Introduction

This chapter presents an overview of the health status of Black Seventh-day Adventists within the context of being Black in America. Included are roots of health behavior for Blacks, the increased need for health awareness in the Black community, and some early contributions of Black pioneers in the SDA medical work.

The chapter also provides background information on the health of Black Americans in the general population as a backdrop for the Black SDA health experience. Some alarming statistics are provided concerning the overall health of Black Americans, and explanations are offered for the differences between the health status of Blacks and Whites. Some of the many interesting programs and activities of the Black SDA membership are examined, including information about a new phase of the Adventist Health Study, in which Black California Adventists will take part.

The last part of this chapter is an appeal to readers to earnestly consider their health behavior in light of what has been discussed. Some viable recommendations are offered for solving health problems of church members and the organization.

Historical Influences on Blacks’ Health

Many health professionals believe that the experience of slavery has had a profound effect on the health of Blacks in America. It is difficult to assess the exact impact of years of poverty, hard work, and abuse. However, according to researcher Richard Williams, privation and suffering have indeed taken a toll on the health of Black Americans.1

Stolen from homeland and family, African slaves endured a tragic 10-week trip across the Atlantic Ocean. Packed in tightly and chained to the bottom of the ship, the slaves could not sleep on their right or left sides. There was very little fresh air and no sunshine in the crowded quarters. The foul smell and high levels of carbon dioxide made breathing difficult.

Nearly all suffered from yellow fever, measles, malaria, leprosy, smallpox, pains in the head and back, chills, fever, nausea and infections. The death rate reached 16 slaves per 100 on average. Each slave was given one-half pint of water a day. In spite of dehydration and illness, most miraculously survived.

On the plantation the slaves were forced into negative lifestyle habits—including insufficient time to sleep, inadequate meals, unbelievably stressful situations, and other health-destroying experiences. Slaves ate the fatty and undesirable parts of animals (for example, chitterlings, which are the intestines of hogs).

Slave mothers used their creative talents and blended the fatty meats with the meager vegetables they were given to make somewhat tasty meals. It took ingenuity to take foods that were mostly rejected by Whites and prepare tasty meals of such food items as pickled pork, salt bacon, blackstrap molasses, cabbage, peas, onions, cornbread, corn soup, cornmeal mush, and hoecake. Very few slaves were allowed to eat a variety of fruits.

Many of these harmful habits have persisted in the Black community. For example, many Blacks do not drink enough water. Slaves worked in the field under the hot sun and were usually allowed only two breaks a day for water and food. In summary, the conditions under which the slaves were brought to America, their inhumane treatment, and their inability to decide their own destinies all predisposed Blacks to poor health practices.

Health Awareness in the Black SDA Church

The roots of health awareness for Black Seventh-day Adventists can be traced to Ellen G. White and the pioneers of the Adventist Church. Early in the church’s history Ellen White made urgent appeals about the plight of Blacks in the South. At first her appeals were largely ignored, but later health reform became an integral part of the Adventist message. The body was emphasized as being the temple of the Holy Spirit.

Table 1 provides a time line of important dates and activities in the history of health awareness among Black SDAs. The table includes some of the significant events in the church’s health history, including Ellen White’s first vision outlining health reform issues, along with accomplishments of Black SDA workers and information on health institutions.

The SDA Church was officially organized in May 1863. Ellen White was given her health vision just a few
weeks later, in June 1863, the same year the Emancipation Proclamation went into effect. During the years immediately following the Civil War, the infant Adventist Church had few ministers and even fewer dollars to send workers south to labor among the recently freed slaves. More established denominations sent teachers south, but the newly formed Sabbathkeeping church was struggling for survival.

It was providential that James Edson White, son of James and Ellen White, experienced at age 44 a notable transition in his religious life. Although in business for himself, he sensed a tremendous urgency to do something for the recently freed slaves in the South. Together with Will Palmer, from Battle Creek, Edson envisioned a missionary journey that would take the gospel of salvation to the people of the South. He had a love for boats and thought that a missionary steamer could be prepared.

In March 1894 they started work on a steamer to be called The Morning Star. The General Conference finally sponsored the project and assigned them to work in the area of Vicksburg, Mississippi. Although many of the newly converted Black Adventists became healthier as a result of adopting a way of life that excluded alcohol and tobacco, they often didn’t fit into the social settings that they had formerly espoused. In addition, the dietary restrictions of Leviticus 11 prohibited them from eating pork, crabs, and other unclean animals.

Louis B. Reynolds uses the story of Anna Knight’s early experiences to illustrate the awkward position many people face when they try to adopt new eating patterns. Anna Knight, a Black SDA pioneer, was thrust into such a position when she joined the church in the early 1890s. Her family members in Mississippi were not able to understand her religion. Loud family quarrels erupted over her refusal to eat like everybody else. Many Black Adventists were forced into similar positions.

