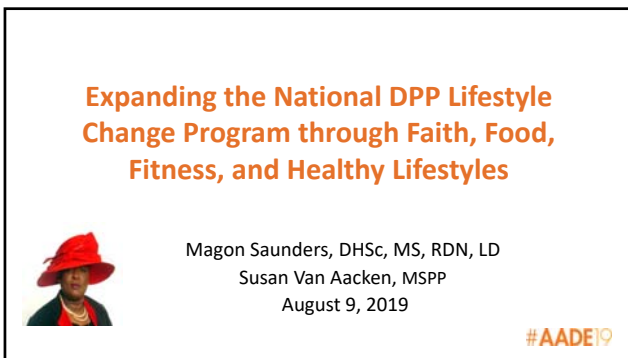
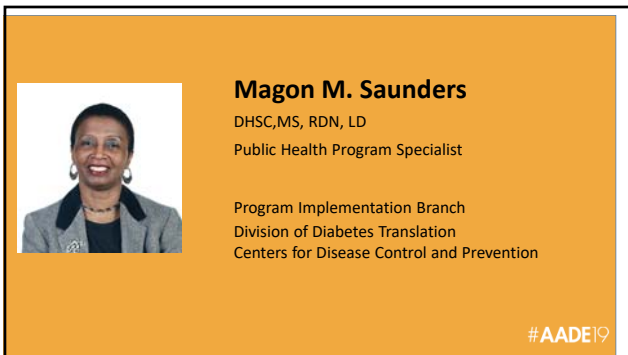



1



2



3



Susan Van Aacken, MSPP
Public Health Advisor

Program Implementation Branch
Division of Diabetes Translation
Centers for Disease Control and Prevention

#AADE19

4

Disclosure to Participants


- Notice of Requirements For Successful Completion
 - Please refer to learning goals and objectives
 - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
- Conflict of Interest (COI) and Financial Relationship Disclosures:
 - Magon M. Saunders, DHSc, MS, RDN,LD – Has No COI/Financial Relationship to disclose
 - Susan Van Aacken, MSPP- Has No COI/Financial Relationship to disclose
- Non-Endorsement of Products:
 - Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products displayed in conjunction with this educational activity
- Off-Label Use:
 - Participants will be notified by speakers of any product used for a purpose other than for which it was approved by the Food and Drug Administration.

#AADE19

5

Disclaimer

The information presented here is for training purposes and reflects the views of the presenters. It does not necessarily represent the official position of the Centers for Disease Control and Prevention.



#AADE19

6

Objectives

- Discuss the burden of diabetes and prediabetes in Americans, but particularly in African Americans.
- Describe the work of CDC-funded organizations working in the faith-based setting.
- Articulate lessons learned in efforts to prevent type 2 diabetes in the faith-based setting.
- Identify resources to support type 2 diabetes prevention activities in faith communities.
- Discuss potential next steps for educators and how to best partner with faith-communities.



#AADE19

7

Icebreaker – Faith and Diabetes!

Today, when it comes to working with faith communities, what's **ROCKING** your world in the diabetes community?



#AADE19

8

Prediabetes and Diabetes: The Current Public Health Challenge

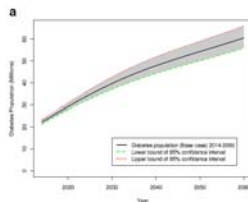


30 million Americans have diabetes

84 million American adults have prediabetes

9 out of 10 adults with prediabetes don't know they have it

Current Projections of U.S. Cases of Diabetes by 2060




Centers for Disease Control and Prevention. National diabetes statistics report: estimates of diabetes and its burden in the United States, 2014. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention, 2014.
 Projections of the future diabetes burden in the United States through 2060. Liu, Theodore J, Thompson, Ying G, Cheng, Weidong, Zhuo, Ping Zhang, Edward Gregg and Odehachi A. Balka. Population Health Metrics (2018) 18:8.

