THE CENTER FOR AFRICAN-AMERICAN HEALTH

2007 ANNUAL AFRICAN-AMERICAN HEALTH SURVEY REPORT

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The Center for African American Health
Empowering the Community to *Live Well!*

About the Center for African-American Health
The Center for African-American Health is a community-based organization providing disease prevention and disease management programs to African Americans living in the metro Denver area.

Its mission is to improve the health and well-being of African Americans, who have higher rates of illness, disability, and premature death from diseases such as cancer, diabetes and cardiovascular disease. Its vision is an African-American community healthy in mind, body and spirit; filled with individuals taking responsibility for their own health and contributing to the enrichment of the community.

The Center partners with a wide variety of health-education and health-delivery organizations to provide culturally-appropriate disease prevention and disease management programs to thousands of African Americans each year.

SURVEY METHODOLOGY

From January-June 2007, the Center for African-American Health conducted its annual health survey with its Faith and Health Ministries' (FHM) partners in the metropolitan Denver area. The Faith and Health Ministries' program is a collaboration of over 75 black churches committed to improving the health and wellbeing of the African-American community. This collaborative has successfully implemented a matrix of health initiatives in metropolitan Denver that have been instrumental in addressing health disparities through community partnerships.

The survey instrument was developed by the Center's Director of Research and Evaluation with the assistance of Center staff and FHM partners. The major categories of inquiry were cardiovascular disease, health literacy and communication, diabetes, depression, physical activity/nutrition, and general health behaviors. The demographic and cardiovascular disease (CVD) knowledge questions used are subsets of the 2003 Behavioral Risk Factor Surveillance Survey (BRFSS). The CVD questions were specifically inserted as part of a Center CVD awareness and education strategy.

Two thousand two hundred and ninety-eight (2,298) surveys were distributed among 33 churches. A convenience sample of 1,642 respondents resulted in a 71% response rate. Over 70 FHM health liaisons were invited to participate by distributing, collecting and managing incentives -- a one-dollar commemorative coin. The liaisons were provided with a predetermined number of surveys and one-dollar coins (based on church size), and surveys and coins that were not distributed were returned to the Center, allowing for the monitoring of survey distribution and collection. Survey progress was monitored and tracked by the Center's Health Literacy Coordinator. Surveys for each church were similarly coded and no other identifiable information was included. Ethnicity of the survey sample is shown in Figure 1.

Figure 1

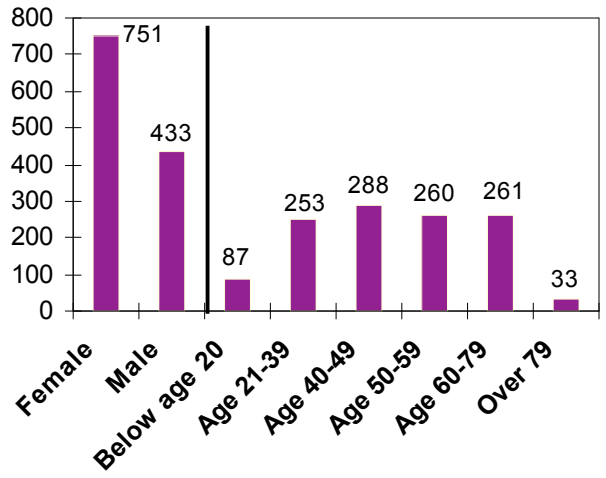
Ethnicity	%	*n*
African American	86	1188
Asian	1	20
Latino	3	36
Native American	5	69
Caucasian	3	48
Other	2	30
Missing		251

African-American Survey Respondents

Survey respondents were 86% African American and 14% from other ethnic or racial groups, (Figure 1). However, the Center for African-American Health is an institution that is primarily focused on "improving the health and well being of the African-American community." Therefore, this report is a discussion of the responses of African Americans to the survey.

