The Journal of Healthcare, Science and the Humanities

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CONTRIBUTING AUTHORS
Preface

Contributing Authors

Ehsan Abdalla, DVM, MSc (Hons) (Vet PATH), MSc & PhD (Epidemiology and Risk Analysis) a Tuskegee University faculty member and two-time graduate. In 2011, she earned her second Master from the College of Veterinary Medicine (CVM). In 2017, she earned her PhD in the Interdisciplinary Pathobiology. From 2011-2012, Dr. Abdalla has been appointed as a research associate and from 2012-2017, she has been appointed as a research associate professor in the Department of Pathobiology, CVM. In 2017 to present, she has been appointed as a Director of Analytics in the Department of Graduate Public Health and in 2019 to present, she has been appointed as an Assistant Professor in the same Department. Dr. Abdalla is a member in the Research Centers in Minority Institutions (RCMI), serving as a community liaison on cervical, breast cancer, HIV/AIDS and COVID-19. From 2010-2019, she was a recipient of ten awards in elimination of health disparities. She has been a PI and Co-PI on some grants funded by the USDA, NIH and other agencies. Nationally and international, her training and expertise are tailored to community-based epidemiologic research. Dr. Abdalla's career goal is to provide a framework for health services related researchers, practitioners, and policymakers to guide future cervical, breast cancer, HIV/AIDS and COVID-19 health disparities research.

David Augustin Hodge, Sr., Ph.D., D.Min., M.T.S., M.Ed. is Associate Director of Education at the National Center for Bioethics in Research and Healthcare at Tuskegee University and Senior Associate Editor of the Journal of Healthcare, Science, and the Humanities. From undergraduate to graduate school David's primary work was in Christian theology, Christian ethics, and Christian education. He now works with (pragmatic) bioethics, neuroethics, and public health ethics as they intersect with virtue, empathy and care ethics. He taught in this genre for over two decades, primarily in South Florida, as a visiting lecturer in philosophy, theology and ethics at the Interdenominational Theological Center, and critical thinking, ethics and philosophy at Georgia State University. Additionally, for several years he was a primary writer for the adult Sunday School lessons and one of the Townsend Press, commentary authors for the National Baptist Convention, U.S.A., Sunday School Publishing Board. Dr. Hodge has published three books, primarily for women, God of Our Silent Tears: Women of the Bible Healing Women of Today, God of Our Silent Tears: A Five Week Journey, and In the Midst of My Tears: The Bible Speaks to Abandonment, Betrayal, Rejection and Loss. Developing a strong desire to pursue more complex questions in ethics and philosophical theology, David pursued a second doctorate degree, earning a (secular) Ph.D in philosophy supervised by virtue and care ethicist Michael Slote. His dissertation topic: Jesus the Virtue Ethicist: A Metaethical Anticipation of Moral Sentimentalism, Empathy and Care. Dr. Hodge is globally published in peer-reviewed journals.

Oyoyo Egiebor-Aiwan, M.D., MPH is currently a Resident Physician in the Department of Psychiatry Neuroscience Institute at Southern Illinois School of Medicine, Springfield, Illinois. She obtained her medical degree from Windsor University School of Medicine, St. Kitts, and a master’s in Public Health (MPH) from Tuskegee University, Alabama. She has also practiced as a general physician in her home country Nigeria. Dr. Egiebor-Aiwan is interested in understanding the impact of infectious and chronic diseases on mental health specifically in unreserved communities.
Preface

**Isra Elhussin, M.D., Ph.D. (candidate)** is currently a third-year Ph.D. student in the Integrative Bioscience Ph.D. Program at Tuskegee University. Before joining Tuskegee, she earns her medical degree from UPPER NILE University, Khartoum, Sudan. She also completed her master’s degree in Biology at Tuskegee University in July 2018. As a physician, she understood the high value of training in a research setting. Emphasizing prevention and primary care is something that she practices day-to-day in her work and her life. Her master’s degree was mostly focused on identifying novel gene targets involved in tumor progression and metastasis, leading to developing early diagnostic and targeted therapeutic strategies for patients with ovarian cancer metastasis. She is currently continuing her journey through Integrative Bioscience Ph.D. Program at Tuskegee University to focus on Cancer Health Disparities and build an active cancer research track with excellent skills and training in biomedical and clinical informatics. Her ultimate goals are to land a research career in a medical and research center where she can start cutting-edge cancer research leading to clinical trials and, hopefully, vast improvement of cancer patient’s outcomes.

**Brandon R. Isome, D.Min., Ed.S., M.Div., M.S.E.**, is currently a Doctor of Philosophy student at the University of Georgia in Athens, Georgia. Dr. Isome served as a Post-Doctoral Public Health Ethics Fellow at the National Center for Bioethics in Research and Health Care at Tuskegee University. Dr. Isome has received numerous awards over the years and holds multiple positions on the local, state, and regional levels. He received his Bachelor of Arts Degree (B.A) from American Baptist College in Nashville, Tennessee. Deciding that he needed to further his education, Dr. Isome matriculated through the Interdenominational Theological Center in Atlanta, Georgia, where he earned a Master of Divinity Degree (M.Div) with a concentration in Homiletics and Worship. He was a recipient of the Isaac R. Clark Preaching Award. Later, he completed his second Master’s Degree at Samford University in Educational Leadership (M.S.E). In that same year, he enrolled in the Doctor of Ministry (D.Min) Program at the interdenominational Theological Center. Additionally, he completed his Educational Specialist Degree (Ed.S) at Samford University.

**Rueben Warren, DDS, M.P.H., Dr. PH, M.Div.** is currently the Director of the National Center for Bioethics in Research and Health Care and Professor of Bioethics at Tuskegee University in Tuskegee, Alabama. He also serves as Director and Adjunct Professor of the Institute for Faith-Health Leadership and Adjunct Professor of Public Health, Medicine and Ethics at the Interdenominational Theological Center (ITC) in Atlanta, GA. From 1988 to 1997, Dr. Warren served as Associate Director for Minority Health at the Centers for Disease Control and Prevention (CDC). From 1997 to 2004, he was Associate Director for Urban Affairs at the Agency for Toxic Substances and Disease Registry (ATSDR). From 2005 to 2007, Dr. Warren served part-time as the Director of Infrastructure Development for the National Center on Minority Health and Health Disparities at the National Institutes of Health in Bethesda, MD. From 2004 to 2009, he was on leave from the National Center for Environmental Health-CDC/ (ATSDR) in Atlanta, where he served as Associate Director for Environmental Justice.
Gwendolyn West, D.Min., M.A., is a television producer, media executive, and serve as a college Professor, teaching Religion, Ethics and Mass Communication classes. She is a small-town girl from Leesburg, Georgia with big ideas that moved to Miami, Florida in 1984 for better opportunities and to seek more people to serve. Along with her busy schedule as a single mother of three children, West also, found time to organize the first African American television network in South Florida, UTV in 1994. This channel can be viewed on broadcast television using the digital spectrum and the ROKU streaming devise. West prides herself on the development of a network the speaks for the voiceless; which she affectionately refers to as the Genuine Urban Voice. She is best known for creating television ministries for a wealth of pastors all over the United States as she picked up the nickname – the TV Lady. In addition to her accomplishments as a teacher, professor and Television mogul, West goes back to her hometown each year to celebrate the elderly citizens who helped her and others along the way. Her motto is, “she did not come to this earth just to live and die.” Her goal is the reach as many people as possible to empower them with the self-awareness that they too can accomplish anything they desire.

Andrew A. Zekeri, Ph.D., is professor of sociology and graduate faculty in the Department of Psychology and Sociology at Tuskegee University. His research focuses on rural poverty, family well-being, food insecurity and nutrition among single mothers in Alabama Black Belt, and conspiracy theories about HIV/AIDS and food insecurity among HIV-positive patients. Dr. Zekeri also studies social and behavioral sciences perspective on rural health disparity issues, community and economic development in the rural South. He has published articles in several international refereed scholarly journals. In 2015, Zekeri’s book, “Issues and Challenges of the American Rural South,” was published by Cognella Academic Publishing. In 2020, the second edition of Prof. Zekeri’s book “Issues and Challenges of the American Rural South” was published by Cognella Academic Publishing, San Diego, California. He holds a PhD in rural sociology from Pennsylvania State University.
2019 Public Health Ethics Forum

ETHICAL DILEMMAS IN CHILD AND ADOLESCENT HEALTH

FRIDAY, APRIL 26, 2019
8:00 A.M. TO 4:15 P.M.

CDC ROYBAL CAMPUS
1600 CLIFTON RD NE | ATLANTA, GA 30329

TOM HARKIN GLOBAL COMMUNICATIONS CENTER | AUDITORIUM A
2019 Public Health Ethics Forum: Ethical Dilemmas in Child and Adolescent Health

Presented by: Office of Minority Health and Health Equity, Centers for Disease Control and Prevention and the National Center for Bioethics in Research and Health Care at Tuskegee University
April 26, 2019, 8:00 a.m. – 4:15 p.m.
CDC Roybal Campus, Tom Harkin Global Communications Center – Auditorium A
1600 Clifton Road NE, Atlanta, GA 30329

The goal of the 2019 Public Health Ethics Forum is to consider factors that affect healthy development among children and adolescents, particularly youth of color, and how to identify and address ethical implications for public health interventions.

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<th>Subject</th>
<th>Speaker/Location</th>
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<td>7:30 a.m. – 2:00 p.m.</td>
<td>Registration Student Poster Exhibits Open</td>
<td>Conference Lobby Area</td>
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<tr>
<td>8:00 a.m. – 9:00 a.m.</td>
<td>Welcome and Remarks</td>
<td>Leandris Liburd, PhD, MPH, MA, Director, Office of Minority Health and Health Equity (OMHHE), Centers for Disease Control and Prevention (CDC)</td>
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<td>Anne Schuchat, MD (RADM, USPHS, RET), Principal Deputy Director of CDC</td>
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<td>Rueben Warren, D.D.S., M.P.H., Dr.P.H., M.Div., Director, National Center for Bioethics in Research and Health Care at Tuskegee University</td>
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<td>9:00 a.m. – 11:30 a.m.</td>
<td>Opening Plenary: Theme Parks, Rap and Moral Dilemmas – Ethics and the Least of These</td>
<td>David Hodge, PhD, DMin, M.Ed., M.T.S., Associate Director of Education and Associate Processor, National Center of Bioethics in Research and Health Care at Tuskegee University</td>
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<td>9:45 a.m. – 10:00 a.m.</td>
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<td>10:00 a.m. – 11:30 a.m.</td>
<td>Panel: Social and Physical Determinants of Adolescent Health</td>
<td>Moderator, Dr. Rueben Warren</td>
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<td></td>
<td>Adolfo Berduo</td>
<td>Member, Latino Youth Leadership Academy and Student, Chamblee Charter High School – Atlanta, Georgia</td>
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<td>Kendarius Ivey</td>
<td>Member, Bridge Builders Program and Student, Booker T. Washington High School – Tuskegee, Alabama</td>
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<td>Emma MacDonald</td>
<td>Member, VOX Teen Communications and Student, Rockdale Magnet School – Atlanta, Georgia</td>
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<td>Maya Martin</td>
<td>Member, VOX Teen Communications and Student, Agnes Scott College – Atlanta, Georgia</td>
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<td>JaMyia McNeil</td>
<td>Member, Bridge Builders Program and Student, Booker T. Washington High School – Tuskegee, Alabama</td>
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<td>11:30 a.m. – 12:15 p.m.</td>
<td>Poster Session</td>
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FROM THE EDITOR’S DESK
Message from the Editor

Rueben C. Warren, DDS, MPH, Dr. P.H. MDiv
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Before highlighting the contents of this edition, I must acknowledge the loss of a dear friend and mentor, Bailus Walker PhD, MPH, who transitioned April 9, 2020. Dr. Walker retired as Professor of Environmental and Occupational Medicine and Toxicology Howard University College of Medicine. His many distinguished positions including, but are not limited to the following: Professor of Environmental Health at the School of Public Health, State University of New York in Albany, Dean of the Public Health Faculty, University of Oklahoma Health Sciences Center, Commissioner of Public Health for the Commonwealth of Massachusetts and Chairman of the Massachusetts Public Health Council, State Director of Public Health for Michigan, appointed by the governors of the respective states, Director of the Occupational Health Standards Division, Occupational Safety and Health Administration (OSHA) U.S. Department of Labor, President of the American Public Health Association, Distinguished Fellow of the Royal Society of Health (London, England), Distinguished Fellow of the American College of Epidemiology, NIH Advisor on environmental and community health aspects of biodefense research, member of the Institute of Medicine, (IOM) National Academy of Sciences (NAS) member on on numerous IOM - NAS commissions/committees including the Board of Environmental Studies and Toxicology and Chairman of the Committee on Toxicology, Senior Science Advisor (Environmental Health) to the National Library of Medicine, Chairperson of the Advisory Committee, Agency for Toxic Substances and Disease Registry (Centers for Disease Control and Prevention), Editorial Board, Journal of Healthcare for the Poor and Underserved, Chairperson of the Advisory Committee, Graduate Public Health Program, College of Veterinary Medicine and Bioethics Visiting Scholar, National Bioethics Center, both at Tuskegee University. Dr. Walker has published over 100 scientific articles, and his book chapters are too numerous to name. Dr. Walker served on numerous select national and international committees. As a graduate of Kentucky State University, in my view, his commitment to implementing graduate public health programs, particularly at HBCUs is unmatched. He served on, at least, 5 MPH Advisory Committees at HBCUs, literally developing the curriculum at several of them. Global public health is better because of Bailus Walker!

I also must pause to acknowledge the murder of Mr. George Floyd, by specific members of the Minneapolis, Minnesota Police Department. The historic and continuing killing of Black men and women has spurred the world community to protest and acknowledge that structural racism is rampant globally, and Black Lives Matter. There appears to be a remerging consciousness to
create, maybe for the first time, an equitable society in the United States. The manta, “I can’t breathe” symbolizes a demand for social justice.