#AADE19

9

Diabetes in African Americans



- In 2017, African Americans made up 14.6% of the U.S. population (Black Demographics, 2019. The African American population. Retrieved from <https://blackdemographics.com/>.)
- African Americans are twice as likely as Whites to have diabetes, and more than 6 million have the disease. (Centers for Disease Control and Prevention. Diabetes Report Card 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2018. Retrieved from <https://www.cdc.gov/diabetes/pdf/data/statistics/national-diabetes-statistics-report.pdf>.)
- One in two African American children born in the year 2000 is predicted to have diabetes. (Gregg, E. W, Zhuo, X, Cheng, YJ, Albright, A.L, Narayan, V. K. M. Thompson, T. (2014). Trends in lifetime risk and years of life lost due to diabetes in the USA, 1985–2011: a modelling study. Retrieved from [https://www.thelancet.com/action/showPdf?pii=S2213-8587\(14\)02703-5](https://www.thelancet.com/action/showPdf?pii=S2213-8587(14)02703-5).)

#AADE19

10

African Americans and Diabetes

Percentage of US Adults Aged 18 or Older with Diagnosed Diabetes, by Racial and Ethnic Group, 2013-2015
2017 Diabetes Report Card

Racial and Ethnic Group	Percentage
American Indian/Alaska Native	15.1%
Asian	8.0%
Hispanic	12.7%
Black, non-Hispanic	12.1%
White, non-Hispanic	7.4%

Centers for Disease Control and Prevention. Diabetes Report Card 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2018. Retrieved from <https://www.cdc.gov/diabetes/pdf/data/statistics/national-diabetes-statistics-report-2017-2018.pdf>

#AADE19

11

Other African American Health Data

- The death rate for African Americans decreased by 25% from 1999 to 2015.
- But, African Americans ages 18-49 are 2 times as likely to die from heart disease than Whites.
- African Americans ages 35-64 years are 50% more likely to have high blood pressure than Whites.
- Young African Americans are living with diseases more common at older ages, such as diabetes, stroke, and high blood pressure.

Source: Centers for Disease Control and Prevention (2017). African American health: Creating equal opportunities for health. Retrieved from <https://www.cdc.gov/vitalsigns/aahealth/index.html>.

#AADE19

12

Other Health-related Considerations

- African American women have the highest rates of being overweight or obese compared to other groups in the U.S. In some instances, this is culturally acceptable. (U.S Department of Health and Human Services, Office of Minority Health, 2017. Obesity and African Americans. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25>)
- About four out of five African American women are overweight or obese. (U.S Department of Health and Human Services, Office of Minority Health, 2017. Obesity and African Americans. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25>)
- Religiosity may reduce the risk for obesity in African American women. (Dodor, Robinson, Watson, et al. 2017)
- African American women have an emotional dedication to the symbolism of food derived from traditional cultural food practices passed down from generation to generation. (Sumlin & Brown 2017)
- Tailored and culturally adapted programs can be beneficial in helping African Americans implement strategies to prevent type 2 diabetes.



13

What Might be the Role of Allostatic Load in Diseases that African Americans Face?

Stress, Environment, etc.



14

What is Allostatic Load?

- The allostatic load is the “wear and tear” on the body which grows over time when the individual is exposed to repeated or chronic stress.
- It represents the physiological consequences of chronic exposure to fluctuating or heightened neural or neuroendocrine response that results from repeated or chronic stress.
- The term was coined by McEwen and Stellar in 1993.

Source: McEwen, B.S. & Stellar, E. (1993). Stress and the individual. Mechanisms leading to disease. Archives of Internal Medicine. 153:2093-2101.



15

Allostatic Load and Health in African Americans

- African American women have a disproportionately higher risk of cardiovascular disease than White women, which may be explained by the uniquely higher allostatic load found in African American women.
- Participation in faith-based activities can reduce allostatic load.
- A significant reduction in allostatic load was also found after participation in a lifestyle intervention.
- More research is needed to determine how lifestyle behaviors and socioeconomic factors influence African American women.

Tomfohr, L. M., Pung, M. A., & Dimadale, J. E. (2016). Mediators of the relationship between race and allostatic load in African and White Americans. *Health Psychology, 35*(4), 322-330. <http://dx.doi.org/10.1037/psw0000024>



16

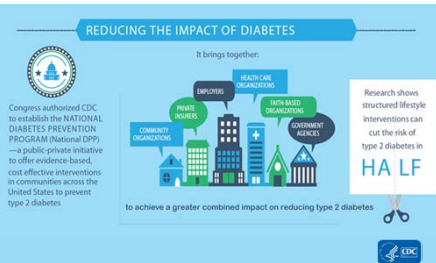
An Overview of the National Diabetes Prevention Program



17

National Diabetes Prevention Program


Largest national effort to mobilize and bring an evidence-based lifestyle change program to communities across the country!