One thousand eleven hundred and eighty-eight (1,188) African Americans responded to the survey, resulting in a 52% response rate for this group. This constitutes the largest query of African Americans of its kind in Colorado. Historically, participation in the Center's surveys has been vastly dominated by females; however, more African-American men participated in the 2007 survey than previous surveys (37%, n=433). Figure 2 illustrates age and gender comparisons. The survey resulted in a lower number of missing data elements, given the number of participants, resulting in increased data reliability.

Figure 2. 2007 Annual Survey Demographics
Number of African Americans by Gender and Age



Four participants did not indicate their gender on the survey
Six participants did not indicate their age on the survey

Focus Groups

The Center for African-American Health convened a number of community groups to gather reactions and reflections regarding data resulting from the survey. Two focus groups consisted solely of survey participants. One group had 11 participants and the other had nine. All participants had no prior exposure to the data results. The presentation of the survey results was hosted and facilitated for the community groups by the Center for African-American Health on October 23 and 24, 2007. The Director of Research and Evaluation and Health Literacy Outreach Coordinator facilitated these groups utilizing the Focused Conversation Method (The Institute of Cultural Affairs, 1991, 1994, 1996, 2000). This method was employed to elicit responses to interpretative questions such as, "What is the importance of this?", "What would you say lies underneath these issues?", "What other things do we need to consider?", and decisional questions—"What are these themes really about?", "Tell a story about what this is about.", "What does this mean to have experienced this?", and "How would you articulate our consensus?" Reflective and objective questions were used as well.

Another forum comprised of FHM health liaisons was hosted and facilitated by the Center for African-American Health on October 27, 2007. There were 28 health liaisons in attendance, with two or three having no prior exposure to the annual survey report data. Once again, the Focused Conversation Method was utilized.

PURPOSE

It may not be widely known that the extent of health disparities for African Americans in Colorado has taken on epidemic proportions. While Colorado is considered one of the healthiest states in America, this is not the case for its communities of color, African Americans in particular. Colorado health statistics substantiate that African Americans have the highest death rate from cancer overall of any ethnic group. The African-American rate of death from specific cancers in Colorado is much greater than the state average for: prostate cancer (2x); colorectal cancer (1.5x); and breast and lung cancer (1.3x). Other health disparities include higher rates of diabetes, cerebrovascular disease, kidney disease and infant mortality. These persistent health inequities take on additional significance when the African-American population in Colorado is compared to whites. Barriers to eliminating these disparities in health care among African Americans in Colorado continue even as African Americans increasingly take charge of their health problems through networks such as the Center for African-American Health.

There are numerous reasons why certain groups, particularly African Americans, receive less than the standard of care and are "sicker than most and dying sooner than they should." (Jo Ann Pegues, personal interview, June 2006). Some of these factors include access to adequate affordable health services (including the rising cost of health insurance), institutional barriers that prevent access to services (such as political policy), environmental factors, education, health literacy, social and economic status, genetics and personal behaviors that contribute to negative health outcomes, social and cultural considerations, and racial discrimination.

Another factor that may contribute to the disproportionate rates of negative health outcomes for African Americans could be the lack of representation from this group in the health delivery professions, including the administrators of health delivery institutions. African-American physicians and other Black health care professionals are underrepresented and rarely enter into medical fields in Colorado. Three percent of all physicians in the United States are African American; a fact that has not changed in over 50 years. Moreover, the number of Blacks entering into medical school has declined. These and other factors have a negative impact on health outcomes for people of color when taken together with the dearth of cultural competence, language barriers, and conscious or unconscious bias by health delivery, public health, and other institutions.

Cultural/social beliefs also may play a role in negative health related outcomes for African Americans in Denver. The Center's 2007 annual survey endeavored to learn if there may be socio-cultural considerations, myths and other 'folk-ways' beliefs or lack of knowledge and education that may contribute to negative health outcomes.

RESULTS/ANALYSIS

Survey collection was terminated in June 2007. Results were numerically coded and entered into Microsoft Excel and converted with the SAS statistical analysis software system from which frequencies and cross tabulations were computed for analysis. Chi square and *t* tests were calculated to compare gender and age differences.