The Fall 2019 edition of the *Journal of Healthcare, Science and the Humanities* includes selected articles from the Annual Public Health Ethics Forum (PHEF) co-sponsored by the National Center for Bioethics in Research and Health Care, Tuskegee University (National Bioethics Center) and the Office of Minority Health and Health Equity at the Centers for Disease Control and Prevention (CDC). Other peer-reviewed articles and commentaries address a broad array of issues from the lens of a transdisciplinary group of contributors. The first PHEF in 2015, was co-sponsored by the National Bioethics Center, CDC and the Master of Public Health Program, Morehouse School of Medicine honoring the 100 Year Anniversary of the death of Booker T. Washington, Founding President of Tuskegee Institute (aka. Tuskegee University). Since then, every year the National Bioethics Center and CDC have co-hosted the PHEF focusing on public health ethics considerations targeting specific vulnerable population groups. In 2019, the PHEF focused on children and youth. The Program Agenda is included in this edition. The keynote address, transformed into a publishable manuscript, an extraordinary youth panel with students from Metropolitan Atlanta, Georgia and Tuskegee, Alabama and the agenda from the 2019 PHEF are included in this edition, so the reader will have a sense of the depth and breadth of the session. Other articles included in this edition have all been peer reviewed.

Dr. David Hodge, Associate Director for Education at the National Bioethics Center, provided an extraordinary keynote address to open the forum. The title of his address, “Conversation on Ethics and Theme Parks,” intertwined themes in philosophy, ethics and theology in ways that captured the attention of the audience throughout the presentation, and solicited a broad array of question when he finished. He thoughtfully, transformed the presentation into a publishable manuscript for this edition of the *Journal of Healthcare, Science and the Humanities* (JHSH). Dr. Hodge raised the empowering question of “what is right and what is wrong” which, can be answered philosophically, theologically and/or ethically. The question of right and wrong is particularly important when addressing the health and well-being of children and youth, especially children and youth of color. Dr. Hodge deconstructed and then reconstructed complicated terms like epistemology, utilitarianism, deontology, metaphysics, ontology and logic, in ways that were clear, non-threatening, and understandable. He used the theme of theme parks, and the metaphor of a rollercoaster to help “older folk” understand the moral dilemmas that young people face. He used theme parks, rap and moral dilemmas to discuss challenges faced by youth in the 21st Century. Most youth have been to a theme park and many ride the rollercoaster. He recalled his traumatic experience on a rollercoaster with his son, who thoroughly enjoyed the experience. For me, the take home message was that while all adults had childhood and youth experiences, they cannot transfer their experiences to fully understand the experiences and perspectives of today’s children and young people. His article provides more details for the reader to explore.

A Social and Physical Determinants of Adolescent Health Youth Panel provided an opportunity for a group of high school and college students from Metropolitan Atlanta, Georgia and Tuskegee, Alabama to share their perspectives on the salient topics that undergirded the 2019
Public Health Ethics Forum. The topics included the following: adolescent access to sexual health education and services, substance abuse and mental health challenges, access to fresh fruits and vegetables, and “what does it mean to be an adolescent?” The students’ names were removed, but their actual responses were transcribed with minor edits. The Bioethics Honors Program (BHP) students, under the leadership of Nina Hylton, President of the BHP, did an outstanding job editing the transcription of the entire panel discussion. Under the guidance of Dr. Hodge, the BPH students continue to engage in a broad array of academic, social, and community activities. The uniqueness of the BHP is that it provide opportunities for the students to take what they are learning in the classroom and translate it into engagement activities. We are very proud of the Bioethics Honors Program students.

Dr. Andrew Zekeri, Professor of Sociology, Department of Sociology and Psychology and Adjunct Professor of Sociology in the National Center for Bioethics in Research and Health Care at Tuskegee University is a regular contributing scholar in the JHSH. His research in Alabama Black Belt counties is widely published in peer review journals throughout the U.S. Dr Zekeri’s article for this edition is entitled, “Household Food Insecurity Is Associated with Self-Rated Health Status among Single Mothers in Alabama’s Black Belt Counties”. He examined the association between household food insecurity and self-reported health status. He collected data from 400 households to measure household food insecurity and self-reported general health status. What seems intuitive concerning food insecurity and poor health status, still needs research to influence public policy for funding and programs to address this problem. At a time when funding for federal food programs are being reduced, research to offset this trend is desperately needed.

Dr. Oyoyo Egiebor-Aiwan and colleagues in the Graduate Public Health Program and other departments in the College of Veterinary Medicine, Tuskegee University completed a study entitled, “The Impact of Race and Geographical Location on the Treatment Options of Cervical Cancer in Black and White Women Living in the State of Alabama.” The Black/White disparities in early diagnosis, treatment options, and mortality rates differ between these two groups, and are consistent with national comparisons; consistently, Black women bare the greater burden. Interestingly, Black women in urban and rural areas, in their study, have better treatment options than their White women, (presumably non-Hispanic White) counterparts. Purportedly, treatment for cancer should result in better survival outcomes. However, in this study, Black women fair worse in each scenario, except for treatment options. Yet, the mortality rates are worse for Black. Why?

Dr. Elhussin, Integrative Bioscience PhD Fellow, Department of Biology at Tuskegee University and colleagues published another paper, presumably from the same dataset entitled, “Disparities in Cervical Cancer Treatment Options between African American (Black) and White Women in Alabama.” The study questioned why younger Black women, living in urban counties with advanced stages of cervical cancer were more likely to receive radiation treatment but were less likely to undergo surgical treatment options. Disadvantaged women particularly, younger Black women living in the Black Belt and other rural counties, did not receive the treatment options available to other women. Their study suggests that access to care, without assessing options
provided to all women, particularly disadvantaged and Black women, may account for desperate mortality outcomes.

Dr. Brandon R. Isome, in his article, entitled, “The Paradoxical Implications of Blackness and the U.S. Constitution: The Intersectionality of King’s “I Have a Dream” Speech and Educational Inequalities”, writes about continual inequities experienced by Black people in the United States that are promised guarantees to all U.S. citizens. He uses the oratorical genius of Dr. Martin Luther King Jr’s use of the “promissory note” during his speech at the 1963 March on Washington for Jobs and Freedom, to emphasize the ongoing fight that African Americans wage for the rights and privileges purportedly, granted through “American citizenship.” The anti-black educational policies and practices that came before and after Brown v. Board of Education that King’s highlights with term “promissory note” make clear that King’s dream has yet to be realized.

The last article by Warren and colleagues, on “Enhancing African Americans Participation in Clinical Trials” is a reprint from a 2019 edition of the Journal of Medicine, Ethics and Public Health. With permission to reprint from the (JEMPH), this article documents the longstanding problems of engaging African Americans in human subjects research in the midst of bioethics and public health ethics violations. The research was funded by the Eli Lilly and Company to determine how to ethically engage African Americans in human subject research, specifically, clinical trials. The article was initially published in English and French in the Journal of Ethics, Medicine and Public Health, an international peer review journal. The readership of the JEMPH may be different from those who read the JHSH, so we were granted permission by JEMPH to reprint the article to assure both audience have access to the findings. The primary finding in the article is trustworthiness must precede trust, if equity in the research enterprise is expected.

Dr. Gwendolyn West’s Commentary, “Unsilenced and Redeemed,” challenges the audacity of others particularly, non-Hispanic White women and men, to speak for and about Black and African American women. She is intentional in distinguishing between the terms Black connoting race, and African American which designates an ethnic group within the Black race, to highlight so the reader will appreciate the difference between the two, in spite of the U.S federal government’s failure to distinguish between the two. Dr. West recounts the abuse that Black women experienced, dating back to enslavement in the U.S. She also documents abuse of women of African descent in European. Reading her Commentary highlights the double jeopardy of racism and sexism experienced by women of African descent.

These are the best of times and the worst of times. The JHSH strives to provide valid and ethical information so the reader can make informed decisions about their journey towards Optimal Health. Enjoy!
“Theme Parks, Rap and Moral Dilemmas—Ethics and the Least of These,”
(Keynote: Public Health Ethics Forum/CDC Atlanta)

David Augustin Hodge, Sr., Ph.D., D.Min., M.T.S., M.Ed.
Associate Director of Education/Associate Professor/Senior Associate Editor of JHSH
National Center of Bioethics in Research and Health Care
Adjunct Associate Professor in Philosophy in the Department of Modern Languages,
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It is an honor to be here among this August group, just to have a conversation, as Dr. Warren just put it, talking back, listening, and engaging. This is an exciting moment for me because I have never done anything like this before. Therefore, if I slip up, trip up, fall over myself, I appreciate your forgiveness. I have the wonderful honor of working with a group of students at Tuskegee University, the Bio-Ethics Honors students and Dr. Warren just asked them to stand so I would not embarrass them any further. But they are here today, and I want them to know that I thank them and appreciate you for your presence at this very moment. Also, I want to thank Dr. Rueben Warren because he invited me a year and a half ago to be his partner at the National Center for Bioethics in Research and Healthcare at Tuskegee University. It has been an amazing ride so far.

We are about to have a conversation about ethics. Given today’s context, the content of our material is about how to understand ethics and issues for children and youth. I also want to give some attention to the overall broader category of what ethics is and what it entails. Many of us have a kind of pedestrian view of ethics; we roll with the punches. But ethics is not easy. Trying to do the kind of work we do daily, trying to figure out (not just as Dr. Warren said a moment ago) that something is right or wrong, but why is it right or why is it wrong? That last inquiry can be extremely tedious. So, I’m going to take us through a session as quickly as I can, and as explanatory as I can, because I want all the older people in the room—given last year’s conversation about elders—to eavesdrop on this conversation. This presentation is for the young people. I needed a metaphor that would work for young people, so I came up with: “Theme Parks, Rap and Moral Dilemmas: Ethics and The Least of These.”

Several years ago, I decided to take my first rollercoaster ride. My family and I went to Space Mountain in Disney World. Ladies and gentlemen, I do not understand how these people make money scaring the life out of people! We actually pay for this foolishness. The idea of riding a rollercoaster, paying to be scared makes no sense to me. This was my first rollercoaster ride; and it was also my last rollercoaster ride.

Last year, my brother and his children took my youngest son Jonathan to Six Flags Atlanta and they invited me to come. But why would I want to do this? It made no sense to me.
When we saw Space Mountain, I thought it was a haunted house. I began hearing a loud sound as we ascended the staircase. It sounded a whole lot like a tornado in the building, but we kept climbing. The noise did not sound like fun. Hearing people scream did not sound healthy. But we continued to climb until we got to the top. The attendants herded us like cattle into short lines with dividing railings, then they placed me into something that looked very much like a coffin. They buckled and strapped me in (This should have been an indication that I should leave). I asked my son, “David, you know, we are Hodges. We are proud Virgin Islanders. We don’t need to do this.” He said, “Daddy, I want to do it.” I said, “We don’t have to.” He said, well, daddy, this looks like fun.” “No, it does not, son. We could walk down these stairs the same way we came up and we will do it with our heads held high.” He said, “No.” I said, “Alright, you sit in front and I will sit behind you and I will hold you.” So, I held him. He said, “Daddy, you’re holding me too tight.” I said, “Hush, son, just accept daddy’s love right here.” If you have ever been to Space Mountain, the ride takes off in this casket device. People talk about near death experiences. They will talk about going through a kind of corridor of light, a tunnel of light. That is what it takes you through. As we go through the tunnel of light, we heard a very loud clack, clack, clack, clack. That clack, clack, clack noise is very ominous. I am certain that the point was to terrify us more.

As we were going through clack, clack, clack, clack, clack, clack, I am holding him tightly, then it starts going up—this is the scariest thing in the world. Not so much because of the ascension, but because you know there will be a descension. When it got to the top, it paused, just to terrify us even more. And then it took off. Now, the idea is, I guess, you are supposed to hold on as tightly as you can and enjoy the ride. But how can you enjoy the ride when you are yelling the entire time? And then it gave a short break and did it again. Now, we got to the very end and this cute little girl, she was very nice, came to me and said, “Sir, let me help you out.” I said, “Go get some help.” She said, “No, I could do it.” I said, “Look, go get some big people to lift me out of this thing.” She said, “No,” and I said, “Please, go get some big people.” So, she got some big people. They lifted me up, my little feet dangled as they took me, sat me down next to a booth, which looked like Lucy’s psychology booth from Charlie Brown. What they did not tell me — and they never asked for permission—they had taken pictures of me, screaming, my eyes and my mouth wide. A little boy pointed and said, “Hey, look at the big guy” and pointed and laughed. And I am like, “What’s he laughing about?” And that is when I saw he was laughing at me. Why was he laughing at me? Because I looked the part of a sick person. Why? Because this is what rollercoasters do to you. This is what theme parks do to you. So now I stick to what I can handle. When I go to Disney World, I go to It is a Small World After All. Here is the thing: I would get on that ride 15 times and it never stresses me.

Theme parks all around this country make a lot of money. You must pick and choose which one you want to terrify you the most. This is what ethics is about. It is a matter of picking and choosing which one of the various theories you want to terrify you the least or you want to use the most. Ethics is a subset of philosophy. There are six major areas of philosophy. One is epistemology, which is the nature of knowledge. Then there’s logic, which is about identifying valid arguments. Metaphysics is about what is real: Do I exist? Am I here now? Are you here now? How do I know I am here? When does time end? When does time begin? Is there such
a thing as time? Metaphysical questions take us into conversations about God—like, is there a God? Then there’s aesthetics/esthetics, which is about beauty and the nature of beauty and so on. Finally, we have ethical theories and ideas. Dr. Martin Luther King, Jr. said, “the time is always right to do what is right.” The word “right” is ambiguous. The time is always right to do what is right, but can we always know what is right? Sometimes, as Dr. Warren said a little while ago, we may not always know the right answers. He kind of stole my thunder. In the cases in which we do not know, he said, go with what is visceral. Go with your gut. But if you have a bad gut and you know you have a bad gut, do not trust your gut, because there are bad gut people—I will talk about them in a moment.

In other words, when we are dealing with ethical theory, the question is what should we do? What ought we do? Given what we see, and given what we use our minds to reason and to understand, what should we do? It is really a wrestle. It is a wrestle trying to figure out and identify the precise kinds of conversations we need to have, because it is about judgments. Ethics is about doing our best to do what we ought to do, which is quite different from the sciences.

