact the Minnesota State University, Mankato Institutional Review Board Administrator, Dr. Barry Ries, at (507)-389-2321 or barry.ries@mnsu.edu with any questions about research with human participants at Minnesota State University, Mankato.

I understand that participation in this project is voluntary and I have the right to stop at any time. My decision whether or not to participate will not affect my relationship with Minnesota State University, Mankato. I am also aware that there are no direct benefits to me as a result of my participation in the research. By completing this survey, I agree to participate in this study and state that I am at least 18 years of age, be literate in English language, and be an attendee or member of at least one of the listed churches:

- The Holy Christian Church, Cathedral (St. Paul, MN)
- The Holy Christian Church, Mankato
- The Holy Christian Church, West (Brooklyn Park, MN)

I understand that none of my answers will be released and no names will be recorded. I understand that risks of participating in this study are less than minimal. I understand that participating in this study will help the researchers better understand the relationship between religiosity and selected health behaviors.

If I am concerned about my mental health after answering the questions, I can seek counseling from any member of the clergy from selected churches that the surveys are being conducted. Neither the investigators nor Minnesota State University, Mankato will be responsible for the cost of mental health services if you decide to request them.

*I have read the above information and understand that this survey is voluntary and I may stop at any time. **By responding to this survey, I am providing my consent.***

Please Keep this copy for your records.

Appendix E

Invitation

Survey Participants Needed

Date: March 13-18, 2012

Location: The Holy Christian Churches

My name is Caprice Jones-Agunbiade and I am a graduate student at Minnesota State University, Mankato. I am currently completing a research project on the Relationship between Religiosity and Selected Health Behaviors for my Masters degree in Community Health. This announcement is to solicit volunteers to complete a 20 minutes survey on religiosity and health, which will allow the researcher to understand the effect of religiosity on health behaviors of African Americans (Pentecostal Faith). There is no compensation for participation.

If you are willing to participate in the research study, please notify the researcher at caprice.jones-agunbiade@mnsu.edu

Sponsored By:

This is a supervised study by Minnesota State University, Mankato, MN. My Research Advisor is Dr. Judith Luebke. She can be reached at (507)-389-5938 or at Judith.luebke@mnsu.edu. Should you have any questions for me, my contact information listed below.

Caprice Jones-Agunbiade (507)-492-2222

Survey Available between: February 23- 29, 2012