A major health reform movement gained interest beginning around 1830 and continuing into the 1840s and 1850s. Sylvester Graham, William Alcott, Horace Fletcher, James C. Jackson, and Russell C. Trall did much to promote interest in health. However, the Civil War soon preoccupied Americans, making it

Table 1
A Time Line of Historical Events in Black Seventh-day Adventist Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1848</td>
<td>Ellen White receives temperance vision about harmful effects of tobacco, tea, and coffee.</td>
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<tr>
<td>1863</td>
<td>Ellen White receives major vision on health at Otsego, Michigan.</td>
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<tr>
<td>1865</td>
<td>First book on health, <em>Health, or How to Live</em>, is published by Ellen White.</td>
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<tr>
<td>1866</td>
<td>The church’s first health paper, <em>The Health Reformer</em>, is published.</td>
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<tr>
<td>1869</td>
<td>The American Health and Temperance Association is organized.</td>
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<tr>
<td>1878</td>
<td>The nursing course is established at Battle Creek Sanitarium by Dr. Kate Lindsay.</td>
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<tr>
<td>1894</td>
<td>James Edson White sails down the Mississippi on the <em>Morning Star</em>, taking the gospel and the health message to Southern Blacks.</td>
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<tr>
<td>1895</td>
<td>The American Medical Missionary College is founded in Battle Creek, Michigan, with 40 students.</td>
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<tr>
<td>1897</td>
<td>Medical work is begun in Cape Town, South Africa, by Dr. R. S. Anthony. A school of nursing is organized in South Africa by Dr. Kate Lindsay.</td>
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<tr>
<td>1901</td>
<td>Dr. Lottie Blake, first Black Adventist physician, graduates from American Medical Missionary College in Battle Creek, Michigan.</td>
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<tr>
<td>1903</td>
<td>Dr. Lottie Blake begins sanitarium treatments in Nashville, Tennessee.</td>
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<tr>
<td>1905</td>
<td>A school of nursing is organized in Loma Linda, California.</td>
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<tr>
<td>1907</td>
<td>The Medical Missionary Department of the General Conference is organized.</td>
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<tr>
<td>1909</td>
<td>The first graduation exercise is held for nurses at Oakwood College, Huntsville, Alabama.</td>
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<tr>
<td>1914</td>
<td>Hadley Hospital opens as a clinic in Washington, D.C.</td>
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<tr>
<td>1927</td>
<td>Mrs. Nellie Druillard opens Riverside Sanitarium, Nashville, Tennessee.</td>
</tr>
<tr>
<td>1934</td>
<td>The Medical Cadet Corps is organized.</td>
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<tr>
<td>1935</td>
<td>Riverside Sanitarium is donated to the Seventh-day Adventist denomination.</td>
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<tr>
<td>1943</td>
<td>Lucy Byard is denied treatment at Washington Sanitarium and Hospital when it is discovered that she is Black. She dies of pneumonia.</td>
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<tr>
<td>1947</td>
<td>The American Temperance Society and International Temperance Association constitutions are adopted.</td>
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<tr>
<td>1948</td>
<td><em>Listen</em>, official magazine of the American Temperance Society, is launched.</td>
</tr>
<tr>
<td>1952</td>
<td>Hadley Hospital opens as a full-service medical and surgical hospital.</td>
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<tr>
<td>1959</td>
<td>The Five-Day Plan to Stop Smoking is developed.</td>
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<tr>
<td>1976</td>
<td>Samuel DeShay, M.D., is first Black American to head the General Conference Health Department.</td>
</tr>
<tr>
<td>1983</td>
<td>Riverside Sanitarium is sold to a non-SDA group.</td>
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<tr>
<td>1985</td>
<td>The first infant heart transplant surgery is performed at Loma Linda University Medical Center.</td>
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<tr>
<td>1992</td>
<td>Hadley Hospital is sold to a non-SDA group.</td>
</tr>
<tr>
<td>1995</td>
<td>The Adventist Church is operating approximately 167 hospitals and sanitariums, 17 food companies, and 340 dispensaries and clinics worldwide.</td>
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</tbody>
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difficult for health reformers to gain the ear of the people.

In the 1860s and 1870s interest in health reform appeared to wane. During that period Ellen White was shown the harmful effects of tobacco, tea, and coffee. She was also shown that the people waiting for the coming of the Lord should spend their precious dollars on spreading the gospel rather than on these toxic substances. Besides these economic and health arguments, Ellen White added a spiritual perspective—tobacco impaired the mental faculties and could jeopardize one’s ability to respond to the Holy Spirit.

A longer, more detailed vision was given to Ellen White on the evening of June 5, 1863, at a friend’s home in Otsego, Michigan. The vision lasted about 45 minutes and outlined the Adventist health message. Liquor was to be abandoned. A meatless diet was shown to be most healthful. Relationships between physical, mental, and spiritual health were described. Sometime after this vision Ellen White wrote: “Whatever injures the health not only lessens physical vigor, but tends to weaken the mental and moral powers.” “The relation that exists between the mind and the body is very intimate. When one is affected, the other sympathizes. . . . Grief, anxiety, discontent, remorse, guilt, distrust, all tend to break down the life forces and to invite decay and death. . . . Courage, hope, faith, sympathy, love, promote health and prolong life. A contented mind, a cheerful spirit, is health to the body and strength to the soul.”

The Relationship Between Biblical Health Principles and Health Outcomes

The SDA Church believes in the Bible as a rule of faith and accepts both the Old and New Testaments. Many Old Testament principles expound on health. For example, Exodus 15:26 promises that if the Israelites would follow the principles that God gave to them, He would “put none of these diseases” on them that He had put on the Egyptians.