The sciences are descriptive. They are describing things as they are in the natural world or society. But ethics is generally prescriptive. The ethicist is saying, “These are the kinds of things that we ought to do if we’re going to function in a good environment—in a good society.” Years ago, a fellow by the name of Charles Darwin—I am sure you have heard of Mr. Darwin. His theory is called Social Darwinism, “we’re better off being kinder—more altruistic to each other.” To use the language of President George H. W. Bush, we need to be “a kinder gentler nation.” Charles Darwin defends the idea that we evolve better as a species when we are altruistic. One of the most beautiful things about this world is if your car breaks down on the highway, you need simply to wait, and somebody will stop to help you. Or if you have been harmed, typically somebody is going to help because the world is better off with people who help others versus people who do not. There are areas of emphases in our moral judgment, and I will emphasize these in each moral theory.

Acts, rules and maxim, consequences, character, caring relationships. We use these terms in our everyday language; and they speak to a kind of moral theory. Motives, acts, consequences. Motives and character are incredibly important in virtue ethics. Acts and rules are major in deontological ethics. Consequences is definitive in utilitarianism. Look at these words. These are the kinds of words or terms that we, if these are our motivations or inclinations, ought to develop and see where they lead us, in terms of developing a constructive view of what ethics is. So, to answer the question about goodness and rightness and what makes for good and what makes for right gives us several different theme parks of ethical theories. This is the kind of stuff that could drive you crazy. Because when you look at them, it seems a lot like ethical relativism, “I do what I want to do” or it seems like cultural relativism. “I do what my culture says I ought to do.” Then there is the Divine Command Theory. What does God have to say about what is right and what is wrong? Is something right or wrong because God says so?
Let us take a moment to talk about these theme park of ideas. I went to Universal Studios Orlando to ride the *Incredible Hulk*. Some genius sat down and said, “I’m going to make a ride that’s going to make people very unhappy.” When you look at the faces of the riders, about two or three of them look like they are excited, but many appear unhappy. Ethical theories are like a theme park. There are a whole lot of them, and you must figure out which one of these ethical rides you want to take. It is sort of like rap music for those of you who like rap. Against public opinion, often non-Black adults, all rap isn’t distasteful, vulgar or misogynistic; I like Tupac, for example, but not all of Tupac’s lyrics (incidentally, I can’t imagine liking all the lyrics of anyone I support musically). When Tupac is rapping about *Changes*, I am into Tupac. When he is rapping about *Dear Momma*, I am into Tupac. When he is rapping about some other stuff he says – No! Tupac, you are a little off center. I am not into that. You must find conversations or genres that will work for you ethically and morally.

There are two sides to this conversation. One is ethics. Ethics is derived from the word *ethos*, which is simply about character. What is my character? For example, when a doctor says, “I am qualified to tell you that the course of treatment will likely generate the best results,” then that doctor is speaking from a kind of ethos. In other words, he is saying that I am in position -- my credibility’s in position to share something with you. My character is in position. The words *ethical* or *ethics* or *ethos*, are terms that were defined by the ancient Greeks. As a matter of fact, in the ancient world, the only kind of ethics they really employed was something we will discuss called *virtue ethics*.

Then there’s morals. Morals differ from ethics. And do not stress yourself with this. This is a fun talk right now. But morals differ from ethics and that ethics are more philosophical or tends to be more philosophical and morals tend to be more personal. I derive from my morals and customs and values and so on. So, it tends to be more personal. But then it is against all corruptive when you start talking -- in 1958, we started talking about moral philosophy. Right? So now we do not really have to hold on to those kinds of descriptive anymore. But one of the things that we need to understand is that ethics is part of what it means to be human, what it means to develop as a human personality. What should I do? What is mankind? And additive theory must consider human nature and human behavior. In other words, ladies, and gentlemen, it does not make sense to talk about ethics if we cannot do it. You know? We are, as human beings, we have certain constraints. There are some things that we cannot do. There are some places our mind cannot go. And then there’s places that a mind absolutely will go. For example, I do not have the time to tell you about when I gave a kidney to a student. I do not have the time to talk about that. A student needed a kidney. I gave a kidney. Student called me, years later and said -- every year, give me a card. It says, “Thank you, Dr. Hodge, for giving me another opportunity at life.” Then a few years later he sent me a card that says -- with a little picture, he had a son and he named his son David and on the back of the picture, it says, “Thank you, Uncle David. Without you, I couldn’t be here.” That is called supererogatory, that is when you go over and above the call of duty, when you do more than is morally expected of you. Now, if I told you I gave a kidney to my son, Jonathan, you would say, “And that is what you’re supposed to do.”
Until you give a kidney to a student. Look at you. You look all teary-eyed. You look like, “Oh my God, wow. That’s such a nice thing.” Well, here is the problem. I really did not give a kidney to a student. Right? That did not happen, but it is a good story, right? Which leads to some of the problems in ethics, because how do we know when something is true or false? Because when I just told that story, it sounded true, didn’t it? As a matter of fact, as I am up here talking about it,

I started believing it. Dr. Liburd, she was looking at me like, “Oh, David, I love you.” And when I said it was false, she looked away from me. She is no longer my friend. She is saying, “You are giving a lecture on ethical and you’re unethical yourself.” Ladies and gentlemen, we are constrained in certain ways, such that we would say that some things make sense to us and other things do not. It is part of how we develop, how we have embedded codes to behave in a certain way. Part of that development is our conscience because conscience guides our moral lives. Our conscience dictates what we should and should not do. And sometimes, if you could do something bad and it does not bother you, what do people say? You have no conscience.

My mother used to tell my brother, not me, my brother and mom, if you are watching now, not me. She used to tell my brother, when he eats too much food or he ate more than his share, “Boy, you are not going to conscience it up.” You do not have any conscience. In other words, you do not know when to stop. Dr. Warren’s word, it is a kind of gut thing. We all should have a conscience. And such that a person does not have a conscience, then we must raise questions about whether they can be moral, whether they can be ethical. So, I am not going to go through this long dissertation but suffice to say that our conscience governs our critical thinking. It governs our rational capacity. It puts parameters on our emotions and how we should feel about certain things. Immanuel Kant, the great philosopher, says, “The good will is good in itself.” And he went on to say that “We should be governed by this good will.”

He said, “Two things excite me. The starry skies above and the moral law within.” Because it seems to be something that we could always look -- when we see something that is universally wrong, we admit it. We say, hey, it is universally wrong to hurt anybody, but for some reason, it seems even more wrong to harm “innocent” and “vulnerable” children. We were driving in today and we heard about an athlete, a football player I think, and they recorded how he talked about punching his three-year-old. That shut me down because it is wrong -- the moral law would end. It governs us. It governs us rationally, even if you are an atheist or have no God concern, you are still governed by reason or sentiments. So, no one is without excuse. In our modern world, ethics is about the philosophy of right or wrong.

Morals is about my personal views of right and wrong; ethics is more philosophical.

Ethical relativism argues that people can never be mistaken about what is morally right or wrong because there is no objective or universal moral statements of truth. Instead, there are only opinions. In other words, it would have been so easy had morality been written in the clouds, “These things are wrong,” so anytime there is an issue, we just look to the clouds
Articles

and say, “Hey, that is wrong.” But we do not have that, says the ethical relativist. But somehow, on the inside, we feel like we do have something of that sort. Ethical subjectivist would argue, “No, I do want to do what is right. What is right is what I say is right.” Opinions express what a person believes. It does not have to be backed up by reason or facts. An ethical subjectivist does whatever he or she wants to do. They interpret life to their taste. A danger for the subjectivist is that the only requirement is that they do what they believe is right. If they believe that giving money to the poor is right, then it is right. But if they believe discriminatory practices are right, they are right. If they believe that it is right to discriminate against Jews, Blacks, women, gays, lesbians or whomever, then it is right. So ethical subjectivism has its good parts, but it also has its danger.

Cultural relativism also has its good (theme park) points. What is right for you and what is wrong for you is defined by your culture. And what if you do not believe in God or if you believe in God, which one? Are we talking about Jehovah, Allah or are we talking to something more eastern, like Buddhism, Jainism, or Syncretism? How are we supposed to understand God?

Perhaps we should just make ethics be a part of our ego. Egoism argues that I do what is in my best interest. I am not going to go through ethical egoism here, because it is just too much fun stuff, but the major part that I wanted to start closing my talk on ethics by looking at three theories. First, deontology. Where there’s bioethics or public health ethics, there has to be a theory that undergirds that ethical theory. Once you have a buy-in on the theory, then you can have conversation partners. If we are going to talk about, say, bioethics, then we must have a theory -- one of those many theories I talked about -- that undergirds it. And once we develop the principles or understand how that undergirding theory works, then we will know how it will function in the operating theory that you want to use, sort of like software and hardware. If you have the correct software, it can run; we can do some major work on a computer hardware, system. But if we do not have a software that is going to fit, it may not fit accurately. It may not take you to where you want to go. So undergirding bioethics is typically what we mentioned earlier: deontology. Obligations and duty govern. This means that bioethics has a tremendous regard for respect of persons, benevolence, and justice.

On the other hand, another moral theory is utilitarianism, which argues that what is right or wrong is based upon what the consequences. In other words, imagine this situation. What if you are in a scenario where you must kill one person to save 50 lives? What would you do? What should you do? Utilitarianism, i.e., the greatest good is what brings about the greatest happiness for the most people. Public health ethics is typically grounded in utilitarianism, because essentially this is what public health is all about: it is about population. It is about social ethics and social regard. We have situations where we have scarce resources. But we must do the best with the resources we have to reach the most people we can. Thus, utilitarianism governs. I stole those words from Dr. Drue Barrett. This is what public health ethics is, is identifying and clarifying ethical dilemmas.

We had a young man to lecture at last week’s Public Health Ethics Intensive at Tuskegee. He is my former student and now he is a licensed therapist. When I want to know
about young people, I go to him because I have no idea. I had no idea, for example, that there was a drug problem in the suburbs. Before I heard about opioids and crystal meth, he was the one who told me, “Dr. Hodge, it’s coming and its coming fast.” Public health ethics and bioethics, operating without grounding, cannot do much.

Thus, the operative questions are, how do I ground public health ethics? How do I ground bioethics? I ground them in virtue and care ethics, and I have a good reason for doing this. As Captain Wilkins read the last sentence of my dossier, he said, my dissertation was on “Jesus and Virtue Ethics.” Jesus gave us something in virtual ethics that Aristotle did not. Jesus gave us notion of love and the notion of compassion. Jesus’ terms were less impactful in the rational Enlightenment, but the 18th century became very prominent with the words like “empathy” and, in the 20th century, “care.” Consequentially, I tend to ground my work in public health ethics, not in utilitarianism, and not in deontology (consequences and rules, respectively), but I ground it in what is closest to my faith tradition. Regardless of your faith, the cause of your beliefs, your tradition, there are some principles in religious tradition that are very similar to virtue and relational care ethics. For example, benevolence, and being kind.

Benevolence is doing good. It is not just being kind; it is the will and action of doing good. Empathy is having a certain kind of other-regarding feeling, but compassion is going beyond the feeling and demonstrating some action.

Thank you very much for indulging me for the last 40 minutes. And young people, this day is yours. Take this opportunity to say the things that you always wanted to say and felt you could not. And if it is deeply personal, there are enough trustworthy adults in this room to whom you can turn for compassion. You can trust those who are trustworthy. Thank you very much for indulging me with these words. Blessings upon you. Take care.

Question:

I was interested in what you were saying about the greatest happiness for the most people and that concept. I work for Feeding America and the food banking world and programs that are intended to help people get enough food. And I find that a conundrum that we think about frequently is this concept of sort of scale versus specificity. So is it quantity, serving a lot of people and doing the best we can there versus knowing that, as we have these deeper programs or interventions, we can actually probably make a bigger difference, but it’s to a smaller number of people. So, I was just wondering if you had any sort of thoughts on that?

Dr. David Hodge:

There you go. Thank you very much. I appreciate the question. The dilemma that that question motivates is precisely why I am not a utilitarian, though there’s some good work to be done in utilitarianism, medical actions like xenotransplantation are usually utilitarian arguments to demonstrate why we should have respect for animal lives and so on and so forth. I go with virtue ethics and care ethics because Aristotle said it this way. He said, “Find the virtuous person and follow them and then habituate their virtues.” In other words, we cannot be wrong
when we are operating out of good motives and gracious character. So, your safeguard is that you know you have done your best. Where there's quality or quantity, you know you can sleep well at night, because you did your best in each situation. But if we put it to a purely utilitarian situation, then you may fall into some other kinds of discriminatory behaviors. For example, if when we start talking about utilitarianism and start balancing the many versus the minority, then we would have a problem. The minority is typically a race, a gender, a religion, or a sexual orientation. Therefore, we must be cautious. If, on the other hand, you are operating out of a sense of character, then you are not constrained to operating by numbers but by what is the right thing to do. That is why I ground my ethical theory in virtue ethics over against the opposite.

Question (Dr. Dru Barrett):

It was, I think it was very -- your use of narrative and story really brought these concepts to life. And as you know, we are trying to look more at how we can use narrative ethics approaches, to better have people learn about ethics. And I think scientists often have a hard time with that, there. They just want to express the facts. They do not, it is more difficult, I think to sort of understand their approaches. So, I am wondering if you could talk some about like what you see -- you know, you are obviously an expert in telling, you know, bringing the stories to life and presenting a narrative. And I wonder if you have any tips for scientists and how they can do a better job in that area.

Dr. David Hodge:

That is a good question, tips for scientists. Part of the work that we do, often is to critique the work of the scientists to kind of hold them up to a standard and a level because, for example, back to the statement I just made on xenotransplantation, scientists given an opportunity, they are running very fast into taking animal organs and putting them into human beings. And just to speak slowly here, we need to ensure that we have empathy, and this is where relational ethics come into play. Right? Now, relational ethics and virtue ethics are not the same. Relational ethics came out of the feminist conversation, not the radical feminists, but the more relational feminists.