Health Insurance/Health Care Provider

While the vast majority of African Americans surveyed report having health care coverage through private insurance or public programs, 15% do not have coverage, and an additional four percent aren't sure. This finding is consistent with data from the Colorado Health Institute, and others, which show the uninsured rate for African Americans at about 15%. However, the Center's survey analysis uncovers a significantly higher percentage of African-American men than women who report having no health coverage, (Figure 3).

Figure 3

Do you have any kind of health care coverage?

	Yes	No	Don't know/Not sure
Total	81% (n=958)	15% (n=179)	4% (n=44)
Women	84% (n=627)	13% (n=94)	3% (n=26)
Men	76% (n=328)	20% (n=84)	4% (n=18)

The survey also asked African Americans if they have someone they think of as their health care provider. Seventy percent say they have one (or more) persons they think of as their health care provider, but 28% of African Americans surveyed **do not**.

Figure 4

Do you have one person you think of as your health care provider?

Yes, only one	Yes, more than one	No	Don't know/Not sure
53% (n=624)	17% (n=201)	28% (n=330)	2% (n=22)

Cardiovascular Disease

Cardiovascular disease (CVD) is the leading cause of death for all populations in Colorado and in the United States, but its impact is even greater for minorities. The heart disease death rate among Black men, for example, was 29 percent higher than for white men and 55 percent higher for Black women in 2002, according to the Centers for Disease Control and Prevention (CDC). However, white patients are more likely to receive screening and treatment for cardiac risk factors than are Blacks. While CVD disparities for African Americans in Colorado are substantial, the lack of education and awareness regarding the symptoms of CVD may contribute to the phenomena.

The Center's 2007 annual survey included the knowledge questions from the 2003 Behavioral Risk Factor Surveillance Survey (BRFSS), Figure 5.

Figure 5

Stroke & heart attack knowledge questions

Discomfort in the jaw, neck or back are symptoms of a heart attack?
Discomfort in the arms or shoulder (are symptoms of a heart attack?)
Sudden trouble walking, dizziness, or loss of balance (are symptoms of a stroke?)
Severe headache with no known cause (is a symptom stroke?)

Survey results expose CVD education and awareness as points of serious concern. Twenty-eight percent answer all of the CVD knowledge questions incorrectly and 60% are either unsure, answered no, or did not answer cardiovascular disease question number four, "Do you think severe headache with no known cause is a symptom of a stroke?"

Survey results suggest that African-American women are more knowledgeable about CVD symptoms than African-American men. Gender comparison (cross tabulations) shows statistical significance for African-American females having more CVD knowledge than African-American males. This finding could result in clinical significance when determining the level of CVD education needed for newly diagnosed African-American men. A randomized control study could confirm this observation. Figure 6 illustrates the general results of the CVD query. The Center is formulating a CVD intervention aimed at bringing additional education, awareness and chronic disease self-management to the community.

Figure 6

Response to Stroke & Heart Attack Knowledge Questions				
% of all Respondents	Female % Correct	Male % Correct	All Respondents Under age 50 % Correct	All Respondents Over age 50 % Correct
28% had 0 Correct	25	31	25	29
15% had 1 Correct	16	14	19	11
20% had 2 Correct	20	21	21	20
18% had 3 Correct	19	17	18	18
20% had 4 Correct	21	18	18	22

Diabetes

There continues to be a serious disparity in health care and outcomes for African Americans living with diabetes. The Center has learned through its Focus on Diabetes self-management initiative that most program participants with diabetes have limited or no follow up with their health care provider. Myths about diabetes abound in the African-American community and continue to be a major threat to health related quality of life. We believe progress has been made; however, much more work needs to be done.

For example, while 80% of survey participants respond correctly that diabetics who are not having problems still cannot eat any and all the foods they want, 30% incorrectly indicate that diabetes can be cured, and another 25% are not sure. Twenty percent do not know what pre-diabetes is and 40% indicate they are not aware what pre-diabetes is.