The Israelites stressed the health ideals of the Bible. Genesis 1:29 and 3:18 pointed out that God gave humans an original vegetarian diet. When after the Flood they strayed from these principles, He allowed them to include meat in their diet. But He laid down certain safeguards. For example, no blood or fat from the animal was to be consumed (LEV. 3:17; 7:22-27; 17:10-14; 1 SAM. 2:16). These rules helped protect the Israelites from disease, and the same principles were taught by early Adventist believers.

Many of the proscriptions of the Old Testament included laws designed to reduce the spread of diseases carried by infectious microorganisms. Attention to such laws would have prevented numerous deaths from infectious diseases in the United States during the nineteenth century. The first column of Table 2 provides a summary of the leading causes of death in America in 1850. During that year all 10 leading causes of death were from preventable infectious diseases.

With the development and use of vaccines and other defenses against infectious diseases, the death rates from those causes began to decrease. As noted in Table 2, infectious diseases were the top three leading causes of death in 1900, with diphtheria, another infectious disease, at the bottom of the list.

Health researchers today are following an alarming trend in the death rates of Americans. No longer are people dying of preventable illnesses caused by microorganisms that we can control. Instead, people are making “lifestyle choices” that are negatively affecting their health. To illustrate, half of the 10 leading causes of death in 1990 have much to do with lifestyle practices. Heart disease, cancer, chronic obstructive lung disease, HIV infection, hyperten-

<table>
<thead>
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<th>Table 2</th>
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<tr>
<td><strong>A Comparison of the 10 Leading Causes of Death in America From 1850 to 1990</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1850</th>
<th>1950 (rate/100,000 deaths)</th>
<th>1990 (rate/100,000 deaths)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tuberculosis</td>
<td>1. Pneumonia and influenza (202.2)</td>
<td>1. Heart disease (702.0)</td>
</tr>
<tr>
<td>2. Dysentery</td>
<td>2. Tuberculosis (194.4)</td>
<td>2. Cancer (174.0)</td>
</tr>
<tr>
<td>3. Malaria</td>
<td>3. Diarrhea, enteritis, ulceration of the intestine (142.7)</td>
<td>3. Cerebrovascular diseases (43.5)</td>
</tr>
<tr>
<td>4. Typhoid fever</td>
<td>4. Diseases of the heart (137.4)</td>
<td>4. Accidents (33.6)</td>
</tr>
<tr>
<td>5. Pneumonia</td>
<td>5. Intracranial lesions of vascular origin (106.9)</td>
<td>5. Chronic obstructive lung diseases (28.1)</td>
</tr>
<tr>
<td>6. Diphtheria</td>
<td>6. Nephritis (81.0)</td>
<td>6. Diabetes (15.7)</td>
</tr>
<tr>
<td>7. Scarlet fever</td>
<td>7. All accidents (72.3)</td>
<td>7. Suicide (11.2)</td>
</tr>
<tr>
<td>8. Meningitis</td>
<td>8. Malignant neoplasms (64.0)</td>
<td>8. Cirrhosis of liver (9.5)</td>
</tr>
<tr>
<td>10. Smallpox</td>
<td>10. Diphtheria (40.3)</td>
<td>10. Pneumonia and influenza (2.3)</td>
</tr>
</tbody>
</table>
sion and stroke, and cirrhosis of the liver are often directly related to poor dietary choices, physical inactivity, use of tobacco and/or alcohol, and stress. It is estimated that by 2010 cancer will be the leading cause of death in America. The lungs, colon and rectum (colorectal cancer), breast, prostate, and pancreas are the six sites where cancer develops most frequently.

Black Americans, in particular, need to give attention to biblical laws and health. For example, the link between diet and certain forms of cancer has been scientifically documented in numerous studies of religious groups throughout the world. According to studies cited in David Nieman’s book *The Adventist Healthstyle*, the lowest risk of fatal heart disease occurred in SDA men and women who practiced the vegetarian diet from an early age. Risk of developing cancers of the pancreas or prostate were decreased in individuals who consumed higher amounts of dried beans and fruits, as well as vegetable protein products.

Table 3 gives a summary of SDA health principles and how they relate to the leading causes of death among Blacks, according to the *Report of the Secretary’s Task Force on Black and Minority Health*. The eight health principles of the Seventh-day Adventist lifestyle include proper diet, exercise, pure water, exposure to sunlight and fresh air, adequate daily and weekly (Sabbath) rest, self-control, and trust in divine power. The leading causes of death among Blacks in America are cardiovascular disease and stroke, conditions related to chemical dependency, cancer, diabetes, homicide, unintentional injuries, infant deaths before the first birthday, and AIDS.

Turning our attention to Table 3, we notice that cardiovascular disease risk is related to seven of the eight principles. In other words, individuals who follow the seven principles that are marked in the column labeled “cardiovascular disease and stroke” can greatly reduce their chances of premature illness, disability, or death resulting from these conditions.

Based on the available data on why people die in America, it is clear that the Bible’s guidelines for healthful living are urgently needed to improve both quality and length of life. In his book *How to Be Filled With the Holy Spirit and Know It*, Garrie F. Williams explains that our purpose in obeying health laws is not to increase our longevity; nor is it a ticket to heaven. Rather, healthy choices improve our ability to respond appropriately to the Holy Spirit. “When I realized that the only way the Holy Spirit can have access to my life is through my brain cells, I decided to observe the eight laws of good health that have brought vitality to the body and clarity of mind to millions of people.” He quotes Ellen White’s statement in *Counsels on Diet and Foods*: “God cannot let His Holy Spirit rest upon those who, while they know how they should eat for health, persist in a course that will enfeeble mind and body.”