And their conversation is about getting to know people, being in conversation with people, to use your word, Dr. Barrett, to understand their narratives. The work that Dr. Warren and I do, in terms of the research in clinical trials, has to do with going into the community, getting to know the people. The good part of, say, xenotransplantation against transplanting animal organs into a human, is that there is a whole lot of benefits. There are a 110,000 people each year on the waiting list for a kidney or heart or other organ, but only 30,000 surgeries are being done based upon low availability. What if you can give someone a pig kidney, which would give her five more years of sustained life until a kidney become available?

There is some good here. However, you cannot just walk into a Muslim community and give somebody a pig kidney. There must be some conversation and that is where the narrative, the relationships come in. Now, the scientist is on a very purposeful trajectory. We must get it done by a certain time, right? They have these constraints. But the human beings
with whom we are dealing move very slowly. Dr. Warren pointed out the notion -- the contract between trust and trustworthiness in the larger scheme. We do not have to go into those conversations, but we know what they are. But there are communities that justifiably do not trust scientists or medical clinicians. So, it takes more and more time. My endocrinologist goes into Seminole county, into the Seminole community in South Florida (where the Hard Rock Cafe is and the other casinos to offer free clinics). It is an extremely wealthy community. He tried to have a conversation, but the problem is they are saying, “Wait a minute, we don’t trust you.”

Now, the Trail of Tears occurred several years ago; nevertheless, “We still don’t trust you.” So relational care ethics, Dr. Barrett, will be extremely helpful in building conversation and community. One of the things I foster, in terms of the public health conversation, how do we define public can be quite misleading or misunderstood. Because public could be numerical, public, or political. But public can also be community. This is where I think public health ethics needs to be mostly -- that is, to understand that the people we’re dealing with, regardless of the science, and though the scientists are starting to understand, that the people we are dealing with are real people, with real stories and real tragedies. There must be a conversation, not a kind of patriarchal pushing of oneself into a person’s community.

Question (Dr. Leandris Liburd):

Dr. Hodge, thank you so much for your talk. I have a question. This is something that we are grappling with right now, in the Office of Minority Health. So, we have a series of definitions that define our work -- health disparities, health equity, health inequity, social determinates of health and there and others. And we are finding that the more we engage in this work, the more nuanced our understanding of it is, particularly from a standpoint of wanting to act. And so, in our definition of health equity, we talk about things that have three characteristics. They are avoidable, they are systematic, and they are unfair. And so, I am interested in how you think about what is fair, particularly in a cultural context of the U.S., of what I am going to just describe as rugged individualism.

Dr. David Hodge:

Thank you, Dr. Liburd. In 1972, one of our great academics, John Rawls, wrote a book entitled *A Theory of Justice*. His major argument was one called justice as fairness. There is no fairness that is dissociated from justice. Part of the problem, going into these conversations, is that the word justice seems very abstract. As a matter of fact, relational ethicists have struggled about how to understand the word justice because they are relational. They are not abstract. Justice is not something in the sky somewhere. They are talking about what is right in front of us. So, John Rawls’ conception of justice as fairness is one that would work. The other part of my definition is the importance of reaching the least, the lost and the left out—to prioritize those who simply do not have access. The other people can hold their own. If we are not doing good acts for the least, the lost and the left out, then we are not being fair. And if we are purposefully blinding ourselves to the least, the lost and the left out, then there is something extremely egregious about what we call our ethical philosophy.
Household Food Insecurity Is Associated with Self-Rated Health Status among Single Mothers in Alabama’s Black Belt Counties

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Abstract
This study was conducted in Alabama’s Black Belt Counties to examine the association between household food insecurity and self-reported health status. Data were collected from 400 households to measure household food insecurity and self-reported general health status using the U.S. Food Security Module. In bivariate analyses, household food insecurity was significantly associated with health status as some mothers from food insecure households were significantly more likely to rate their health as fair/poor. In regression analysis model controlling for potentially confounding variables, household food insecurity was still associated with poor self-reported health status. Food intake of some household members was reduced, and their eating patterns disrupted at times because the household lacked money for obtaining food. Policy changes to increase economic resources and access to federal food programs are needed to reduce household food insecurity in this region. Gendered experiences in the context of consequences of poverty should not be ignored.

Keywords: Food Insecurity, Self-Rated Health Status, Single Mothers, Alabama's Black Belt
Introduction

Household food insecurity, defined as the “limited or uncertain availability of nutritionally adequate and safe foods, or limited or uncertain ability to acquire food in socially acceptable ways to feed the whole household” (Coleman-Jensen et al., 2019; Zekeri, 2019) continues to affect millions of American families in the rural south. Household food insecurity is a social problem that disproportionately affects households in rural areas.

In previous research of single mothers in the Black Belt counties, those who experienced food insecurity had significantly lower levels of income, less education, and were more likely to be African Americans and report higher depressive symptoms than women from food secure households (Zekeri 2019; 2010; 2016; Zekeri et al., 2016). The aim of the present study is to determine if household food insecurity is a specific correlate of self-reported health status. The central hypothesis guiding this analysis is that food insecurity among household headed by poor single mothers is associated with their health status. This is suggested because household food insecurity is embedded within the context of poverty which is likely to produce anxiety and fear that may take a toll on physical health.

Several studies have examined the impact of food insufficiency as measured by a scale derived from the National Health and Nutrition Examination Survey III on health status among adults in urban areas (Dixon, Winkleby, Household Food Insecurity Is Associated with Self-Rated Health Status among Single Mothers in Alabama’s Black Belt Counties Andrew A. Zekeri, B.Sc, M.Sc., Ph.D.& Radimaer 2001; Heflin, Siefert & Williams, 2005; Nelson et al., 2001; Olson, 1999; Roe,1990; Siefert et al., 2001, 2004; Vozoris & Tárasuk, 2003). In these urban studies, self-rated health status is associated with food insufficiency. However, reports of the relationship between household food insecurity and health status in rural areas are limited. Despite its potential impact on health and well-being, surprisingly little research has been done on the relationship between household food insecurity and health status among poor female-headed families in the rural south. Therefore, as an extension of my previous research (Zekeri, 2019; 2011; 2010), the goal of this study is to examine the association between household food insecurity and self-reported health in this poverty-stricken region of Alabama.

Method

The research design combined quantitative and qualitative methods. This research was conducted as part of a larger project, Food Insecurity in Poor, Female-Headed Families in Five of Alabama Black Belt Counties. My prior research from the same data set (Zekeri, 2010; 2016; 2019) focused on food insecurity and depression. In the present investigation, my focus is on household food insecurity and self-reported health status. The survey was designed to measure food insecurity status at the household level. The research is based on a survey, in-depth interviews, and a workshop, and was conducted in collaboration with key informants that helped the researcher gain trust and entry to this community. A sample of 400 households located in five Alabama Black Belt Counties (Bullock, Dallas, Macon, Lowndes, and Wilcox) that were receiving welfare and/or food stamp benefits agreed to participate in the study. The
sample for this study, 400 single mothers was drawn from a list of over 1,000 families in a five-county area of Alabama Black Belt that participated in previous studies carried out by the author (Zekeri, 2010; 2016; 2019).

These counties have many African Americans and individuals living below the poverty level. Also, these are counties where I had previously developed ties with many of the community informants and residents. Households were selected using random stratified sampling methodology. The randomly selected single mothers were located at previous addresses, as well as through community informants and local churches. Once the selected mothers were located, I made personal home visits requesting participation in the study. Most of these single mothers were low-income individuals that had previously helped me understand their world - how they perceived it, coped with it, and interacted with it—and their opinions about electronic delivery of food stamps with the Benefit Security Card (Zekeri, 2010; 2016).

**Alabama’s Black Belt**

Alabama’s Black Belt, the site for this study, is an ideal setting for examining the prevalence and adverse health consequences of food insecurity. Among the poorest places in the United States, this region is characterized by its high concentration of African American residents. Regionally, the Alabama Black Belt’s poverty rates as of 2019 compare to that of the Appalachian mountain region, where the poor are predominantly White, the Rio Grande Valley/Texas Gulf Coast, where the poor are largely Latino, and the reservations of the Southwest, where the poor are largely Native Americans. The Black Belt region suffers from poor employment opportunities, chronic unemployment, limited educational attainment, poor health, high concentration of single parents, and heavy dependence on public assistance programs (; 2019; Zekeri et al., 2016).

**The Study Variables**

Food insecurity was measured using a structured questionnaire based on CFSM and the other questionnaires constructed and used in previous studies, all investigations were approved by the Human Subject Participants Review Committee at Tuskegee University. The CFSM scale is based on respondents’ answers to a series of 18 questions regarding behaviors and experiences known to characterize households that are having difficulty meeting food needs. Face-to-face, in-home, structured interviews were conducted. Consent to participate in the study was obtained from all participants. The interviews lasted approximately 90 minutes. For the present analysis, food security status is a dichotomous variable (food insecure and food secure).

**Dependent Variable**

Self-reported health is the dependent variable. Self-reported health is the respondent’s subjective assessment of her general health. Single mothers were asked to rate their overall health at the time of the of the survey with a standard five-category item for self-rated health, with values ranging from excellent (1) to poor (5). Self-rated health has been shown to be a reliable, valid measure of health, and it is predictive of subsequent functional decline (Idler, Russell&
Davis, 2000). It is a valid and reliable measure of general physical well-being. It predicts mortality net of chronic and acute disease, physician assessment made by clinical exam, physical disability, and health behaviors (Idler & Benjamin 1997).

**Key Independent Variable**

The independent variable of interest is a binary variable that indicates whether a household is food insecure or not. I collected questionnaire data in face-to-face, in-home, structured interviews with single mothers who were heads of the household. The interviews lasted about 90 minutes. Household food insecurity was measured using a structured questionnaire (based on the USDA’s Food Security Core Module). The study was approved by Tuskegee University Committee on Human subjects.

**Control Variables**

To empirically distinguish the influence of household food insecurity and other variables, respondent’s age, race (black or white), educational attainment (years of completed schooling), unemployment, and annual earnings known to be associated with health status in previous research (Heflin et al., 2005; Siefert et al., 2000, 2001, 2004; Stuff et al., 2004; Vozoris & Tarasuk, 2003) are included in the model. Household income (in dollars), and age of single mothers (in years) were included as continuous variables. Race is a dummy variable coded 1 for African Americans. Education level was a dummy variable coded 1 for those with a four-year college degree. Unemployment is also a dummy variable coded 1 if the single mother is unemployed. Taken together, these sociodemographic and work characteristics provide a basic outline of the respondent’s social position.

**Data Analysis**

The analysis employs multiple regression methods using SPSS 14.0. First, health is regressed on food insecurity to determine any statistically significant associations. Then, an expanded form of regression analysis examines effect estimates (regression coefficients) of food insecurity and the control variables on health status.

**Results**

Using the USDA’s Food Security Scale, 36% of the households were classified as food insecure (Table 1). The prevalence of food insecurity in this region contrasts sharply with the national figure, where roughly 11.1% suffer from food insecurity in 2018. Most of the households are African Americans (70%) and 32% had no education beyond high school. Regarding household income, 52.2% earned less than $15,000 and 36.5% had no employment.

**Bivariate Analysis**

Bivariate analysis showed a statistically significant association between household food insecurity and health status (see Table 2). This finding is consistent with some previous research (for example, see Heflin et al., 2005; Olson, 1999, 2005; Siefert et al., 2001, 2004; Stuff
et al., 2004; Vozoris & Tarasuk 2003) that found that the association between household food insecurity and health status is statistically significant. In the bivariate analysis, food insecurity alone explained about 3.6% of the variation in health status.

**Multivariate Analysis**

Table 2 presents the results from regression analysis predicting self-rated health status. Furthermore, and confirming some previous studies (e.g., Siefert et al., 2001, 2004; Stuff et al., 2004; Vozoris & Tarasuk, 2003), model 2 in Table 2 indicated that among the predictor variables, food insecurity is still a statistically significant predictor of health status. Model 2 demonstrated that educational attainment and employment have large and statistically significant relationships to general health. Having a four-year college degree and being gainfully employed are related to better self-reported health as shown by the relatively large parameter estimates. Thus, consistent with previous literature (e.g., Dowd & Zajacova, 2007), higher

<table>
<thead>
<tr>
<th>Dependent</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Status</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td>8.3</td>
</tr>
<tr>
<td>Fair</td>
<td>29.0</td>
</tr>
<tr>
<td>Very Good</td>
<td>29.6</td>
</tr>
<tr>
<td>Excellent</td>
<td>7.9</td>
</tr>
<tr>
<td>Independent Variables</td>
<td></td>
</tr>
<tr>
<td>Prevalence of Food Insecurity</td>
<td></td>
</tr>
<tr>
<td>Food Secure</td>
<td>64.0</td>
</tr>
<tr>
<td>Food Insecure</td>
<td>36.0</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>70.0</td>
</tr>
<tr>
<td>White</td>
<td>28.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.0</td>
</tr>
<tr>
<td>Educational Attainment</td>
<td></td>
</tr>
<tr>
<td>Did not complete high school</td>
<td>31.5</td>
</tr>
<tr>
<td>Completed high school or equivalent</td>
<td>32.7</td>
</tr>
<tr>
<td>Some college of post high school training</td>
<td>23.5</td>
</tr>
<tr>
<td>Completed a college degree</td>
<td>10.2</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>Under $15,000</td>
<td>52.2</td>
</tr>
<tr>
<td>$15,000 to $34,0000</td>
<td>47.5</td>
</tr>
<tr>
<td>Employed (including part-time)</td>
<td>59.3</td>
</tr>
<tr>
<td>Unemployed</td>
<td>36.5</td>
</tr>
</tbody>
</table>

*a Some percentage scores do not sum to 100% because missing data are not reported.
levels of education and employment predict more health-optimistic rating. Income, in contrast, is unrelated to ratings net of other variables. This finding is contrary to the results of other researchers that found low income and neighborhood poverty are linked to poor self-reported in rural women (Kobetz et Al., 2003; Zekeri, 2019) Taken together, the results provided support for the hypothesis: Household food insecurity is associated with health status.