Focus group participants debated the difference between controlling diabetes and curing diabetes. Their positions on either side of the debate were due to either personal experience or other health education. Some of these positions include: that faith can cure diabetes; holistic approaches or vitamins can cure diabetes; or diabetes

has no effect on one's life. There is also confusion over terminology such as pre-diabetes and borderline diabetes. Figure 7 sums up the results of the diabetes inquiry.

Figure 7

Diabetes	Strongly/ Somewhat Agree	Strongly/ Somewhat Disagree	Unsure
A person is pre-diabetic when their blood sugar level is high but not high enough to be diagnosed w/diabetes.	40% (n=461)	20% (n=232)	40% (n=467)
If a person is not feeling bad, then diabetes is not a big problem.	8% (n=89)	74% (n=857)	19% (n=216)
Diabetics who are having no symptoms can eat any and all the foods they want.	8% (n=94)	80% (n=935)	12% (n=142)
Diabetes can be cured.	30% (n=345)	46% (n=526)	25% (n=285)

The Center for African American Health will continue to address diabetes and the myths about it through self-management programs and other educational outreach activities.

Depression

Many African Americans fear the stigma of mental illness and this may prevent them from seeking treatment. There is a tendency among African Americans to minimize the significance of stress and to rely on their ability to prevail in the face of adversity. There also is a perception that African Americans tend to deny the threat of mental illness and strive to overcome mental health problems through self-reliance and determination. Some argue that African Americans are misdiagnosed, overmedicated and excluded from quality mental health treatment. This may be due to a tendency to seek treatment late in their illness or to a failure to communicate all of their mental health issues.

There seems to be an omission of at least three essential factors when the issue of mental health treatment for Blacks is evaluated. They are:

1. Does the stigma of mental illness keep many Blacks from seeking treatment (the label of being 'crazy')?
2. Blacks may be unwilling to burden their families with their mental health issues or treatments (emotional and financial).
3. Does seeking mental health treatment equate to more baggage on top of all the other stress living in America places on the African-American psyche?

These three factors may play a role in why Blacks may be reluctant to take advantage of mental health services.

Figure 8 shows the responses to the survey questions about depression. A large majority of survey participants (85%) agree that seeking mental health counseling is not a sign of weakness. However, 64% also indicate that depression is something many Blacks do not care to talk about. The cause of this apparent contradiction may not be obvious. Is discussing mental health or depression a cultural taboo, as many would suspect, or is it a cultural artifact of African American's dependence upon self-reliance and determination? Could it be both? In any case, stigma, misguided allegiances to coping mechanisms that work against African Americans' successful mental health outcomes, as well as artificial barriers or mismanagement by mental health service providers, must be dealt with.

Figure 8

Depression	Strongly/ Somewhat Agree	Strongly/ Somewhat Disagree	Unsure
Seeking mental health counseling is a sign of weakness.	9% (n=101)	85% (n=992)	6% (n=69)
Being depressed is something many Black folk do not care to talk about.	64% (n=747)	23% (n=273)	12% (n=143)
I would rather have a physical illness rather than a mental illness.	37% (n=422)	35% (n=394)	28% (n=323)

Community focus group participants echoed many sides of the issue regarding African Americans and depression. Some of the comments were: "stigma does exist as a factor in African-American response to depression," "a person's faith is weak if they are overcome by depression," and "many African Americans living with depression should seek treatment for depression."

When discussing faith and depression, some thought depression should be better accepted since biblical figures such as Moses and others were challenged by depression. Some focus group participants felt that the depression issue should be a key focus of ancillary church functions and other outreach. Participants thought that the African-American community should be more supportive to others who may be living with depression.