### Early Black SDA Medical Pioneers and Institutions

**Anna Knight.** The first Black missionary to be sent to India by a mission board of any denomination was Anna Knight, of Laurel, Mississippi. Knight was befriended by John Harvey Kellogg, who influenced her to consider service as a missionary nurse. He invited Knight to attend the 1901 General Conference session in Battle Creek, Michigan. While there she heard that J. L. Shaw and his wife were going to India and needed two nurses to assist with their medical ministry. Knight answered the call.

In India she extracted teeth, lanced boils and abscesses, and did bookkeeping, besides teaching Bible and English

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**Table 3**

<table>
<thead>
<tr>
<th>Cardiovascular Disease and Stroke</th>
<th>Various Cancers</th>
<th>Chemical Dependency</th>
<th>Diabetes (Obesity)</th>
<th>Unintentional Injuries</th>
<th>Infant Mortality</th>
<th>HIV/AIDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proper Diet</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Sunlight</td>
<td></td>
<td></td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Fresh Air</td>
<td></td>
<td></td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Trust in Divine Power</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
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</tr>
</tbody>
</table>
and supervising a vegetable garden. After she returned home, she received a letter from the Southeastern Union Conference proposing that she come to Atlanta to become medical matron of a new sanitarium established to reach the local Black population. She tried it for some months, but the idea did not catch on. Atlanta was too sophisticated to resort to such simple treatments as hydrotherapy.

Knight organized a local branch of the YWCA and used the sanitarium facilities to teach home nursing, healthful cooking, and first aid. She also conducted Bible studies. Through her contacts at the YWCA and the sanitariums she was able to double the membership of the church. In the community she was recognized widely as the nation’s first Black missionary to India. As a result, she was frequently called upon to give lectures on its people and customs.

*Founders of Riverside Sanitarium.* Another Black SDA medical pioneer was Dr. Lottie Blake. Dr. Kellogg urged Dr. Blake to go to the South to establish a sanitarium for the Black population. She began her work in the city of Nashville, Tennessee, in 1903 by opening a sanitarium and a treatment room. Her facilities were often compared with those of larger, more prestigious institutions. Her simple treatments with water and natural remedies were questioned by the sophisticated community. Many people distrusted a female medical care provider. Eventually she was forced to move her operation to another section of the city.

Nellie H. Druillard, a wealthy White woman, had heard Ellen White speak of the terrible health conditions of the people of the South and had promised to build a sanitarium. However, she became so busy with other work that she forgot her promise for a dozen years. Finally an automobile accident put her on her back, and she remembered her pledge. She promised the Lord that if He would restore her health and usefulness, she would proceed with the sanitarium. After a few obstacles were removed, she purchased a piece of property on Young’s Lane, at a bend of the Cumberland River. Thus the facility was appropriately named Riverside Sanitarium.

In the early years of the hospital’s existence training was given in hydrotherapy and nursing. Riverside soon became an established institution, but Druillard, at 80 years of age, found directing a sanitarium too demanding. So in 1934 when they added a new wing for offices, X-ray equipment, treatment rooms, a small operating room, and a laboratory.

Through the years the small hospital grew into an 80-bed acute-care facility that was eventually owned by the Columbia Union Conference. The hospital was purchased by PACIN Health Services in 1992. The sale of Hadley marked the end of Black SDA ownership of medical facilities in the United States.

*Black SDA medical missionaries to Africa.* To name all the Black Adventists who served in overseas medical missionary service is beyond the scope of this chapter. Black student missionaries, volunteers, and paid workers have served distinctively in African medical facilities through the years. However, several key contributors to this field of endeavor deserve mention.

Dr. and Mrs. Samuel DeShay served at Ahoada Hospital in Nigeria. Despite personal danger, they remained at their post until the Nigerian civil war forced them to flee. Instead of returning to the United States, the DeShays served the Ile-Ife Hospital in Nigeria for several years and the Masanga Leprosy Hospital in Sierra Leone for two years, devoting a total of 13 years to foreign medical missionary service.

Among those who gave admirable service as nurses were Greta Graham, at Ankole Hospital in Uganda; Caddie Jackson, Ruby Graves, and Claudia Ann Gordon, at Ile-Ife Hospital in Nigeria; and Gloria Mackson and Naomi Bullard, at Mugonero Hospital in Rwanda. Bullard served also as a teacher/tutor and director of nurses. Gloria Mackson was a nurse/teacher in Tanzania.

Dr. George Benson served at the Benghazi Adventist Hospital in Libya until the government nationalized the hospital. The Bensons ended their term of overseas service at the Gimbie Hospital in Ethiopia. Other doctors who served short-term medical relief stints at Ile-Ife Hospital were Warren Harrison, J. Mark Cox, John R. Ford, and Carl A. Dent.