18

Overview of the National Diabetes Prevention Program


The National DPP relies upon a variety of public-private partnerships with community organizations, private and public insurers, employers, health care organizations, faith-based organizations, government agencies, and others working together to:




Build a workforce that can implement the lifestyle change program effectively



Ensure quality and standardized reporting



Deliver the lifestyle change program through organizations nationwide



Increase referrals to and participation in the lifestyle change program

<https://www.cdc.gov/diabetes/prevention/index.html>

19

The National DPP Lifestyle Change Program

Program Start

1-6

Weekly Sessions
(16 minimum)

7-12

Monthly Sessions
(6 minimum)

Program End

PROGRAM GOAL: Help participants make lasting behavior changes such as eating healthier, increasing physical activity, and improving problem-solving skills

Example modules covered in core curriculum:

- Eat Well to Prevent T2
- Burn More Calories Than You Take In
- Manage Stress
- Keep Your Heart Healthy

Sessions facilitated by a trained lifestyle coach

PARTICIPANT GOAL: Lose 5 – 7% of body weight


#AADE19

20

CDC Recognition


Recognition involves... assuring quality by developing and maintaining a registry of organizations recognized by CDC's Diabetes Prevention Recognition Program for their ability to achieve the outcomes proven to prevent or delay onset of type 2 diabetes

Key Activities




National Quality Standards

- DPRP Standards and Operating Procedures (Updated every 3 years)



Registry of Organizations

- Online registry and program locator map



Data Systems

- Data analysis and reporting
- Feedback/technical assistance for CDC-recognized organizations

#AADE19

21

CDC Investments in the National DPP

1705

Scaling the National Diabetes Prevention Program in Underserved Areas through multi-state networks

1815

Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke

1817

Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes and Heart Disease and Stroke

#AADE19

22

DP17-1705 Cooperative Agreement: Scale and Sustain the National DPP in Underserved Areas

Background

1705 funds 10 national organizations to start new CDC-recognized organizations in underserved areas and in at least three states.

Recipients will reach and enroll at least 1,000 participants in the first year, with continued growth in years 2-5.

Recipients will work with the general population and Medicare beneficiaries and also serve one or more of following priority populations.

Priority Populations

- Men
- African-Americans
- Alaska Natives
- American Indians

- Asian-Americans
- Hispanics
- Pacific Islanders

- People with visual impairments or physical disabilities

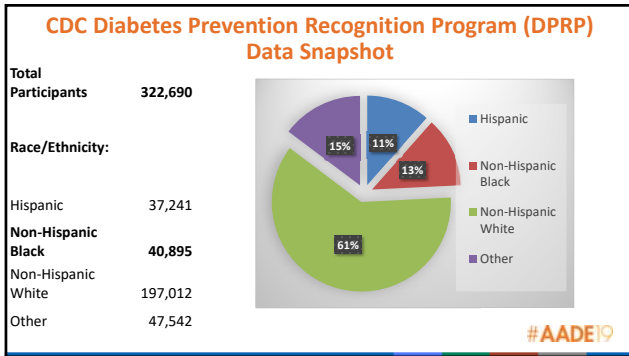
#AADE19

23

1705 Recipients and Priority Populations

African Americans (AA)	American Association of Diabetes Education (AADE), American Pharmacists Association Foundation (APhA), Black Women's Health Imperative (BWHI), Balm in Gilead, Inc. (Balm), Trinity Health
American Indians	HealthInsight
Asian Americans	Trinity Health
Hispanic Americans	AADE, American Diabetes Association (ADA), APhA, BWHI, HealthInsight, National Alliance for Hispanic Health (NAHH), Trinity Health
Medicare Beneficiaries	Association of Asian-Pacific Community Health Organizations (AAPCHO), AADE, ADA, APhA, BWHI, Balm, HealthInsight, National Association of Chronic Disease Directors (NACDD), NAHH, Trinity Health
Native Hawaiians and U.S. Pacific Islanders	AAPCHO
Persons with Disabilities	NACDD
Men	AADE, ADA, APhA, BWHI

24



25

Faith-based Organizations (FBOs) in the DPRP

- o 14 organizations have identified as FBOs.
- o 12 of these orgs have pending recognition status.
- o Two have received preliminary recognition.
- o These FBOs are located in AL, CA, FL, GA, IL, MN, MS, NC, NY, RI, SC, TX, and VA.
- o This is an under-representation of FBOs in the registry.