One focus group discussed an incident involving a young woman who was chronically depressed and committed suicide after three attempts. Some of the group participants had personal knowledge of this situation and believe that the woman could have been saved had there been more social support for her. The overall consensus regarding

depression and the African-American response to it showed that a more holistic approach involving spiritual and professional intervention should be the standard protocol for African Americans seeking success in coping with depression.

Others pointed out that African Americans have a higher tolerance for stress and anxiety due to historical oppression than mainstream American society, citing how many African Americans did not seem to be as negatively impacted mentally by the September 11, 2001 (9/11) attacks.

The Center's depression awareness outreach initiative will continue to dispel myths and rumors about depression, especially as it pertains to African Americans.

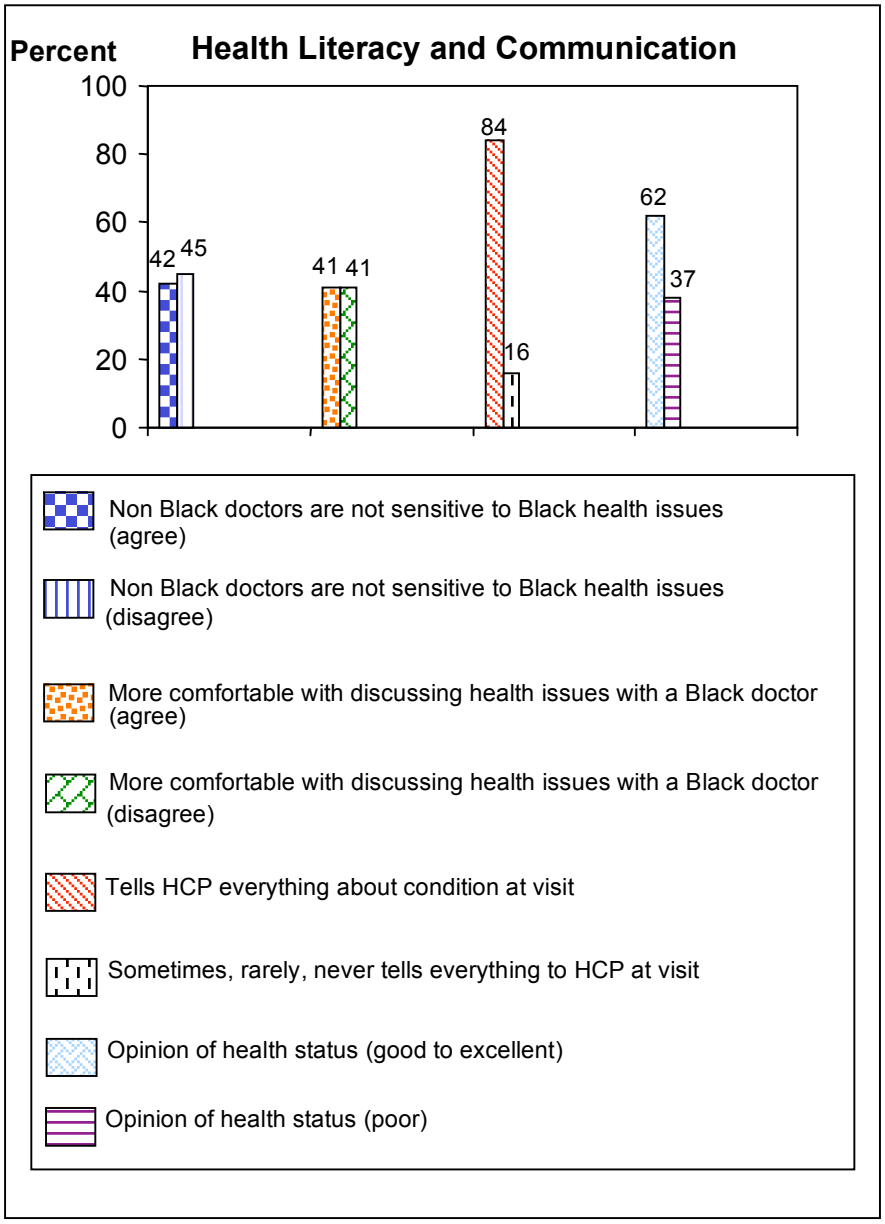
Health Literacy and Communication

In 1993, Kirsch et al (1992) reported on the status of adult literacy in America. Their findings included that approximately 50% of the adult U. S. population function at a reading level of eighth grade or below, and 25% are in the lowest literacy group, functioning at the fifth grade level or below. A recent repeat of the National Adult Literacy Survey, 10 years after the first, unfortunately found no significant improvement. In fact, the results showed that some minority groups were functioning at lower literacy levels (Kutner et al, 2005).

There is continued discussion about the difference between health literacy and educational literacy. Indeed, these differences are arguable. However, some attention must be paid to the 'base elements' of the health literacy/disparity issue, such as communication, trust and dignity, particularly as they relate to health care delivery. For African Americans, these factors go a long way in determining how health care delivery and outcomes play out. Additionally, perhaps health delivery settings could better serve minority and patients of color through a true sense of partnership that would ensure they are better informed about their chronic or other illnesses and the importance (including mechanics) of their treatment plans rather than an expectation to blindly follow 'doctors orders.'

Survey results reveal that there is no difference between the percentages of those who would be more comfortable discussing their health issues with a Black doctor (41%) than not (41%). However, participants under age 50 indicate they are more comfortable with discussing health concerns with a Black doctor than survey participants over age 50 (p value, .0012). Survey participants also are divided on whether or not physicians who are not African American are insensitive to Black health issues (42% agree v. 45 % disagree). Eighty-four percent of respondents report that they tell their health care provider everything about their condition at their doctor's visit.

Figure 9