Dr. Earl Richards inaugurated a flourishing dental practice in Nairobi, Kenya. Mrs. Richards, a registered nurse, gave valuable assistance to the clinic and the church. In 1980 Loma Linda University honored Dr. Richards as Alumnus of the Year.
Current Health Status of Black Americans

Since Black Adventists in the United States are members of the larger community of Black Americans, it is important to view SDA health challenges in the light of the wider Black population. From the arrival of first Blacks in this country in the 1600s until now, the health status of Black Americans has been considerably poorer than that of White Americans. In spite of advances in health science and medical technology, 60,000 deaths in 1985 would not have occurred if Blacks exhibited the same death rates as Whites, according to Dr. James Mason, U.S. assistant secretary for health.

In 1985 Margaret Heckler, then secretary of the Department of Health and Human Services, commissioned a one-year study of the health status of minorities in America. The Report of the Secretary's Task Force on Black and Minority Health identified six priority areas in which excess deaths occurred among Blacks and other minorities: (1) certain types of cancer, (2) cardiovascular disease and stroke, (3) chemical dependency, (4) diabetes, (5) infant mortality, and (6) homicide/unintentional injury ("excess deaths" are those experienced by Blacks beyond what would have been expected if Blacks had the same death rates as those of Whites). Since the publication of that report, AIDS has also been established as a priority cause.

The first national probability sample of Black America was conducted early in the 1970s by researchers at the University of Michigan's Survey Research Center. Results of that extensive survey are now available in Life in Black America, edited by James Jackson (1991). From this and many other sources of data, here are some alarming statistics about the health of Black Americans:

1. In 1993, 58,538 AIDS cases were reported to the Centers for Disease Control. Sixty-six percent of those cases (38,544) were among Blacks. Of the 38,544 cases in Blacks, 532 were in children. Deemed at that time a sign of manliness, this notion persists even today among some Black men.

2. Obesity occurs twice as often in Black women over age 44 as it appears in White women of the same age group.

3. In 1993 the AIDS rate for Black females was 15 times greater than the rate for White females.

Why the Disparity Exists

Lifestyle practices. Lifestyle practices such as smoking, eating foods that are high in fat and cholesterol, and being physically inactive are generally more prevalent in Black communities, according to information from the National Health Interview Survey. The negative consequences of these behaviors may help to explain our health status.

Poverty. Poverty is a possible determinant of the poorer health status of Black Americans. Dr. Harold P. Freeman, director of the Department of Surgery at Harlem Hospital in New York City, describes poverty as a proxy term for a series of negative social events such as low educational level, inadequate social support network, unemployment, and diminished access to health care.

If poverty is indeed a factor in explaining the health disparity, the percentage of Black SDAs living in poverty should be less than that for Black America in general, since the SDA membership is typically more affluent than the national average. This conclusion notwithstanding, we cannot ignore the problem of poverty as an issue in improving Black SDA health status. Culturally ingrained health habits attributable to poverty, such as a high-fat, low-fiber diet, may persist, especially in new converts and among older members.

More roots from slavery. One theory holds that hesitancy among Blacks in seeking medical care may also have its roots in slavery. Access to health care was a privilege offered by the owner of the plantation, a privilege that slaves tried not to abuse. Slaves didn't want the master to think they weren't good workers. Also, male slaves often waived this privilege in favor of needy women and children. Deemed at that time a sign of manliness, this notion persists even today among some Black men.

Inferior care. According to some research, Blacks who enter the health-care system face a number of negative circumstances that influence their willingness to seek help. First, some members of the medical establishment appear to favor patients who are wealthy and/or White. The May 2, 1990, issue of the Journal of the American Medical Association reports that Black men, more susceptible to a certain type of heart attack than White men, were less likely to get special X-rays and a third less likely to undergo bypass surgery.

Data shortages. Decisions about allocating financial and human resources are based on statistical information and the results of previous research. Securing data from residents of rural areas, the homeless and indigent, and the incarcerated is difficult, and these groups—which include many Blacks—are often omitted from the data-gathering process. Thus a shortage of accurate information may have grave effects on the health-care availability of certain segments of the Black community.

What's Being Done About Disparity Issues?

As a result of the 1985 report of the Secretary's Task Force on Black and Minority Health, considerably more attention has been placed on the health of Black Americans. Strategies for reducing the gap are carried out by community-based organizations and federal, state, and local governmental agencies. The immunization of school-age children against certain infectious diseases is an example of a regulatory approach to reducing preventable illness and deaths among Black and minority children.

Where individual behavior cannot be regulated, aggressive health policy changes are needed. Researchers agree that until certain socioeconomic barriers are addressed, the
gap between Black and White health in America will continue to widen. Some of these barriers include low levels of formal education, low income, and fragmented political structures in Black communities. An example of a health policy issue might be discouraging alcohol and tobacco companies that target Black communities with aggressive marketing campaigns.

Other efforts to reduce deaths in Black communities are church-based. Communication networks within churches are often tapped to inform people of a health service and to encourage education and screening activities. Church volunteers are trained to take blood pressure and refer individuals with elevated levels to appropriate health-care providers. Usually the success of organized health education efforts within the church depends on the support of the pastor and church staff.

Current Health Status of Black Seventh-day Adventists

The health status of Black SDAs has been shown to be superior to that of Blacks in the general population. The report of the Secretary’s Task Force on Black and Minority Health indicates that deaths related to chemical dependency are priority areas for prevention, treatment, and education. The church’s proscription of alcohol and other harmful substances places church members who follow the principles of healthful living at low risk of death from cirrhosis of the liver, drug overdose, and respiratory diseases such as emphysema.