**Discussion**

In this study, I have assessed whether household food insecurity is associated with self-rated health status. Similar to some previous studies, household food insecurity is a significant predictor of self-rated health. The association remained statistically significant after controlling for potentially confounding variables, a finding that supports past evidence (e.g., see Heflin et al., 2005; Olson et al., 2004; Siefert et al., 2000, 2001, 2004; Stuff et al., 2004; Tarasuk & Beaton, 1999; Vozoris& Tarasuk, 2003). In a random sample of 724 single women, who were welfare recipients in Northern Michigan, Siefert et al. (2001) found that food insufficiency was significantly associated with poor or fair self-reported health. The current study advances our knowledge of this relationship by focusing on the link between household food insecurity and self-rated health in rural Alabama where access to health treatment can be even more difficult to obtain than in urban areas. Moreover, the majority of the previous studies used a single item measure of food insufficiency, while this study used the U.S. Food Security Module scale to measure food insecurity allowing researchers to be more confident in the reliability and validity of the finding (Alaimo et al., 1998, 2001; Heflin et al., 2005; Siefert et al., 2001, 2004). Race was not a significant predictor of health in this sample from the rural south. Further research is needed to ascertain whether this finding persists in other similar regions.

**Table 2. Standardized coefficients of regression analyses of health status among households**

<table>
<thead>
<tr>
<th></th>
<th>Model 1</th>
<th>Model 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household food insecurity</td>
<td>-.201*</td>
<td>-.147*</td>
</tr>
<tr>
<td>Age</td>
<td>.035</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>.019</td>
<td></td>
</tr>
<tr>
<td>Full-time employment</td>
<td>.237*</td>
<td></td>
</tr>
<tr>
<td>Racea (Black=1)</td>
<td>-.035</td>
<td></td>
</tr>
<tr>
<td>Education attainment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four-year college degree</td>
<td>.161*</td>
<td></td>
</tr>
<tr>
<td>Adjusted R²</td>
<td>.036</td>
<td>.130</td>
</tr>
</tbody>
</table>

*p <.05; a White persons are the reference group
In sum, the association of household food insecurity with self-reported health, regardless of causal direction, shows the precarious situations households face in rural areas. Beyond food problems, households struggle with health problems. The findings highlight the need to prevent household food insecurity and ensure that all rural households are adequately fed to improve health and social well-being. It is also crucial to note that measures of education, earnings, race, and age commonly regarded as key predictors of health are included in the model. The production of health is clearly very complex, but I argue that food insecurity can have a meaningful impact on well-being, along with other factors considered here and a multitude of unmeasured influences. In poor rural areas such as Alabama’s Black Belt, a number of obstacles to health care and health care access could also contribute to poor health status. Alabama’s Black Belt faces a unique combination of factors that create disparities in health care not found in urban communities such as economic factors, cultural differences, and educational attainment.

The future direction of food insecurity research must go beyond just monitoring food insecurity to linking it with medical related outcomes such as health status. Education, employment, and food insecurity are all related health outcomes. Alabama’s Black Belt faces unique challenges in each of these areas.

The study has some limitations. First, the cross-sectional nature of the data makes it impossible to draw causal inferences from the relationships in the model. Further tests of the model should utilize longitudinal data, including a more comprehensive measure of household food insecurity to ascertain the true nature of the associations reported here. Reliance on self-reported health rather than formal diagnosis based upon structured medical interview may be seen as another limitation. Clearly, the ideal study would include screening with self-reported measure of health followed up with a structured clinical interview. The significance of self-reported health, however, should not be underestimated. Research examining food insecurity in relation to objective measure of health is required to confirm the findings of this study.
References


The Impact of Race and Geographical Location on the Treatment Options of Cervical Cancer in Black and White Women Living in the State of Alabama

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Abstract

This study assesses the association between age, race, geographical-location, stage, and treatments of Cervical Cancer (CerCancer) in Black and White women, living in Alabama. Data from 2004-2013 was provided by the Alabama Cancer Registry. To perform Chi-square
and logistic regression tests, SAS-software was used for analysis. In urban counties, Blacks 40–49 years old diagnosed with localized stage of CerCancer were the most likely to receive surgery (74.14%; P < .0001), followed by Whites 17–39 years old diagnosed with regional stage, were the most likely to receive radiation and surgery-radiation sequence (66.32 and 66.67%; P < .0001) respectively. Also, Whites 50 years and older diagnosed with regional stage were the most likely to receive chemotherapy (65.87%; P < .0001). In rural counties, Blacks 40-49 years old diagnosed with regional stage were the most likely to receive radiation (70.37%) and chemotherapy (83.33%) with P = .005 and .003 respectively, followed by Whites 17-39 years old diagnosed with localized stage were the most likely to receive surgery (76.81%; P < .0001). Adjusting for age, stage and county, Blacks had 1.12 (95% CI = .88-1.42) times the odds of receiving more radiation treatment. Blacks had .76 times adjusted odds (95% CI .59-.99) of receiving less surgery compared to Whites. Treatment disparities exist between Blacks and Whites in Alabama.

Keywords: Urban and rural counties of Alabama; Cervical cancer; disparities; Blacks; Whites; SAS software

Introduction

In 2017, it was estimated that there would be 12,820 newly diagnosed cases of CerCancer in the United States (US) (American Cancer Society, 2017). There was a significant decrease in the incidence rate of CerCancer in the US between 1975 and 2013 (14.8 versus 6.5 per 100,000) respectively. This significant decrease was due to the widespread use of screening methods and early diagnosis primarily with the Papanicolaou smear test (Pap test) (American Cancer Society, 2017). Despite this decrease, the incidence and prevalence disparities still persist among women of various racial/ethnic groups especially between White and Black women (Simard, 2012). The 5-year relative survival rates (RSR) for CerCancer from 2006-2013 in Whites and Blacks was 71% and 58% respectively (Howlader N, 2016). In addition, mortality from CerCancer is approximately twice as high in Blacks compared to their White counterparts (4.3 versus 2.2 per 100,000) in the US (Siegel, 2013).

Similar statistics exist in the State of Alabama, with significant disparities existing between Whites and Blacks. In 2017, about 210 new cases of CerCancer were expected to be diagnosed in Alabama (American Cancer Society, 2017), with an incidence rate of 8.6 per 100,000, which is significantly higher than the US rate of 7.6 per 100,000. Within Alabama, Blacks have a significantly higher CerCancer incidence rate than Whites, with a rate of 10.7 versus 8.2 per 100,000 women (American Cancer Society, 2017). In addition, the CerCancer mortality rate in Alabama is 3.2 per 100,000, which is higher than the US rate of 2.3/100,000 (Alabama Statewide Cancer Registry (ASCR), 2017; Centers for Disease Control and Prevention (CDC), 2017). In the State of Alabama, Blacks have a significantly higher CerCancer mortality rate than Whites, with a rate of 5.2 per 100,000 versus 2.7 per 100,000 (Alabama Statewide Cancer Registry (ASCR), 2017; Centers for Disease Control and Prevention (CDC), 2017).
Attributable to racial/ethnic disparities in cancer and its outcomes especially in CerCancer are various reasons and factors. Stage at diagnosis is considered as one of the major reasons for health disparities and poorer prognosis of CerCancer as Blacks are likely to have more advanced cancer at the time of diagnosis than their White counterparts. However, poorer survival rates are also evident for Blacks compared to White women (Siegel, 2013). It is assumed that the differences in the stage of the cancer at diagnosis is a result of underutilization of cancer screening among racial/ethnic minorities (Garner, 2003) as a result, increasing access to screening has been the mainstay of the battle against racial/ethnic disparities in cervical cancer mortality.

Recent data, however, demonstrates that Pap smear screening rates have become quite similar between Whites and Blacks (DeSantis, 2013), yet disparities still exist. Treatment differences have also been ascribed to playing a role in CerCancer disparities. Whites are the most likely to receive a radical hysterectomy for early staged CerCancer (which is the most effective treatment) and the most likely to complete brachytherapy than Blacks (del Carmen, 1999). Studies have also shown that; there are racial differences in diagnostic follow up of abnormal screening examinations which may lead to more advanced cancer stages at diagnosis (Chang, 1996). Nevertheless, some authors have suggested that when socioeconomic factors (education, income, health insurance, etc.) and medical comorbidities are the same, CerCancer mortality is similar across the racial/ethnic groups (Farley, 2001).

The Alabama Breast and CerCancer Early Detection Program (ABCCEDP) founded by the state has provided free breast and CerCancer screening and diagnostic services for Alabama’s underserved women for more than 20 years (Alabama Department of Public Health, 2017). The goal of the ABCCEDP is to reduce breast and CerCancer related morbidity and mortality through screenings in underserved populations in the state of Alabama. Despite screening, disparities still exist. Alabama has a higher CerCancer incidence rate compared to the US with a higher incidence and mortality rate in Black women (American Cancer Society, 2017). Although various factors are associated with CerCancer disparities, less known is about geographic factors. In this paper, we sought to look for the relationship and impact of geographic location and racial factors contributing to CerCancer disparities in women who live in rural and urban counties of Alabama. We hypothesized that; CerCancer treatment disparities exist between Blacks and Whites based on race and geographic location, especially for Blacks living in urban and rural counties of Alabama (Figure 1) (Abdalla E, 2017) compared to their White counterparts.

**Methods**

**Data Source**

The Alabama Department of Public Health (ADPH) Cancer Registry provided the CerCancer data used in this study; this data originally abstracted was from medical records. The data are publicly available data collected by the Surveillance, Epidemiology and End Results (SEER) database. In this study, data was extracted from the database for the years from 2004 to 2013. The SEER program of the National Cancer Institute (NCI) is an authoritative source of information on cancer incidence and survival in the US. The SEER program currently collects
and publishes cancer incidence and survival data from population-based cancer registries covering approximately 30% of the US population. The data was used to define age at diagnosis, race/ethnicity, stage at diagnosis, and treatment regimen. Race/ethnicity was classified using race and comprised the following categories: non-Hispanic Black, and non-Hispanic White. Age was stratified into three groups (17 to 39, 40 to 49, and 50 years and older). Alabama’s Counties as shown in Figure 1 were stratified into three groups (urban, rural BB and other rural Counties) based on previous studies (Weragoda, 2016). The ADPH Cancer Registry uses the SEER, summary staging algorithms, and the extent of disease information (size of tumor, extension of tumor and lymph node status). These data sets can be used to classify CerCancer stages, which were then categorized for analysis as follows: localized, regional, distant and unknown stages. Summary staging tends to be used when doing analysis over time, as there is more consistency over time (Howlader N, 2016).

In this study, we used stratified data by SEER’s historic staging scheme at diagnosis. The gathered information about in situ and invasive CerCancer was used to classify the CerCancer into its four constituent stages. These are: (i) localized (in situ cancer confined to the organ of origin); (ii) regional (spread to adjacent organs and/or regional lymph nodes by direct extension); (iii) distant (extension to organs other than those covered in the regional category or metastases to distant organs or distant lymph nodes); and (iv) unknown stage, cancer of unknown primary origin. Sometimes it is not clear where a cancer may have started. When cancer is found in one or more metastatic sites, but the primary site cannot be determined, it is called a cancer of unknown primary (CUP) or an occult primary cancer (Howlader N, 2016).

Abstracted also from the ADPH Cancer Registry, were the corresponding treatment data. Potential treatments included surgery, radiation, surgery-radiation sequence and chemotherapy, as indicated in the guidelines by the National Cancer Institute (NCI) for cancers at various stages (localized, regional, distant and unknown). Information on the type of hospital or facility that provided the treatments was not available. Created were dichotomous variables indicating which treatment compared with no treatment: (i) surgery; (ii) radiation; (iii) surgery-radiation sequence; and (iv) chemotherapy.

**Statistical Analysis**

The ADPH cancer registry data from 2004 to 2013 indicated that there were 2,124 cases of CerCancer in women aged 17 years and older. Of these cases 2,081, (the final sample size for analysis) were Black and White women, of which 651 (31.3%) were Blacks and 1430 (68.7%) were Whites, who were diagnosed with CerCancer. The statistical analysis done used Statistical Analysis System (SAS) software; version 9.4, SAS Institute Inc., and this included both descriptive statistics and exploratory analysis to show their association. Performed were also frequency distributions to determine the frequency of receiving or not receiving any type of treatment options, between sets of independent and dependent variables. The latter would be the presence of disease of interest, or rates of such disease in the population under study. The independent or predictor variables (or discriminate variables) consist of quantitative variables that include geographic location, age, race, stages and treatment options.
For descriptive analyses, frequency distributions between categorical variables were compared using Chi-Square (χ²) tests. Trends based on indication of patient characteristics are reported descriptively. Cochran-Mantel-Haenszel Statistics test along with Fisher exact tests were used to examine general associations between previously mentioned independent and dependent variables. Analysis using adjusted logistic regression accounted for the effects of confounding variables, yielding odds ratios of the independent effects of race on receiving of a specific treatment option. Potential confounders were chosen for the regression model via backward selection, with a likelihood ratio probability-value (p-value) of less than (<) 0.05 considered sufficient for inclusion into the model. Contrariwise, in the frequency distributions and χ² tests, the counties of Alabama had to be grouped into only urban and rural counties because some of the statistics could not be calculated due to the small number of cases or no data in some of the rural counties, especially in the BBC. In the logistic regression analysis, the counties of Alabama were grouped into (i) urban (ii) the BBC and (iii) other rural counties (Figure 1). All P - values were two-sided with a significance threshold of P<0.05 and categorical variables are expressed in this study as percentages.

Results

Presented in Tables 1-3 and Figures 2 – 10 are the detailed results of this study. Overall, the results show subsequent analysis of the relationship between age, race, geographical location, stage of CerCancer, and selected treatment options of CerCancer in Black and White women, living in urban and rural counties of Alabama from 2004 to 2014. The tables and figures summarize with the corresponding analysis by percentage of race which age group, geographical location or stage of CerCancer were the most likely to receive what form of treatment with a p value of < .0001 than any other age group, stage or race in the given geographical location whether urban or rural county.