#AADE19

26

Why do we need churches or other houses of worship among our National DPP program delivery sites?

#AADE19

27

Religion and Health are Connected.....

- Health is a dynamic state of complete well-being—physical, mental, social, and **spiritual**—and not simply the absence of disease (Vach D., Report from the World Health Organization: Closing the gap in a generation: Health equity through action on the social determinants of health. 1998)



#AADE19

28

What are Faith-based Organizations?

- "FBOs can be characterized as organizations, with or without nonprofit status, that provide **social services** and are either **religiously-motivated or religiously-affiliated**". (Goldsmith, S. Elmickle, W.B. & Pineda, C. (2006). Faith-based organizations vs their secular counterparts: A primer for local officials. Retrieved from <https://www.innovations.harvard.edu/faith-based-organizations-versus-their-secular-counterparts-primer-local-officials/>)
- "FBOs with a health mission can be defined as **trusted places of worship, nondenominational ministries, interdenominational and ecumenical organizations** (churches, synagogues, temples, monasteries, mosques, and other houses of worship and natural centers for spiritual, emotional, and physical wellness, etc.) operating from or within a religious or spiritual setting and led by religious leaders with health commitments or by health professionals with faith commitments." (Saunders, 2019, proposed)
- "FBOs serve individuals, families, and communities, **fostering spiritual, emotional, or physical healing** for individuals and families aligning efforts to renew wholeness in the community. Under CDC's 1705 cooperative, FBOs offer the National DPP lifestyle change program to their members/devotees and/or to the larger community". (Saunders, 2019 (proposed))

#AADE19

29

Main Types of Faith-based Organizations

- Religious congregations
- Organizations sponsored by congregations
- Ecumenical interfaith organizations and/or national networks
- Freestanding religious organizations, which are incorporated separately from congregations and national networks-



(Goldsmith, S. Elmickle, W.B. & Pineda, C., 2006. Faith-based organizations vs their secular counterparts: A primer for local officials. Retrieved from <https://www.innovations.harvard.edu/faith-based-organizations-versus-their-secular-counterparts-primer-local-officials/>)

#AADE19

30

African Americans and Faith

- Historically, the Black Church has been the nucleus of life and health in Black communities.
- Fifty-three percent of African Americans visit a faith-based setting at least once a week.
- Mobilizing congregations to implement the National DPP lifestyle change program holds great promise.

#AADE19

31

Why A Faith-based Approach?

- “Faith in religious orders is not the answer for everyone, but everyone has a faith.”
- “Faith is the ability to completely trust or show an unwavering confidence in another.”
- “Our faith can be placed on a higher deity, upon ourselves, and/or upon the life of another.”

(Source: Canadian Counselling and Psychotherapy Association, 2011. Benefits of Faith. Retrieved from <https://www.ccpa-accp.ca/benefits-of-faith/>)

#AADE19

32

Why Work with Faith-based Organizations?



- Builds community capital, since faith-based organizations are trusted entities.
- Increases access to community and clinical resources and support.
- Engages both clinical and community stakeholders in population health.
- Enhances capacity of both sectors to carry out their missions.
- Maximizes the collective impact of multiple clinical and community stakeholders who can contribute to population health.

#AADE19

33

Some Benefits of Faith Participation

- Increased life satisfaction. (Chida et al., 2009)
- Increases self-efficacy. (Quinn & Guion, 2010)
- Improved cardiovascular health. (Chida et al., 2009)
- Increases the ability to forgive. (Saunders et al., 2013)
- Improved mental health and lower depression scores. (Levin J., 2001)
- Lower C-reactive protein levels or inflammation. (Ferraro & Kim, 2014)
- Increased medication adherence. (Lewin et al., 2005)
- Increase in telomere length. (Hill, Ellison, Burdette et al., 2016)



#AADE19

34

Health Benefits of Faith Communities

- Mormons in Utah have a 30% lower incidence of most cancers.
- Seventh Day Adventists have from 10 to 40% fewer hospital admissions for epidermoid and nonepidermoid malignancies.
- Regular church attenders in Washington County, Maryland, have 40% less risk from arteriosclerotic heart disease.