However, more study needs to be done in this area. Inadequate documentation often leads to generalized, one-time programs that lack the background necessary to meet specific health needs. The lack of documentation also makes it difficult to justify and evaluate programs, because there is no baseline from which to assess change. Following are summaries of major studies on the health of Black SDAs in North America.

The influence of lifestyle on longevity among Black Seventh-day Adventists in California. In a doctoral dissertation on the influence of lifestyle on longevity among Black Seventh-day Adventists in California, Dr. Dale Sumburru studied: (1) data from the 1976 Adventist Health Study; (2) data tapes from the National Center for Health Statistics’ 1979 Wave I of the National Survey of Personal Health Practices and Consequences; and (3) a 1973 study of Black Adventists and Black non-Adventists in Alameda County, California.

Results of Sumburru’s analysis showed some fundamental differences between Black Adventists and Blacks in the general population: (1) Black Adventists tend to be more educated than Blacks in the general population; (2) rates of church attendance tend to be similar in both groups; and (3) Black SDAs sleep fewer hours per night and visit doctors less frequently than other Blacks in the U.S.

When Sumburru compared mortality differences in Black and White Adventists, it was noted that the Black Adventist community includes more converts than the White Adventist community. The negative effects of lifestyle habits developed before conversion to the SDA lifestyle may help to explain excess mortality among Black SDAs. The study also examines various lifestyle practices such as beef, vegetable, and coffee consumption, exercise habits, and obesity with risk of mortality.

Vegatarianism, blood pressure, and physical activity. Dr. Chris Melby, a graduate of the Loma Linda School of Public Health, hypothesizes that Black Adventist vegetarians who exercise regularly have the secret of better health for minority groups in America. According to Dr. Melby, a plant-based diet could enhance prevention and treatment of hypertension and cardiovascular diseases in Black adults despite their greater susceptibility to hypertension.

To examine this hypothesis, he studied a group of Black Adventist vegetarians and compared them to a group of Black Adventist nonvegetarians. He also sampled groups of White vegetarians and White nonvegetarians from the same geographical area in the United States. Using a comprehensive questionnaire, the research team was able to access nutrient intake.

Dr. Melby’s study showed that Black SDA vegetarians exhibited significantly lower systolic blood pressure than Black SDA nonvegetarians, even when age and gender were taken into account. However, the systolic and diastolic blood pressures of Black vegetarians were still higher than the blood pressures of both White SDA vegetarians and White SDA nonvegetarians. Forty-four percent of Black nonvegetarians were hypertensives, compared to only 18 percent of the Black vegetarians. Compared to White vegetarians, Black vegetarians had a significantly lower average intake of potassium, calcium, vitamin D, and magnesium, all of which are inversely related to normal blood pressure. His study also showed that both White and Black vegetarians had significantly less body fat than nonvegetarians.

Exercising vegetarians have a prevalence of hypertension three times lower than sedentary nonvegetarians. Also, the combination of a vegetarian diet and regular exercise is associated with a lower risk of hypertension than either of these factors alone. Dr. Melby found that Blacks reporting at least two sessions per week of leisure-time physical activity exhibited significantly lower blood pressure than those who were sedentary. These results indicate a clear need for further research of the health status of Black SDA members.

Causes of death for Black Adventists in Atlanta. In a pilot study of the mortality profile of Black Seventh-day Adventists residing in Atlanta, Georgia, researchers gathered death certificates of Black SDAs. Seventy-seven percent of the 110 deaths that occurred between 1980 and 1987 were from cardiovascular diseases, and 8 percent were from cancer. The
study raised two important questions for future research:

1. Could the lower cancer rate be explained by the members’ abstinence from tobacco and alcohol and a low-fat vegetarian diet?

2. Was the high proportion of cardiovascular disease deaths among this group a result of the large number of elderly persons in the study group, or could the results be explained by differences in dietary practices?

A pilot study of Black Adventists in California. Because Adventists in California share a number of desirable research characteristics, the National Cancer Institute of the National Institutes of Health has been funding research on health-related outcomes of the SDA lifestyle since 1958. The Adventist Health Study, conducted by researchers at Loma Linda University under the leadership of Gary E. Fraser, M.D., Ph.D., has included Black SDAs in California in every phase. Approximately 10 percent of Adventists in the earlier studies were Black.

The next phase of the Adventist Health Study will include approximately 10,000 Black church members, 20 percent of the total number of Adventists in the upcoming study. The first part of this study will fund the development of a valid, reliable tool for measuring certain dietary, exercise, and other lifestyle practices among Black SDAs in California. Researchers randomly selected members from 30 Black churches in the Pacific Union to participate in this initial phase. It is hoped that a subsequent large study of cancer and other chronic diseases in California SDAs will follow. The study hypothesis will associate diet, exercise habits, psychosocial and demographic attributes, obesity, and medical history with cancer and other chronic diseases.

Activities Promoting Health in Black Adventists

In spite of the dearth of reliable health data on Black SDAs, many Black SDA pastors and church members are involved in educating their churches and communities about healthful living. In this section is a sampling of available health promotion and disease prevention programs.