Access to health care and discussion of health concerns with a physician, however, may not be enough to ensure overall better health and well being. As one observer of the 2007 survey results indicated, "Just because you tell your provider everything, it still does not mean you will get the treatment you need." For example, there are a number of chronic illnesses where the physician has relatively little impact. Diabetes still leads to heart problems and patients still feel poorly on dialysis. The real benefit is in early detection or even prevention; a physician can only do so much once the disease is advanced enough to cause major complications.

In Focused Conversation groups among survey participants, some felt that patients may not be clearly articulating their complaint or simply are not being honest with their doctor. One focus group participant, who is a well known African-American physician in Denver, discussed experiences where the male patient's spouse would come with the patient to the visit because the husband would not truthfully or fully disclose their complaint or situation.

Other focus group discussions revealed that patients are intimidated by doctors. While they indeed believe they should have the right to quality health care without enmity, the consensus was that there ultimately exist a prevailing sense of hostility from health care providers and administrative staff. Solutions to these phenomena might include relationship building on the part of the patient and health care provider or terminating the relationship with the hostile environment and seeking better health care conditions.

It is also worth noting that focus groups participants held the belief that quality health care, even with full access to care, is elusive for African Americans. This underscores the importance of health literacy interventions as many African Americans are not accustomed to quality health care and may not be aware when quality health care is not offered to them. For example, the most widely used prostate cancer screening 'guidelines' recommend screening for African-American men at age 50, in spite of the well documented clinical facts that clearly show African-American men present prostate cancer as early as age 35 with a family history of prostate cancer and at age 40 without a history of prostate cancer.

Perhaps social support could help African Americans live healthier lives. Fifty-two percent feel it would be helpful to have a close friend or family member assist them with following the treatment plan prescribed by their physician. African-American men indicated a statistically significant (.0001) higher appreciation for accepting assistance with their medical treatment plans than Black women who took the survey. Additionally, 58% of respondents feel they would exercise and eat better if everyone in the family participated. The need for social support outreach is clear. The Center is currently formulating a telephone social support outreach activity as a follow-up to its highly successful Focus on Diabetes self-management program. Other social support outreach may be incorporated into the Center's future interventions.