Table 1 and Figure 2 (in Appendix), show that 74.14% of Blacks 40 to 49 years old, living in urban counties and diagnosed with localized stage of CerCancer were the most likely to receive surgery treatment (P < .0001). However, most women diagnosed with localized stage of CerCancer irrespective of race, age group, or geographic location mainly received surgery as the treatment option. Table 1 and Figure 3, show that 66.32% of Whites 17 to 39 years old, living in the same urban counties, diagnosed with regional stage of CerCancer were the most likely to receive radiation treatment (P < .0001). Table 1 and Figure 4, show that 66.67% of Whites 17 to 39 years old, living in urban counties, diagnosed with regional stage of CerCancer were most likely to receive surgery-radiation sequence treatment (P < .0001). As shown in Table 1 and Figure 5, 65% of Whites 50 years and older and 65.8% of Blacks 17 to 39 years old, living in urban counties, diagnosed with regional stage of CerCancer were the most likely to receive chemotherapy treatment (P < .0001).

As shown in Table 2 and Figure 6, 76.81% of Whites 17 to 39 years old, living in rural counties and diagnosed with localized stage of CerCancer were the most likely to receive surgery treatment (P < .0001). Table 2 and Figure 7, show that 70.37% of Blacks 40 to 49 years old, living in rural counties and diagnosed with regional stage of CerCancer were the most likely
to receive radiation treatment ($P = .005$). Table 2 and Figure 8, show that 63.64% of Blacks 50 years and older and Whites 17 to 39 years old, living in rural counties, diagnosed with localized and regional stages of CerCancer were the most likely to receive surgery-radiation sequence treatments with $P = .005$ and $P < .0001$ respectively. Table 2 and Figure 9, show that 83.33% of Blacks 40-49 years old, living in rural counties and diagnosed with regional stage of CerCancer were the most likely to receive chemotherapy treatment ($P = .003$). Overall, in urban and rural counties there were general significant associations with a $P < .006$ between Blacks and Whites who received surgery, radiation, surgery-radiation sequence and chemotherapy treatments, irrespective of all their age groups and all the stages of CerCancer.

A series of logistic regression models were developed using variables for age, race, stage of CerCancer, and county in Table 3 and Figure 10. Adjusted for age, stage and county, Blacks had an odds ratio of 1.12 (95% Confidence Intervals (CI) .88-1.42) of receiving more radiation, also Blacks had an adjusted odds ratio of .76 (95% CI .59-.99) of receiving less surgery compared to their White counterparts.

**Discussion**

In this study, we examined the impact of race and geographic location on the treatment options for the four stages of CerCancer in Black and White women living in urban, rural BB and other rural counties of Alabama, from 2004-2013. In urban counties 66.32% and 66.67% of Whites aged 17-39 years old, diagnosed with regional stage of CerCancer were the most likely to receive radiation and surgery-radiation sequence treatment options respectively, compared to any other age groups and stages whether in Blacks or Whites. Also 65.87% of Whites who are 50 years and older, living in urban counties and diagnosed with regional stage of CerCancer were the most likely to receive chemotherapy treatment option. In urban counties, 74.14% of Blacks aged 40-49 years old, diagnosed with localized stage of CerCancer were the most likely to receive surgery treatment option, compared to any other age groups and stages whether in Blacks or Whites. However, overall there was a general significant association between Blacks and Whites who received surgery, radiation, surgery-radiation sequence and chemotherapy treatment options, living in urban counties, irrespective of all their age groups and all the stages of CerCancer.

In rural counties, Blacks in all age groups (17-39, 40-49 and 50 years and older) and all stages (localized, regional, distant and unknown) of CerCancer were the most likely to receive three treatment options (radiation, surgery-radiation sequence, and chemotherapy). In the three treatment options, 66.67% of Blacks 17-39 years old, and 70.37% and 83.33% of Blacks both 40-49 years old, all diagnosed with regional stage of CerCancer were the most likely to receive surgery-radiation sequence, radiation, and chemotherapy treatments respectively, compared to any other age groups and stages whether in Blacks or Whites. Whereas, Whites in all age groups (17-39, 40-49 and 50 years and older) and all stages (localized, regional, distant and unknown) of CerCancer were the most likely to receive one treatment option (surgery). In the only treatment option, 76.81% of Whites 17-39 years old, diagnosed with localized stage of
CerCancer were the most likely to receive surgery treatment, compared to any other age groups and stages whether in Blacks or Whites. Furthermore, not only was chemotherapy not the most used treatment method for all stages of CerCancer across all age groups in both Black and White women, but Whites 17-39 years old diagnosed with regional stage of CerCancer was the only group that did not significantly receive this treatment option.

Irrespective of age, stage of the disease and location of the patients our study analysis shows that equivalent treatments are not provided to Whites and Blacks diagnosed with CerCancer. These differences in treatment may likely be a contributing factor to the increased CerCancer mortality in Blacks in Alabama compared to their White counterparts. It also indicates that health disparities in CerCancer exist between Blacks and Whites, living in the same counties whether urban or rural. However, the disparities are significantly higher when comparing Blacks, living in rural counties to their White counterparts living in urban counties. Similar findings were seen in a study conducted by Fleming, et al (Fleming, 2014) from 1992 to 2008. They showed that surgical treatments for newly diagnosed CerCancer cases in the state of Maryland were significantly less common amongst Blacks, compared to their White counterparts. Also in the state of Maryland, equivalent treatments were not available to Whites and Blacks with CerCancer.

Proposed are various reasons to account for the poorer outcomes amongst Blacks with CerCancer. Disparities in outcomes may result from unequal access to care due to geographical location or differences in the quality of management care received. They may also most likely result from differences in comorbidities or from biologic distinctions between women of different racial and ethnic backgrounds (Datta, 2006). Major factors that contribute to the differences in outcomes include exposure to the Human papillomavirus (HPV) infection, which is almost exclusively the causative agent of CerCancer; access to high quality regular screening using the Pap test; access to timely treatment; and follow-up care may include regular physical examinations, medical tests, or both. These factors may be affected both by race and socioeconomic status (Fleming, 2014), due to the unavailability of physicians or health care specialists (Cancer.Net, 2019). Women who begin having sex at an early age are at an increased risk of getting HPV infection and ultimately CerCancer, this has also been found in women who have had many sexual partners. Women who have had only one sexual partner may also be infected with HPV (American Cancer Society, 2017). Treatment disparities may also exist because of several factors including the type and stage of cancer, age, possible side effects, the women’s preferences and overall health, and sometimes treatment can be tiered or combined depending on the physician’s treatment preference. The stage of CerCancer is also one of the most significant factors when considering treatment options as some treatment options have better outcomes than others and less side effects for a given stage (Cancer.Net, 2019). It has been shown that multiple factors play a part in increasing the risk of both persistent HPV infection and eventual progression to cancer, including a suppressed immune system, a high number of childbirths, and cigarette smoking. Increased risk of CerCancer is also associated with long-term use of oral contraceptives (American Cancer Society, 2017).
Other studies have also shown that women with low education level, older age, obesity, smoking, and those living in poor neighborhood have the lowest rate of screening for all ages and races (American Cancer Society, 2017). This may account for the increase in incidence and poorer outcomes of CerCancer in Blacks, living in either urban or rural counties of Alabama. However, this is not the case as Blacks have a significantly higher screening rate compared to Whites 88.5% and 74.9% respectively in Alabama (American Cancer Society, 2017). Differences in follow up for abnormal screening results, may also account for the diagnosis of CerCancer at late stages at the time of diagnosis, but they do not also explain differences in outcomes of the stage of CerCancer in Blacks compared to Whites in rural and urban counties of Alabama (American Cancer Society, 2017).

According to the studies of Rauh-Hain, et al (2013) (Rauh-Hain, 2013), Blacks were less likely to receive surgical therapy and the most likely to receive radiotherapy when compared to Whites. This in not in agreement with our study as Blacks aged 40 to 49 years old, living in urban counties and diagnosed with localized stage of CerCancer were the most likely to receive surgery treatment (74.14%), compared to any other age groups and stages whether in Blacks or Whites. Also Blacks 40 to 49 years old, living in rural counties and were diagnosed with regional stage of CerCancer were the most likely to receive radiation and chemotherapy treatments (70.37% and 83.33%) respectively, compared to any other age groups and stages whether in Blacks or Whites.

In most rural counties of Alabama whose population is predominantly Black, there is a limited number of gynecologic oncologists, which makes it inadequate to provide the necessary medical care for the population. Therefore, patients who are living in these counties are facing some difficulties such as travel cost and time in order to seek specialist medical care. Consequently, this can have however, impact follow up visits especially for those with abnormal Pap smear tests, which require regular follow-ups. This can therefore, result in late diagnosis, incomplete treatments and follow up for women with CerCancer which can potentially lead to poorer outcomes and health disparities (Chang, 1996; Garner, 2003; Simard, 2012).

One of the major limitations in our study using Chi-Square (χ2) tests for the analysis was because of the paucity of the data, especially for those women diagnosed with CerCancer and living in rural Black Belt counties (BBC) of Alabama. As a result, we had to combine CerCancer data from other rural counties to rural BBC of Alabama to compare them with their counterparts living in urban counties. This may have influenced the final analysis results as shown in our study particularly the results showing that Blacks 40 to 49 years old, living in rural counties and diagnosed with regional stage of CerCancer. The most likely treatment options available for these patients were radiation or chemotherapy at 70.37% and 83.33% of the time respectively.
Conclusion

The findings of this study revealed that there are disparities in the available treatment options of CerCancer between Blacks and Whites, living in Alabama. These disparities in treatment are attributable to race, geographical location, age and stage of the disease. Remarkably, Blacks in some age groups and some stages of the disease, in both urban and rural counties received more treatment options, compared to their White counterparts. In spite of all this, Blacks still had higher mortality rates, compared to Whites in the state of Alabama. Further studies focusing on factors contributing to these disparities in treatment options, which may lead to the high mortality disparities in cervical cancer between the two racial groups, are needed. These studies could potentially lead to the development of new strategies that could be beneficial to reducing and ultimately eliminating these health disparities.

Author Contributions

Oyoyo Egiebor-Aiwan, MD, MPH: Is the first author and major conceiver and designer of the manuscript. Participated and made major contributions to the analysis, interpretation of the data and writing of the manuscript. Critically reviewed manuscript and approved the final version.

Ehsan Abdalla, DVM, MSc (Hons) (Vet PATH), MSc & PhD (Epidemiology and Risk Analysis): Is the corresponding author, participated in the conceiving and designing of the manuscript. Made major contributions to analysis, interpretation of the data and writing of the manuscript. Critically reviewed manuscript and approved the final version.

Isra Elhussin, MD, MS, Integrative Bioscience (IBS) PhD Fellow: Made substantial contributions to analysis and interpretation of the data. Critically reviewed manuscript and approved the final version.

David Nganwa, DVM, MPH: Participated in designing of the manuscript. Made substantial contributions to analysis, interpretation of the data and writing of the manuscript. Critically reviewed manuscript and approved the final version.

Ronald Peaster, MS, Integrative Bioscience (IBS) PhD Fellow: Made substantial contributions to analysis and interpretation of the data. Critically reviewed manuscript and approved the final version.

Crystal M. James, JD, MPH: Participated in the writing of the manuscript and critically reviewed manuscript and approved the final version.

John Heath, MS, PhD: Participated in the writing of the manuscript and critically reviewed manuscript and approved the final version.

Lecarde Webb, MPH, PMP, Integrative Bioscience (IBS) PhD Fellow: Made substantial contributions to analysis and interpretation of the data. Critically reviewed manuscript and approved the final version.
References


Table 1. Differences in cervical cancer treatment options received in patients living in urban counties of Alabama by race, age groups and stages, from 2004 to 2013.

<table>
<thead>
<tr>
<th>Treatment by Stage</th>
<th>Blacks Age groups (in years)</th>
<th>Whites Age groups (in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17-39</td>
<td>40-49</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized</td>
<td>70.21</td>
<td>23.68</td>
</tr>
<tr>
<td>Regional</td>
<td>25.53</td>
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</tr>
<tr>
<td>Distant</td>
<td>4.26</td>
<td>2.63</td>
</tr>
<tr>
<td>Unknown</td>
<td>0.00</td>
<td>10.53</td>
</tr>
<tr>
<td>Radiation</td>
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<td></td>
</tr>
<tr>
<td>Localized</td>
<td>26.67</td>
<td>75.00</td>
</tr>
<tr>
<td>Regional</td>
<td>62.22</td>
<td>20.00</td>
</tr>
<tr>
<td>Distant</td>
<td>6.67</td>
<td>0.00</td>
</tr>
<tr>
<td>Unknown</td>
<td>4.44</td>
<td>5.00</td>
</tr>
<tr>
<td>Surgery &amp; Radiation Sequence</td>
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<td></td>
</tr>
<tr>
<td>Localized</td>
<td>41.18</td>
<td>51.47</td>
</tr>
<tr>
<td>Regional</td>
<td>47.06</td>
<td>41.18</td>
</tr>
<tr>
<td>Distant</td>
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<td>1.47</td>
</tr>
<tr>
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<td>5.88</td>
</tr>
<tr>
<td>Chemotherapy</td>
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<td></td>
</tr>
<tr>
<td>Localized</td>
<td>25.00</td>
<td>71.11</td>
</tr>
<tr>
<td>Regional</td>
<td>65.00</td>
<td>22.22</td>
</tr>
<tr>
<td>Distant</td>
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<td>0.00</td>
</tr>
<tr>
<td>Unknown</td>
<td>2.50</td>
<td>6.67</td>
</tr>
</tbody>
</table>

*P* statistically significant difference (Mantel-Haenszel chi-square tests *P*-value <0.05).
Column percentages exclude those with missing data. Non-missing categories add up to 100%, except due to rounding.
Percentage (%) = column %; Y= Yes, received treatment; N= No, did not receive treatment

^ Statistic not displayed due to fewer than 15 cases.
Table 2. Differences in cervical cancer treatment options received in patients living in rural counties of Alabama by race, age groups and stages, from 2004 to 2013.

<table>
<thead>
<tr>
<th></th>
<th>Blacks</th>
<th></th>
<th>Whites</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age groups (in years)</td>
<td>17-39</td>
<td>40-49</td>
<td>50 &amp; older</td>
</tr>
<tr>
<td><strong>Treatment by Stage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized</td>
<td>(%</td>
<td>(%)</td>
<td>*P</td>
<td>(%)</td>
</tr>
<tr>
<td>Radiation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery &amp; Radiation Sequence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*P* statistically significant difference (Mantel-Haenszel chi-square tests P-value <0.05).