Blacks in the Washington, D.C., area have access to Dr. Samuel DeShay’s PLUS 15 program, a 15-day, medically controlled lifestyle approach to the treatment of high blood pressure and high blood cholesterol, without the use of drugs. Built on health principles gleaned from the Bible and the Spirit of Prophecy, PLUS 15 has benefited thousands since it began in 1985. In 1990 a book was published with the same title. Plans include the sale of PLUS 15 franchises nationwide.

According to Joy Peterson, a registered dietitian, recent studies show that potassium has a protective effect in the regulation of blood pressure. The recommended daily allowance of potassium is approximately 4,000 milligrams per day. However, the average American consumes about 2,500 milligrams of potassium per day. Dr. DeShay has observed that Blacks who experience a severe type of hypertension consume as little as 1,600 milligrams of potassium a day.

Fast foods and foods that are high in fat do not provide as much potassium as we need, according to Peterson. As Americans consume greater quantities of fast foods, convenience foods, and foods that are high in fat, we can expect an increase in high blood pressure and other cardiovascular problems. Nutritionists are recommending an increase in consumption of baked potatoes, broccoli, and other dark, leafy green and yellow vegetables, as well as bananas, apples, figs, strawberries, legumes, and other fruits as good sources of potassium.

The link between diet and disease has been identified through numerous epidemiological studies of populations throughout the world. An estimated 10-70 percent of all cancers are related to dietary factors. To understand more about the relationship between diet and cancer, the National Cancer Institute has awarded grants to nine recipients nationwide. NCI’s 5-a-Day program is designed to promote the increased intake of fruits and vegetables.

Differences in age-adjusted rates for cancer in African-American and White North Carolinians led to a decision to target this population with a 5-a-Day program. A consortium proposed to use the Black churches in the affected counties as channels to reach the African-American population with a program to increase awareness of the diet-cancer link. The research project, Black Churches United for Better Health, recommends five servings of fruits and vegetables a day. Dr. Bethany Jackson, a Black SDA at the University of North Carolina, plays a key role in this important study.

The Seventh-Day Diet, a resource book coauthored by Chris Rucker, a Black SDA health educator, and Jan Hoffman, contains practical ways to live healthfully and happily and includes numerous recipes for healthful foods. Physician and writer Donna Willis serves as a medical news editor for NBC’s Today. Many SDA health and temperance leaders have ongoing projects to assist members and their communities.

Recommendations to Improve Health in the Twenty-first Century

Establishment of networks of Adventist health professionals. It is recommended that networks of Adventist health professionals be formed in metropolitan areas nationwide. Health training and certification would be a primary focus of these networks.

One disturbing reality about health education in the Black Adventist organization is that we no longer have a strong health and temperance system, and that lack of emphasis has had negative results. For example, even though we claim that only about 10 percent of our church members use alcohol, when this is stratified according to age, it be-
comes alarming. Statistics from the Institute of Alcoholism and Drug Dependency at Andrews University show that approximately 25 percent of members who are under the age of 25 use alcohol.31

As we compete with the media for our youths’ attention, the voices of our health and temperance leaders are becoming more and more silent. Two of the nine unions in the North American Division are without health and temperance departments and directors. Many of the conferences have no health directors, and those conferences that have directors sometimes require that they have many other roles, thus limiting the amount of attention that can be given to this area of responsibility. A survey of health and temperance directors showed that most have difficulty putting in five hours a week on purely health-related work.

Our colleges and other institutions could benefit by forming links with our churches. The colleges usually have behavioral science, nutrition, and other departments that would make good alliances for creating networks of Adventist health professionals. Churches are being forced into a partnership with the divine. As we compete with the media for our youths’ attention, the voices of our health and temperance leaders are becoming more and more silent. Two of the nine unions in the North American Division are without health and temperance departments and directors. Many of the conferences have no health directors, and those conferences that have directors sometimes require that they have many other roles, thus limiting the amount of attention that can be given to this area of responsibility. A survey of health and temperance directors showed that most have difficulty putting in five hours a week on purely health-related work.

Therefore, we recommend a resurgence of involvement and interest in such activities as yearly temperance oratorical contests held on the elementary, junior high, high school, and college levels. Vegetarianism and other health concepts should be among the topics addressed by students. Also, health and temperance departments should be strengthened in every regional conference of the North American Division, and partnerships may be formed among the church’s institutions.

Outreach activities. Many Black Americans deal daily with prejudice, stress, undesirable living quarters, domestic conflict, violence, and general unhappiness. Life’s burdens can seem overwhelming. Prayerful, person-to-person outreach activities—such as demonstrations of simple food preparation and natural remedies, health fairs with planned follow-up activities, and small group studies of the Bible’s wholistic health principles—can bring hope to the troubled and burdened. Church members, neighbors, coworkers, and friends can benefit from spreading health-related messages of hope.

An often-cited study by Lester Breslow and colleagues at the University of California at Los Angeles showed that one of the most significant indicators of good health is a person’s attitude. In summary, it is not just what we put into our mouths that affects our health; it’s also what we put into our minds. Outreach activities could focus the mind on building a positive outlook through improved health habits.

Recommendations for Individuals

Preparation. The first phase in making changes in an individual’s personal health, the “preparation” phase, is perhaps the most challenging and the most rewarding. First, find a quiet place with as few distractions as possible and pray for the courage to confront whatever challenge or health problem that you are facing. Make an honest appraisal and admission. Say: “This weight, or craving, or food obsession, or unhealthy relationship, is out of my control. In this area of my life, all my willpower and resolve have proved ineffective and left me disheartened from failed attempts.”