Physical Activity and Nutrition

It is widely known that successful health outcomes, including reversal of negative chronic health trends, are linked to physical activity and nutrition. With the exception of affordable nutritious foods, physical activity could be the most cost effective method to improve personal health outcomes. Many African Americans over the age of 35 may not be physically active due to their busy lifestyles. As noted above, survey participants indicate that they would exercise and eat more nutritious foods if all their family participated. They understand that a person should get physical activity even when they are compliant with taking their medications (88%). While the need for social support seems evident as a stimulus for African-Americans' increased physical activity, nutrition and medical treatment plan compliance, the fact is that everyone should be encouraged to eat healthy food, participate in regular physical activity and comply with medical treatment plans (not just the person who needs it the most) so that everyone will reduce their risk of chronic illness.

Survey results indicate no real consensus around the question of African-American women getting more physical activity if it did not result in hair grooming issues. However, when the issue was raised in focus group discussions, a spirited conversation ensued and two camps emerged. According to cross tabulations by age and gender; women over age 50 believe that the issue of hair as it pertains to aesthetics should not be critical to women who desire to be physically active. This was also evident in group discussions. Women under age 50 tend to support both physical activity and aesthetics as crucial to the decision to be physically active.

Thirty-nine percent of survey respondents state their belief that physical activity for African-American women would increase if there were fewer hair grooming issues to contend with and 42% believe it is not likely physical activity would increase if there were fewer hair grooming issues. Figure 10 shows these data.

Figure 10

Physical Activity and Nutrition	**Very likely or Somewhat likely**	**Not very likely or Not at all likely**	**Unsure**
I would exercise and eat better foods if all my family participated	58% (n=666)	32% (n=364)	10% (n=118)
Black women would probably get more exercise if it did not 'mess' up their hair	39% (n=455)	42% (n=485)	19% (n=215)
People who take their medicines do not need to work-out	**Strongly Agree or Somewhat Agree**	**Somewhat Disagree or Strongly Disagree**	**Unsure**
	6% (n=125)	88% (n=1013)	6% (n=68)

For African-American women, physical activity often conflicts with several factors, including the time and cost to personally groom or pay for professional hair care services. Societal and cultural norms bring pressure upon African-American women to keep their hair looking in *perfect* condition. Unfortunately, the styles that are easily maintained and convenient for exercise, such as *the natural* or *braiding*, are not always accepted in the workplace. The significance of hair maintenance and other barriers such as child care, work schedule, cost and availability of gym facilities, and transportation may have influence upon Black women's participation in routine exercise. It is important to address these and other cultural and social economic considerations when discussing this issue.

The Center for African-American Health is keenly sensitive to these matters and offers the following thoughts. Hair, in the Christian context, is a "woman's glory" and as such takes on certain importance in terms of care, preservation and treatment because it was once considered a primary source of beauty and object of marital service. While the significance of hair has changed compared to this context, the importance of hair from a biblical perspective has not completely diminished and should be recognized as a critical component in this discussion. On the other hand, some women are balancing the struggle between the need for personal grooming, overall personal presentation and the cost of hair care with the importance of physical activity. These women may tend to employ other options such as 'braiding,' the 'natural look', or investing to maintain the hairstyle of their choice. The Center for African-American Health understands the significance of hair care as it relates to physical activity and encourages Black women to make the additional commitment to physical activity.

General health-seeking behaviors

In this section of the annual survey, participants moved from self disclosure to stating their opinions regarding African Americans' health seeking behaviors. Results of the health seeking behaviors portion of the survey are illustrated in Figure 11.

Health seeking behaviors for many African Americans may appear sporadic. Results from the annual survey suggest that respondents believe that in some cases Blacks may be reluctant to seek treatment because they are afraid to hear bad news (63%), the cost for treatment may be too high (62%), or due to lack of adequate health insurance (65%).

Focus group participants believe that African-American culture may work against optimal health seeking behaviors. The African-American response to seeking treatment for health issues may be driven by a host of reasons, such as mistrust for

health care providers, fear of negative diagnosis, inadequate or no health care coverage and lack of education.