Source: Vaux, K., 1976. Religion and Health. Religion and Health. Preventive Medicine, 5,552-36.

#AADE19

35

A Great Faith and Health Observation— Do you Agree?

- “Having a strong faith and being embedded in a web of relationships formed by churchgoing have definite health benefits,” said Dr. Lisa Berkman, an epidemiologist at the Yale University School of Medicine.

#AADE19

36

Important Role of Faith Communities

- **Spread the word** about diabetes and prediabetes; dispel myths.
- **Provide access** to credible information.
- **Create healthy** environments.



#AADE19

37

Create Healthy Environments

- Increase access to healthy foods and drinks.
- Increase access to physical activity.
- Advocate for safe and healthy environments.



#AADE19

38

How Can FBOs Get Involved in the National DPP?

- **Option 1 - Promote** health and awareness of prediabetes and the National DPP among congregants at risk for type 2 diabetes.
- **Option 2 - Screen, Test, and Refer** to area CDC-recognized lifestyle change programs by hosting health screening events at church.
- **Option 3 - Offer** the National DPP lifestyle change program at your church with a CDC-recognized organization partner, or as part of your health ministry.

#AADE19

39

**Creating Awareness:
Award-Winning Prediabetes Awareness Campaign**
Ad Council, AMA, ADA, CDC

www.DolHavePrediabetes.org

40

Award-Winning Prediabetes Awareness Campaign
Ad Council, AMA, ADA, CDC

[Mike Jones's Prediabetes Journey](#) #AADE19


41

Health screenings for members through church partners

#AADE19

42

Option #3: Offering the National DPP Lifestyle Change Program at your FBO




43

Is your organization ready to offer the National DPP lifestyle change program?

Requirements:


- Use of a CDC-approved curriculum
 - You can use a curriculum developed by CDC, or you can develop your own or use that of another organization (with permission), as long as CDC approves it.
- Ability to begin offering the lifestyle program within 6 months of receiving approval from CDC
- Capacity and commitment to deliver the program over at least 1 year, including at least 16 sessions during the first 6 months and at least 6 sessions during the last 6 months
- Ability to submit data on participants' progress – including attendance, weight loss, and physical activity – every 6 months
- Trained lifestyle coaches who can help build participants' skills and confidence to make lasting lifestyle changes
- Designated individual(s) to serve as the program coordinator



44

Other Considerations: Program Sustainability

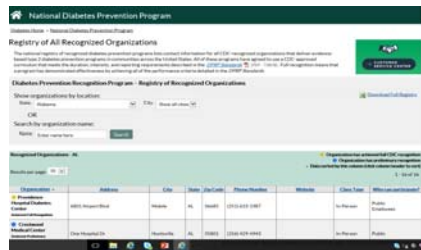
- Is my organization well-positioned to do this?
 - Complete the Organizational Capacity Assessment: <https://www.cdc.gov/diabetes/prevention/pdf/capacity-assessment.pdf>
- Does your organization have access to a large number of people at high risk for type 2 diabetes and the ability to offer at least 1 class cohort every year?
- If no to either of the above, consider partnering with another CDC-recognized organization to offer a class at your location



45

Find a CDC-recognized Organization Near You

https://nccd.cdc.gov/DDT_DPRP/Registry.aspx



#AADE19

46

An Example of How Faith Communities Fit in the National DPP

#AADE19

47

One Vision for Prediabetes Action At Church

Local Action by:

- **Urban Health Resource (UHR)** in Detroit, MI
 - UHR is the CDC-recognized organization (full recognition).
 - The insurer, Priority Health, is reimbursing as of 2019 for delivery at the church site.
- **Rosedale Park Baptist Church** Detroit, MI
 - Rosedale Park Baptist Church is a host location for National DPP lifestyle change program classes.
 - With support from:
 - **Black Women's Health Imperative (BWHI)** funding via CDC, 2014-2017. Rosedale sustained classes after CDC funding ended.

#AADE19

48

Once participants are recruited and enrolled, what does a lifestyle coach do if we agree to host the program?

Find the things that inspire your group to work together and peak their interest in activities they enjoy.



#AADE19

49

Champions and Current and Former Participants

Participant testimonials may be used during the service to inspire others to join the class.

Testimonials also help participants stay committed, because others are watching their progress.