Preparation is letting go of the tendency to do things our way. It is “giving in.” Ellen White put it this way: “The Lord can do nothing toward the recovery of man until, convinced of his own weakness, and stripped of all self-sufficiency, he yields himself to the control of God. Then he can receive the gift that God is waiting to bestow. From the soul that feels his need, nothing is withheld. He has unrestricted access to Him in whom all fullness dwells.”32

When preparation is accompanied by earnest prayer and self-disclosure to the God who knows our every weakness, we are ready for the second phase, prioritizing.

Prioritizing. The prioritizing phase is one of hope. Preparation may leave us feeling somewhat empty.33 After all, our culture rewards behavior and attitudes that reflect self-reliance and self-confidence.34 However, giving up control of our lives to the power of God does not mean that we cease to take responsibility for our lives and our actions. It means that we set a new goal: to take God at His word and trust Him to guide us in our journey toward optimal health.35 Prioritizing allows us to form the foundation for success. We place our faith in God’s ability to do for us what we cannot do for ourselves. We enter a partnership with the divine.

Ellen White makes two important statements about “perfect health”: “Perfect health depends upon perfect circulation”36 and “In order to have perfect health our hearts must be filled with hope and love and joy.”37 So good health does not refer only to good eating habits.

Personal inventory of health habits. The third phase involves taking an inventory of our health habits. In the context of His love and acceptance of us, we can begin to access our current health status through dietary evaluation, blood pressure and/or cholesterol screening, lung function, physical fitness testing, or an inventory of lifestyle stressors (under the care of a health professional). Sometimes this assessment is just what is needed to motivate one to positive health behavior change.

Christian professionals in psychology and other helping professions provide a valuable resource in assessing one’s current state of health affairs, especially in regard to psychological issues that may underlie a health problem. For example, the problem of being overweight is often more than just a matter of imbalance between caloric intake and energy expenditure. A counselor may assist individuals in
determining whether overeating results from associating food with comfort or is a stress-management technique, then help the individual find alternative ways of obtaining comfort or managing stress.

Planning. Actual successful change occurs over time, one behavior at a time, often including relapses. Thus the “planning” phase might include arranging rewards as incentives for the desired behavior changes. For example, some people promise themselves a weekend vacation if they accomplish a certain health goal within a certain time frame.

Planning may also mean adding the desired changes to your daily schedule. Making space for your new behavior in everyday activities helps validate your choice to succeed. Writing down advantages and disadvantages of the desired behavior works well for some people. Organizing a network of supportive family members, coworkers, friends, and neighbors is a strategy that has proved effective in behavior change. A phone call to a support person at the time of a crisis can make a big difference. Careful observance of these phases, with prayerful dependence on God, can help us to achieve our health goals.

Conclusion

In the past few years leading medical and scientific authorities have noted a difference between the occurrence of disability and death among Adventists and their cohorts in the general population. Adventists have lower risk of death from certain types of cardiovascular disease and cancers of the stomach, colon, prostate, breast, and lung. The lower risk of death and illness from these diseases has been associated with the avoidance of tobacco, alcohol, and beverages containing caffeine. In addition, approximately 50 percent of all Adventists follow a diet that excludes eating meat.

Some researchers have hypothesized that this lower occurrence of disease and death exists also in Black Adventists, compared to Black Americans in the general population. However, since few studies have compared the health attitudes and practices of Black Adventists to Black non-Adventists, this hypothesis is still unsupported in the scientific literature.

Along with the positive outcomes of the Adventist lifestyle, SDAs have another important reason to follow the health principles outlined in the Bible and the writings of Ellen White. Our major objective should be to allow the Holy Spirit to have full access to our lives through the “avenues to our souls” (the senses governed by the brain). Garrie Williams says it well: “While no one is going to earn his or her way to heaven by drinking six glasses of pure water per day, the lack of proper fluids in the body will cause a deterioration to certain organs and a clouding of the mind that will make it difficult to perceive spiritual things and spiritually dangerous situations.”

As we approach the twenty-first century, Adventist individuals and organizations that are directed by the Holy Spirit have an opportunity to make a profoundly positive difference in the health status of Black Americans. Ellen White writes: “God cannot let His Holy Spirit rest upon those who, while they know how they should eat for health, persist in a course that will enfeeble mind and body.” Much can be accomplished on a personal and organizational level to promote improved health in our communities. May God help us to meet this challenge.

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1 Richard Williams, They Stole It, but You Must Return It (Rochester, N.Y.: Hema Publishing, 1986).
9 White, p. 127
10 Black and Minority Health.
11 Ibid.
14 Black and Minority Health.
18 “Current Trends.”
22 Ibid.
23 Black and Minority Health.
27 D. Sumbururu, “The Influence of Lifestyle on Longevity Among Black Seventh-day Adventists in California.”


P. Mutch et al., Alcohol and Other Drug Use Among College Students (Berrien Springs, Mich.: Institute of Alcoholism and Drug Dependency, 1994).


Friends in Recovery.


Garrie Williams, p. 149.

White, Counsels on Diet and Foods, pp. 55, 56.