Figure 11

Health seeking behaviors		
Do not want to have medical problems treated because	**% Checked**	**% Not checked**
Afraid to hear the bad news	63 (n=749)	38 (n=436)
Once treatment is started the condition gets worse	16 (n=193)	83 (n=1369)
Medical costs are too high	62 (n=739)	38 (n=446)
No insurance	65 (n=771)	35 (n=414)
Easier to suffer than to hassle with the health care system	21 (n=245)	79 (n=940)
Hope that the illness heals itself or goes away	49 (n=575)	51 (n=610)
Another family member had the same problem so, why bother	22 (n=260)	78 (n=925)
Other	14 (n=162)	86 (n=1023)

DISCUSSION

The 2007 Annual Health Survey is the largest query of African Americans of its kind in Colorado. Its purpose was to learn if there may be socio-cultural considerations, myths and other 'folk-ways' beliefs or lack of knowledge and education that may contribute to negative health outcomes. What we found through analysis of our data, and feedback from discussion groups, the Center's Board of Directors, and other constituents is that there certainly are beliefs and other considerations that may contribute to negative health outcomes for African Americans. For example, some group participants suggest that Black physicians are not as knowledgeable as others physicians and they were apprehensive about discussing their personal health issues with a Black doctor for fear of confidentiality being breached. This is a concern since current trends (such as the Sullivan Commission of 2003) suggest that an increase in the number of well trained African-American physicians would improve the health outcomes for Black patients. Moreover, these assumptions by survey participants suggest even greater need in the area of better communication between African-American patients and their health care providers, regardless of their race/ethnicity. The Center for African- American Health is formulating its Health Literacy Initiative and will include in its curriculum methods that would foster increased trust and cohesion between patient and physician.

We also found that our emphasis in the areas of diabetes self-management, cardiovascular disease, and mental health education and awareness are completely on target. Strengthening these programs and other outreach could help deal a blow against health disparities affecting African Americans in metro Denver. Our survey

results also suggest a need for social support interventions that could improve the Center's outreach results.

Survey Strengths

The Center for African-American Health enjoys a rich tradition of trust and cooperation with the metro Denver African-American church community. This mutual partnership is rooted in the shared belief that the Black church is the preeminent institution for enrichment and change in the African-American community. Many thousands of African-American lives have been touched through joint health initiatives made possible by this spirit of mutual respect and cooperation. However, much more work must be done in order to reverse the negative and disparate health outcomes for Blacks in metro Denver and Colorado. The Center for African-American Health and its Faith and Health Ministries partners are poised to take advantage of additional ways to bring about positive changes in community health outcomes.

Management of the 2007 annual survey resulted in fewer missing data issues resulting in more usable data. Survey participation by African-American males appeared significantly higher than in previous surveys. Efforts to include even more males will include utilizing males to assist in promoting and proctoring future survey efforts.

Sharing survey results with community members proved informative and highly effective. Their qualitative feedback was instrumental and very useful in confirming the survey results and acquiring additional insights into the major issues.

Future plans for the annual survey include controlling for missing data, developing fact sheets extracted from the survey report that would give feedback to the community, and surveying a community sample that is not from the Faith and Health Ministries' partners. We believe these actions will add comparative data, rigor and additional validity to the process. In addition, the Center is interested in determining if there might be questions that our partner institutions would like to include in the next annual survey.

Survey Weaknesses

In several query categories, there did not appear to be a clear consensus. However, both sides of these issues are worth taking note of. The Center continues to formulate interventions relevant to these areas of interest or need in the community.

Some questions need to be reworded to improve clarity.

A minor age adjustment variable was included to exclude individuals from under the age of 18 from taking the survey; however, 87 youths managed to participate.

The ideal random sample method was not possible for our survey. The fact that convenience sampling had to be used may compromise the generalizability of the results. It is possible that data from our FHM constituents may not be representative of Denver area African Americans.