#AADE19

50

Work creatively to inspire and measure success



Incentive Programs

#AADE19

51

Ending the class in a hustle



#AADE19

52

Or a stretch...



#AADE19

53

And....showing what a fried fish sandwich really looks like



#AADE19

54

Switch to a healthy Thanksgiving!



#AADE19

55

Low fat grilling gets male participants involved



#AADE19

56

Creating an atmosphere of healthy peer pressure at the church



#AADE19

57

Healthy habits extend to Sunday School



#AADE19

58

Joining in healthy activities together...



#AADE19

59

Research shows that when people stay in the year-long program, they lose weight

Analysis of data has offered insights on promising practices to keep people in the program for a full year



Information Session Organizations that held an information session / introductory session (e.g., "Session Zero") to recruit participants had higher overall attendance, higher attendance during months 7 – 12, and longer participant duration in the year-long program.



Self-Referral / Word of Mouth: Organizations that used self-referral or word of mouth recruitment strategies were more likely to see an increase in attendance of African American participants over the year-long program.




Barriers to Participation: Organizations that used strategies to address participant barriers, such as providing free or reduced-price child care or transportation, were more likely to have higher participant attendance during months 7 – 12 and to have longer participant duration in the year-long program.

DP12-1212 Year 1 – Year 3 Data as of September 30, 2015; Year 4 data as of June 2017

#AADE19

60


Lessons Learned from National Organizations



61

Lessons Learned and Promising Practices


- Engage Pastors and key church influencers (e.g. First Ladies, Health Ministry Leaders, Parish Nurses, etc., early in the process.
- Educate Pastors to familiarize them with the National DPP lifestyle change program.
- Engage Pastors as National DPP champions.
- Coordinate with other health promotion programs so that the church leaders and congregations are not overwhelmed.



62

Lessons Learned (continued)

- Engage former attendees as coaches or as National DPP champions across the church.
- Develop and share short, easy to understand, but consistent messages.
- Start small, and make gradual changes to the church's food and exercise culture.
- Consider offering additional healthy activities such as walkathons, shopping tours, etc. that support the program to engage and retain participants.



63

NATIONAL DPP RESOURCES TO ENHANCE YOUR FAITH-BASED EFFORTS

64

National DPP Customer Service Center
NationalDPPCSC.cdc.gov

Purpose: Provides a hub for resources, training, and technical assistance for CDC-recognized program delivery organizations and other National DPP stakeholder groups

<p>Find Resources and Info</p> <ul style="list-style-type: none"> • Quickly and easily find resources and events relevant to your needs (FAQs, toolkits, training videos, webinars, etc.) • Discuss opportunities and challenges with the National DPP community 	<p>Receive Technical Assistance</p> <ul style="list-style-type: none"> • Engage with technical assistance coordinators and subject matter experts via the web-based platform or email • View the status of and update existing technical assistance requests 	<p>Provide Feedback and Input</p> <ul style="list-style-type: none"> • Submit feedback on your satisfaction with the technical assistance, resources, and web-based platform • Share success stories and suggest additional resources
---	---	--

#AADE19

65

Take Away Messages

01/ **RAISE AWARENESS** of prediabetes and the National DPP
 • www.cdc.gov/diabetes/prevention/prediabetes-type2


02/ **REFER PEOPLE** at risk to a CDC-recognized lifestyle change program
 • www.cdc.gov/diabetes/prevention/lifestyle-program

03/ **OFFER THE PROGRAM** by working with a CDC-recognized organization
 • www.cdc.gov/diabetes/prevention/lifestyle-program

#AADE19

66

“Churches are the perfect place to promote health in Black or other minority communities”.



Window of opportunity for embedding the National DPP lifestyle change program in church health ministries.