Column percentages exclude those with missing data. Non-missing categories add up to 100%, except due to rounding.

Percentage (%) = column %; Y = Yes, received treatment; N = No, did not receive treatment

^ Statistic not displayed due to fewer than 15 cases.
Table 3. Adjusted odds ratios for receiving a particular treatment, among Black and White patients living in urban, rural Black Belt and other rural counties of Alabama and diagnosed with cervical cancer, from 2004 to 2013.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Surgery</th>
<th>Radiation</th>
<th>Surgery &amp; Radiation Sequence</th>
<th>Chemotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1822</td>
<td>48.85%</td>
<td>47.31%</td>
<td>13.17%</td>
<td>37.21%</td>
</tr>
<tr>
<td>Age group in years, OR (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17-39</td>
<td>452</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>40-49</td>
<td>463</td>
<td>0.944</td>
<td>1.235</td>
<td>1.311</td>
<td>0.955</td>
</tr>
<tr>
<td>50 &amp; older</td>
<td>907</td>
<td>0.375</td>
<td>1.826</td>
<td>1.249</td>
<td>0.715</td>
</tr>
<tr>
<td>Race, OR (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whites</td>
<td>1246</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Blacks</td>
<td>576</td>
<td>0.375</td>
<td>1.826</td>
<td>1.249</td>
<td>0.715</td>
</tr>
<tr>
<td>Stage, OR (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Localized</td>
<td>893</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Regional</td>
<td>540</td>
<td>0.058</td>
<td>3.064</td>
<td>0.584</td>
<td>5.457</td>
</tr>
<tr>
<td>Distant</td>
<td>230</td>
<td>0.105</td>
<td>9.353</td>
<td>1.057</td>
<td>7.954</td>
</tr>
<tr>
<td>Unknown</td>
<td>159</td>
<td>0.026</td>
<td>0.390</td>
<td>0.035</td>
<td>0.594</td>
</tr>
<tr>
<td>County, OR (95% CI)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>997</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Other Rural</td>
<td>724</td>
<td>0.928</td>
<td>0.846</td>
<td>0.832</td>
<td>1.043</td>
</tr>
<tr>
<td>Rural BBC</td>
<td>101</td>
<td>0.078</td>
<td>0.508</td>
<td>0.308</td>
<td>0.725</td>
</tr>
</tbody>
</table>

*Logistic regression models included variables for age, race, stage, and county. A separate regression model was built for each treatment. Those missing particular treatment data were excluded from the relevant regression models.

OR (95% CI): odds ratio (95% Confidence Intervals).

*Odds ratio shows statistically significant effect (p<0.05 via logistic regression).
Figure 1. Urban, rural Black Belt and other rural counties of Alabama (Abdalla E, 2017).
Figure 2. Frequency distributions among Black and White women living in urban counties of Alabama, diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received surgery treatment from 2004 to 2013.

Figure 3. Frequency distributions among Black and White women living in urban counties of Alabama diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received radiation treatment from 2004 to 2013.
Figure 4. Frequency distributions among Black and White women living in urban counties of Alabama diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received surgery & radiation sequence treatment from 2004 – 2013.

Figure 5. Frequency distributions among Black and White women living in urban counties of Alabama diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received chemotherapy treatment from 2004 to 2013.
Figure 6. Frequency distributions among Black and White women living in rural counties of Alabama diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received surgery treatment from 2004 to 2013.

Figure 7. Frequency distributions among Black and White women living in rural counties of Alabama diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received radiation treatment from 2004 to 2013.
Figure 8. Frequency distributions among Black and White patients living in rural counties of Alabama, diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received surgery and radiation sequence treatments from 2004 to 2013.

Figure 9. Frequency distributions among Black and White women living in rural counties of Alabama diagnosed with localized, regional, distant and unknown stages of cervical cancer, and had received chemotherapy treatment from 2004 to 2013.
Figure 10. Adjusted odds ratios for receiving a particular treatment, among White and Black women living in urban, rural Black Belt and other rural counties of Alabama and diagnosed with cervical cancer, from 2004–2013.
Disparities in Cervical Cancer Treatment Options between African American (Black) and White Women in Alabama

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Authors’ Note
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Abstract

There are disparities in cervical cancer treatment options between Black and White women in Alabama. This study design is to identify and assess factors contributing to the prevailing inequalities in cervical cancer treatment options between Blacks and Whites, who are living in urban, Black Belt (BB), and other rural counties of Alabama. The data of our study population, which was comprised of 2,124 cases of cervical cancer in women 17 years and older, were extracted from the 2004 to 2013 dataset of the Alabama Department of Public Health (ADPH) Cancer Registry. Using SAS software for the analysis, frequency distributions, chi-square, and logistic regression tests were generated. Racial disparities in cervical cancer treatment options for Blacks living within the same counties as Whites still exist. The study analysis showed that younger Blacks living in urban counties with advanced stages of cervical cancer were more likely to receive radiation treatment but were less likely to undergo surgical treatment options (p-value < .0001). Younger Blacks living in the BB and other rural counties were mainly treated with radiation for the early stages of cervical cancer (p-value 0.001), while older ones received surgery (p-value < .0001), and combined therapy of surgery and radiation (p-value 0.05). When adjusted for age, stage of cancer, and county of residence, Blacks had 2.76 (95% CI 0.90-8.86) times the odds of receiving immunotherapy compared to Whites. Blacks had 0.74 times adjusted odds (95% CI 0.58-0.95) of undergoing less surgery compared to Whites. Our study findings suggest that cervical cancer treatment options and control interventions targeted towards disadvantaged women, particularly Blacks living in the BB and other rural counties have the potential to reduce and/or eradicate this preventable disease.

Keywords: Cervical cancer; disparities; Alabama counties; Blacks; Whites; SAS software

Introduction

Cancer is a significant public health problem worldwide and is the second leading cause of death in the U.S. Cervical cancer affects the cells of the cervix in the lower part of the uterus that connects to the vagina distally. The majority of cervical cancer cases are caused by various strains of the human papillomavirus (HPV), primarily type 16 and 18. HPV proteins, E6 and E7, are consistently expressed in tumor cells (Borysiewicz et al., 1996). HPV infection is the most common sexually transmitted infection in the U.S; usually, however, when the body is exposed to HPV, the immune system is activated and prevents the virus from infecting the person. Unfortunately, the virus can survive for years and initiate the transformation of some cells on the surface of the cervix into cancerous cells. On the other hand, oral contraceptive pills, genetic, epigenetic, and environmental factors can increase the risk of developing cervical cancer.

Cervical cancer is the second leading cause of death due to cancer in women between 20 to 39 years old, underscoring the need to improve screening rates in this age group, as well as increasing the acceptance of and access to human papillomavirus vaccination (Siegel, Miller, & Jemal, 2017). There are three U.S. Food and Drug Administration (FDA) approved vaccines (Gardasil®, Gardasil-9®, and Cervarix®) that prevent HPV infection and therefore prevent the primary cause of cervical cancer (“U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2017 submission data (1999-2015): U.S.
Cervical cancer is usually a slow-growing cancer, with no overt clinical signs in its early stages. In the advanced stages of the disease, the most common signs and symptoms are vaginal bleeding, vaginal discharge and pelvic pain (“Cervical cancer symptoms”, 2018). Classification of cancers is a crucial step in determining the best treatment plan. The International Federation of Gynecology and Obstetrics (FIGO) system (“Cervical Cancer Stages (FIGO (International Federation of Gynecology and Obstetrics) staging system),” 2019) and the American Joint Committee on Cancer (AJCC) have developed systems to stage cervical cancer. Both systems are based on the tumor extent, spread to any lymph nodes, and distant metastasis. The stages are classified as a range from 0 to IV, with many subcategories within each numerical stage. If abnormal cells are detected on the Pap smear, a colposcopy procedure is then performed. A colposcopy uses a light microscope to examine the external surface of the cervix during a pelvic examination. A biopsy from the affected area undergoes a histopathologic examination to determine whether the changes are precancerous or are cancerous. Treatment options may include surgical treatments such as conization, hysterectomy or radical hysterectomy, radiation therapy, combined therapy of both surgery and radiation and/or chemotherapy (Chuang et al., 2016).

Recently, new treatment options which are immune-based cancer treatments have been introduced. To treat cervical cancer that has spread or recurred, immunotherapy is used. The occurrence of HPV-induced cancer is strongly associated with several factors. These include among others: failure to mount a robust HPV-specific type 1 T-helper and CTL responses; the lack of CD8+ T cells migrating into the tumor; the induction of HPV16-specific regulatory T cells; and the influx of regulatory T cells into the tumor (Welters et al., 2008). Monoclonal antibodies (mAbs) are outstanding treatment options for many cancers. Researchers have developed newer forms of mAbs, by attaching them to other therapeutic substances to enhance their effectiveness (“Immunotherapy and Immuno-oncology”, 2018). The U.S. Food and Drug Administration (FDA) recently approved the first Checkpoint Immunotherapy pembrolizumab (Keytruda, Merck). It targets the PD-1 immune checkpoint, in patients with advanced, treatment-resistant cervical cancer that expresses PD-L1 (“How is Immunotherapy Changing the Outlook for Patients with Cervical Cancer?,” 2018). Pembrolizumab is prescribed to women whose cervical cancer metastasizes or recurs after chemotherapy. Immunotherapy, also called biologic therapy, is a new treatment option designed to boost the body’s natural defenses to fight the cervical cancer. It uses materials made either by the body or in a laboratory to improve, target, or restore immune system function. The immune checkpoint inhibitor pembrolizumab (Keytruda) is used to treat cervical cancer that has recurred or spread to other parts of the body during or after treatment with chemotherapy. Different types of immunotherapy can cause different side effects. Common side effects include skin reactions, flu-like symptoms, diarrhea, and weight changes (Cancer.Net., 2019).
In 2020, an estimated 13,800 cases of invasive cervical cancer are expected to be diagnosed, and 4,290 deaths are estimated to occur from cervical cancer (American Cancer Society, 2020). In the past 40 years, the number of cases of cervical cancer and the number of deaths from cervical cancer have decreased significantly. This decline largely is due to many women getting regular Pap tests for early detection (“National Institutes of Health (NIH) Cervical cancer: NIH Consensus Development Conference Statement,” 1996). Cervical cancer incidence rates declined by half between 1975 and 2014 from 14.8 per 100,000 to 6.9 per 100,000 respectively due to the widespread uptake of screening, primarily with the Pap test but the declines have slowed in recent years.

In Alabama, there were 1,148 new cases of cervical cancer from 2011 to 2015. For every 100,000 women, nine cervical cancer cases were reported. Over those years, 488 women died from cervical cancer. For every 100,000 women in Alabama, four died from cervical cancer (“U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on November 2017 submission data (1999-2015): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute;,” 2018). The 5-year relative survival rate for cervical cancer is 69% for White women and 56% for Black women. The five-year survival rate is 92% for the 46% of patients diagnosed when the cervical cancer is still in the early stages but falls to 17% for women diagnosed with late-stage disease (“Cancer Facts & Figures 2018, American Cancer Society,” 2018).

Materials and Methods

The data for our study population, was comprised of 2,124 cases of cervical cancer in women who were 17 years and older, were extracted from the 2004 to 2013 dataset of the Alabama Department of Public Health (ADPH) Cancer Registry. The percentage of patients receiving treatment combinations were compared between race (Black and White), age group (17-39 years, 40-49 years, and 50 years and older), and cervical cancer stages (stage I, II, III, and IV). We conducted a series of analyses to determine whether disparities exist in CerCancer treatment options between the two races in the three groups of counties (urban, rural Black Belt (BB) and other rural counties of Alabama)). For the analysis, to generate frequency distributions, chi-square (Mantel-Haenszel), and Fisher exact test to assess multivariate predictors and to determine the frequency and association of receiving any treatment or lack of it between sets of independent and dependent variables the SAS software was used. Adjusted analysis using logistic regression accounted for the effects of confounding variables, yielding odds ratios of the independent effects of race on undergoing of a specific treatment. Potential confounders were chosen for the regression model via backward selection, with a likelihood ratio p-value of ≤0.05 which was considered sufficient for inclusion into the model. Inversely, in the frequency distributions and Chi-Square ($\chi^2$) tests, we stratified the counties of Alabama into two groups (urban and other rural counties) due to small sample size or no data in some of the rural counties, especially in the rural BBC. The logistic regression analysis takes into account the small sample size or no data in Alabama counties. Therefore, Alabama's counties were stratified into three groups [(urban, rural BB and other rural counties) Figure 1] (Abdalla E, 2017)].
In this study, the Surveillance, Epidemiology and End Results (SEER) staging system, and is which is based on the FIGO classification system was used. The classification of cervical cancer was into four stages. Stage I (IA1,IA2,IB) represents the localized stage (cancer is confined to the original organ); Stage II (IIA, IIB) and Stage III (IIIA, IIIB) represent the regional stage (cancer spreads to regional lymph nodes and/or spreads to immediately adjacent organs/tissues); Stage IV (IVA, IVB) represent distant stage (cancer metastasizes to distant organs/tissues). Age was stratified into three groups (17-39 years, 40-49 years, and 50 years and older). Percentages represent the frequency of receiving or not receiving any cervical cancer treatment options among Black and White women stratified by the three age groups and four stages of cervical cancer. Using graphical software, plotted along the y-axis were the percentages while on the x-axis were plotted the treatment types based on Cervical Cancer stage and race. The statistical analyses were conducted using SAS software (Version 9.4, SAS Institute Inc., Cary, NC, USA). All P-values were two-sided with a significance threshold of P<0.05.

Results

The detailed results of this study are presented in Tables 1 to 3 and Figures 2 to 11. Our analysis was comprised of 2,124 cases of cervical cancer, of these only 2,081 cases were the final sample size used for analysis comprised of 651 Blacks, and 1,430 Whites. Our results show subsequent analysis of the relationship between race, age group, geographical location, stage of cervical cancer, and selected treatment options of cervical cancer in Black and White women, living in urban, rural BB and other rural counties of Alabama from 2004 to 2013. The tables and figures summarized the comparison of treatment options stratified by race, age group, geographical location and stage of cervical cancer.