67

Selected References

- Black Demography (2019). The African American population. Retrieved from <https://blackdemographics.com/>
- Centers for Disease Control and Prevention (2017). African American health: Creating equal opportunities for health. Retrieved from <https://www.cdc.gov/vitalsigns/aahealth/index.html>
- Centers for Disease Control and Prevention. Diabetes Report Card 2017. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2018. Retrieved from <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>
- Centers for Disease Control and Prevention. (2003). Lifetime risk for Diabetes Mellitus. Retrieved from <https://jamanetwork.com/journals/jama/fullarticle/197439>.
- Chida, Y. Steptoe, A., Powell, L. H. (2009). Religiosity/spirituality and mortality: a systematic quantitative review. Psychotherapy and Psychosomatics, vol. 78, no. 2, pp. 81-90, 2009.
- Dodor, B.A., Robinson, M.A., Watson, R. et al. The Impact of Religiosity on Substance Abuse and Obesity in African Americans Journal of Religion and Health (2018) 57: 1329. <https://doi.org/10.1007/s10943-017-0523-9>
- Fruh, S., Mulekar, M.S, Crook, E., Hall, H.R., Adams, J., & Lemley, T. (2018). The Family Meal Challenge: A Faith-Based Intervention to Empower Families. Journal Of Christian Nursing. 35.3.191-197.
- Gregg, E. W, Zhuo, X, Cheng, Y.J, Albright, A.L, Narayan, V.K.M, Thompson, T. (2014). Trends in lifetime risk and years of life lost due to diabetes in the USA, 1980-2011: a modelling study. Retrieved from [https://www.thelancet.com/action/showPdf?pii=S2213-8587\(14\)00701\(61-5](https://www.thelancet.com/action/showPdf?pii=S2213-8587(14)00701(61-5)
- Goldsmith, S, Ermickle, W.B, & Pineda, C. (2006). Faith-based organizations vs their secular counterparts: A primer for local officials. Retrieved from <https://www.innovations.harvard.edu/faith-based-organizations-versus-their-secular-counterparts-primer-for-local-officials>

#AADE

68

References (continued)

- Hill, T.D., Ellison, C.G., Burdette, A.M., Taylor, J., Friedman, K.L., 2016. Dimensions of religious involvement and leukocyte telomere length. Soc. Sci.Med.163,168e175).
- Ferraro, K. F. & Kim, S. (2014). Health benefits of religion among Black and White older adults? Race, religiosity, and C-reactive protein. Social Science and Medicine. 120.92-99.
- Levin J. (2001). God, Faith and Health: Exploring the Spirituality-Healing Connection.
- Lewin, J., Chatters, & Taylor. (2005). Religion, Health and Medicine in African Americans: Implications for Physicians. Journal of the National Medical Association. 97.2.237-250.
- Koenig, H. & Zaben. F.N. (2013). Private religious activity and cardiovascular risk. Annals of Epidemiology. 23. 246-247.
- McEwen. B.S. 7 Stellar. E. (1993). Stress and the individual. Mechanisms leading to disease. Archives of Internal medicine. 153.2093-2101.
- Saunders, M, M, Curtis, D., Alexander, A., & Williams, E. (2013). Can Christian Divorce Support Groups Influence Forgiveness and Health Outcomes in Black Divorcees? A Phenomenological Investigation. Journal of Divorce & Remarriage. 54 (7). 550-575.
- Sumlin, L.L. & Brown, S.A. (2017). Culture and food practices of American women with type 2 diabetes. The Diabetes Educator. 43.6. 565-575.

#AADE

69

References Cont'd

- Taylor R.J, Chatters L.M, Levin J. (2004) Religion in the Lives of African Americans: Social, Psychological and Health Perspectives. Thousand Oaks, CA: Sage Publications; 2004.
- Tomfohr, L. M., Pung, M. A., & Dimsdale, J. E. (2016). Mediators of the relationship between race and allostatic load in African and White Americans. *Health Psychology, 35*(4), 322-332. <http://dx.doi.org/10.1037/hea0000251>
- Yach D. (1998). Report from the World Health Organization: Closing the gap in a generation: Health equity through action on the social determinants of health. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3263147/>
- VanderWeele, T. J. & Shields. A. E. (2016). Religiosity and telomere length: One step forward, one step back. *Social Science and Medicine. 163*.176-178.
- Vaux. K. (1976). Religion and Health. *Religion and Health. Preventive Medicine.5*.552-36.
- U.S Department of Health and Human Services, Office of Minority Health, 2017. Obesity and African Americans. Retrieved from <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25>

#AADE19

70

Acknowledgements

The presenters would like to acknowledge the support of several CDC colleagues as well as staff at the Black Women's Health Imperative and the Balm in Gilead in developing this presentation.



#AADE19

71

Magon Saunders hcu1@cdc.gov
Susan Van Aacken zq17@cdc.gov

Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
www.cdc.gov/diabetes



ADE19

72



73