In urban counties, as presented in Table 1 and Figure 2, 77.12% of Whites 40 to 49 years old living and diagnosed with stage I of cervical cancer were significantly the most likely to receive surgery treatment option with a p-value of <0.0001. On the other hand, 1.85% of Blacks 17 to 39 years old and diagnosed with stage IV of cervical cancer were significantly the least likely to receive surgery treatment option with a p-value of <0.0001. In Table 1 and Figure 3, 51.11% of Whites 17 to 39 years old living in urban counties and diagnosed with stage III of cervical cancer were significantly the most likely to receive radiation treatment option with a p-value of <0.0001. While 6.98% of Blacks 17 to 39 years old and diagnosed with stage IV were significantly the least likely to receive the same form of treatment with a p-value of <0.0001. As shown in Table 1 and Figure 4, in urban counties, 65.45% of Whites 17 to 39 years old and diagnosed with stage I of cervical cancer were significantly the most likely to receive surgery-radiation sequence treatment option with a p-value of <0.0001. Whereas, 1.61% of Blacks in the same age group and diagnosed with stage IV were significantly the least likely to receive the same form of treatment with a p-value of <0.0001. Table 1 and Figure 5 show that 100% of Whites 17 to 39 and 40 to 49 years old living in urban counties and diagnosed with stage III and stage II of cervical cancer respectively were significantly the most likely to receive immunotherapy treatment options with a p-value of 0.004. Blacks in age groups 17 to 39, 40 to 49 and 50 years and older and diagnosed with stage I and stage IV of cervical cancer never
received immunotherapy treatment options. While, in Whites in all age groups, except for those 50 years old diagnosed with stages I, III and IV never received the same treatment option.

In rural counties, as shown in Table 2 and Figure 6, 77.61% of Whites 17 to 39 years old and diagnosed with stage I of cervical cancer were significantly the most likely to receive surgery treatment option with a p-value of <0.0001. On the other hand, 2.24% of Whites in the same age group and diagnosed with stage IV were significantly the least likely to receive the same form of treatment with a p-value <0.0001. In Table 2 and Figure 7, in rural counties, 45.57% of Whites 17 to 39 years old and diagnosed with stage III of cervical cancer were significantly the most likely to receive radiation treatment option with a p-value of <0.0001. While 8.00% of Blacks 40 to 49 years old and diagnosed with stage IV were significantly the least likely to receive the same form of treatment with a p-value of <0.0001. As presented in Table 2 and Figure 8, 63.64% of Blacks 50 years and older living in rural counties and diagnosed with stage I of cervical cancer were significantly the most likely to receive surgery-radiation sequence treatment option with a p-value of 0.002. Whereas, 4.55% of Blacks in the same age group and diagnosed with stage IV were significantly the least likely to receive the same form of treatment with a p-value of 0.002. Regarding immunotherapy treatment option, Table 2 and Figure 9 indicate that there were no significant differences between Blacks and Whites diagnosed with cervical cancer stratified by the three age groups and the four cancer stages.

In this study, a series of logistic regression models were developed using variables for age group, race, cervical cancer stage and counties of residence (urban, rural BB and other rural) (Table 3 and Figures 10 to 11). Adjusted for age, stage and county of residence, Blacks had 2.76 (95% CI 0.90-8.86) times adjusted odds of receiving more immunotherapy treatment option, also Blacks had 0.74 (95% CI 0.58-0.95) times adjusted odds of receiving less surgery treatment option, compared to their White counterparts. Both Blacks and Whites 50 years and older and diagnosed with cervical cancer had 0.244 (95% CI 0.061-0.884) times adjusted odds of receiving less immunotherapy treatment option, compared to those 17 to 39 years old. Additionally, both Blacks and Whites 50 years and older had 1.707 (95% CI 1.311-2.224) times adjusted odds of receiving more radiation treatment option, compared to those 17 to 39 years old. Our results show that Blacks living in urban counties regardless of their age whether in early or advanced stages of the disease, they are likely to receive immunotherapy treatment option. In addition, Black women were more likely to receive radiation and less likely to receive surgery compared to their White counterparts.

**Discussion**

In this study we examined the racial differences in cervical cancer treatment options in urban, rural BB and other rural counties of Alabama between 2004 and 2013, controlling for age groups and cervical cancer stages. Previous studies in the U.S show higher mortality rates from cervical cancer in Blacks compared to Whites (Howell, Chen, & Concato, 1999). This disparity can be explained primarily by the fact that Blacks are most likely to be diagnosed for the first time when cervical cancer is already in more advanced clinical stages. Lack of access
to screening services and barriers to care have been suggested as explanations for the more advanced stages at presentation and consequently the higher mortality rates in Blacks due to cervical cancer (Chen, Trapido, & Davis, 1994; Howell et al., 1999; Shelton, Paturzo, Flannery, & Gregorio, 1992). More importantly, our study suggests that the higher mortality rates among Blacks with cervical cancer could be due to the less aggressiveness and inappropriate treatment options in this minority population. We advocate that equivalent treatment options are made available to Black and White patients with cervical cancer in Alabama counties. Black women are usually presented with more advanced stages of the disease which lead to higher mortality rate among them. Differences in care and treatment options availability may contribute to the racial disparities in outcomes for women with cervical cancer. These differences in outcomes may be emanating from the unequal access to healthcare or from biologic distinctions between women of different racial and ethnic backgrounds. They may also arise from variations in comorbidities that usually accompany a cancer diagnosis (Fleming, Schulterman, Tracy, & Temkin, 2014). Although lower educational attainment, older age, obesity, smoking, and neighborhood poverty have been found to be independently related to a decreased likelihood of recent Pap smear screening. Previous studies, however, demonstrate that Pap smear screening rates have become quite similar between Black and White women (Fleming et al., 2014; Harlan, Bernstein, & Kessler, 1991).

In this study, 100% of Whites 17 to 39 and 40 to 49 years old living in urban counties and diagnosed with stages III and II of the disease respectively were significantly the most likely to receive immunotherapy treatment option. Even though, Blacks never received 100% of this treatment option, there were the most likely to receive the same treatment option in stages II and III in all of their age groups. Whereas, their White counterparts 50 years and older were the only ones to receive immunotherapy treatment option in all stages of cervical cancer. In rural counties, 100% of both Blacks 17 to 39 years old diagnosed with advanced stage IV of cervical cancer and Whites 17 to 39 and 40 to 49 years old diagnosed with advanced stages III and IV of the disease respectively. These three age groups of Blacks and Whites were the most likely to receive immunotherapy treatment option compared to the other three treatment options (surgery, radiation and, surgery and radiation sequence). However, there were no significant differences between Blacks and Whites diagnosed with cervical cancer stratified by the three age groups and the four cancer stages. Our logistic regression results showed that when adjusted for age, stage and county of residence, then the immunotherapy treatment option is the most likely to be offered to Blacks living in urban counties regardless of their age whether in early or advanced stages of the disease. In addition, Black women were more likely to receive radiation treatment option and less likely to receive surgery treatment option compared to their White counterparts.

Surgery is the most common treatment option for stage I cervical cancer in both Blacks and Whites. In urban counties, Whites compared to Blacks in all age groups diagnosed with this stage of disease were the most likely to receive this treatment option. Although, in urban counties, both Blacks and Whites of all age groups and with all stages of cervical cancer, the trends for receiving radiation as the treatment option were of an undulating nature. The trend ranged from a highest of 51.11% in Whites 17 to 39 years and diagnosed with stage III of the disease to a lowest of 6.98% in Blacks in the same age group but diagnosed with stage IV of
the disease. In rural counties like in urban counties, surgery is also the most common treatment option in both Blacks and Whites. However, in rural counties, Whites compared to Blacks in all age groups diagnosed with stage IV of the disease were the most likely to receive this treatment option, expect in Blacks 50 years and older who were the most likely to receive this treatment option than their White counterparts in the same age group. Similarly, as in urban counties, both Blacks and Whites living in rural counties in all age groups and with all stages of cervical cancer, the trends for receiving radiation as the treatment option were of an undulating nature. The trend ranged from a highest of 45.57% in Whites 17 to 39 years old, diagnosed with stage III of the disease to a lowest of 8% in Blacks 40 to 49 years old, and diagnosed with stage IV of the disease. In contrast to our findings regarding surgery and radiation treatment options by race, age, stage and county, a previous study shows that among women diagnosed with early stage of cervical cancer, non-Hispanic Black women were more likely to receive radiation treatment option and less likely to receive surgery treatment option, which is the standard treatment of care. Similarly, in the same study, it stated that in the late stages of cervical cancer, non-Hispanic Black women were less likely to receive the surgery treatment option. The percentages receiving radiation treatment option across races were similar for late stage disease. In both late and early stage disease, the proportion of Hispanic women receiving radiation and surgery was similar to non-Hispanic White women (Markt et al., 2018). Additionally, previous studies showed that Black patients were less likely to receive surgical therapy and more likely to receive radiotherapy compared with their White counterparts (Fleming, S. et al 2014, Rauh-Hain JA et al. 2013). Our study confirmed their statement that Blacks received different treatment options than Whites even when adjusted for stage at diagnosis.

As for Blacks and Whites of all age groups, living in urban counties diagnosed with all stages of cervical cancer, the trends for receiving surgery and radiation sequence as the treatment option were also of an undulating nature. The trend ranged from a highest of 65.45% in Whites 17 to 39 years and diagnosed with stage I of the disease to a lowest of 1.61% in Blacks in the same age group but diagnosed with stage IV of the disease. In Blacks and Whites of all age groups, living in rural counties diagnosed with all stages of cervical cancer, the trends for receiving surgery and radiation sequence as the treatment option were also of an undulating nature. The trend ranged from a highest of 63.64% in Blacks 50 years and older and diagnosed with stage I of the disease to a lowest of 4.55% in Blacks in the same age group but diagnosed with stage IV of the disease. Overall, in urban counties, Whites 17 to 39 years and diagnosed with stage I of cervical cancer were the most likely to receive surgery and radiation sequence treatment option, whereas in rural counties Blacks 50 years and older and diagnosed with stage IV of the disease were the most likely to receive the same treatment option.

Our analysis, however, has some limitations. Although several prognostic factors are included in the analysis, not all of them are considered. Information on life-style or other individual factors such as screening access and use, socioeconomic status and comorbidities were not available from the Alabama Department of Public Health (ADPH) Cancer Registry dataset or accessible from the SEER database. Therefore, in this analysis, those factors are not considered. In addition, there was no demographic data for example, income, education and employment link to the cervical cancer treatments in Alabama. Some cervical cancer data
regarding treatments especially the immunotherapy treatment option were missing for patients living in urban, rural BB and other rural counties. Contrariwise, in the frequency distributions and χ² tests, the counties of Alabama are in only two groups, urban and rural counties. This is because some of the data was not possible to calculate due to the small number of cases or no data in some of the rural counties, especially in the BBC.

Conclusion

In this study, our results using chi-square test showed that patterns of racial disparity and inequality, all contribute to an environment in which Black women living in urban, rural BB and other rural counties of Alabama were less likely to receive the four cervical cancer treatment options (surgery, radiation, surgery and radiation sequence and immunotherapy). In some treatment options, Blacks diagnosed with different stages and age groups living in different counties were the most likely to receive cervical cancer treatment options, compared to their White counterparts. In urban and rural counties, it is only in the immunotherapy treatment option that both Blacks and Whites received 100% treatment in some stages and age groups, compared to the three other treatment options. Our logistic regression results showed that immunotherapy treatment option is in most cases likely to be for Blacks living in urban counties, compared to those living in rural BB and other rural counties, regardless of their age whether in early or advanced stages of the disease. In addition, Black women were less likely to receive surgery treatment option and more likely to receive radiation treatment option, compared to their White counterparts. These disparities may be due to lack of consistent health insurance coverage as a significant barrier to treatment and care. Without consistent and reliable health insurance, many low-income women are obliged to postpone or forget treatment, including routine Pap smears and follow up screening for abnormal results. Early detection matters and gaps in health insurance coverage can mean that warning signs, which could help in detection and prevent progression of the cervical cancer, before missing the signs.

We recommend that in order to improve treatment of cervical cancer with immunotherapy treatment option in minorities, more clinical research is needed in three major areas:. First, identify scientifically rational combinations that are likely to work better together than alone, then, learn how to create personalized immunotherapy or combination treatment regimens based on each patient’s unique cancer and immune response. Finally, discover new cancer markers that will allow early prediction about the treatments that are most likely to be safe and effective for a specific patient. We suggest that minority participation in clinical trials should be increased and also to include samples and genomic data from diverse populations to help in edge cutting research which will lead eventually to improved minority outcomes in cervical cancer treatments.
Author Contributions

Isra Elhussin, MD, MS, Integrative Bioscience (IBS) PhD Fellow: Is the first author and major conceiver and designer of the manuscript. Participated and made major contributions to the analysis, interpretation of the data and writing of the manuscript. Critically reviewed manuscript and approved the final version.

Ehsan Abdalla, DVM, MSc (Hons) (Vet PATH), MSc & PhD (Epidemiology and Risk Analysis): Is the corresponding author, has given significant intellectual inputs and supervised the work, participated in the conceiving and designing of the manuscript. Made major contributions to analysis, interpretation of the data and writing of the manuscript. Critically reviewed manuscript and approved the final version.

David Nganwa, DVM, MPH: Participated in designing of the manuscript. Made substantial contributions to analysis, interpretation of the data and writing of the manuscript. Critically reviewed manuscript and approved the final version.

Ronald Peaster, MS, Integrative Bioscience (IBS) PhD Fellow: Made substantial contributions to analysis and interpretation of the data. Critically reviewed manuscript and approved the final version.

Oyoyo Egiebor-Aiwan, MD, MPH: Made substantial contributions to analysis and interpretation of the data. Critically reviewed manuscript and approved the final version.

Crystal M. James, JD, MPH: Participated in the writing of the manuscript and critically reviewed manuscript and approved the final version.

John Heath, MS, PhD: Participated in the writing of the manuscript and critically reviewed manuscript and approved the final version.

Lecarde Webb, MPH, PMP, Integrative Bioscience (IBS) PhD Fellow: Made substantial contributions to analysis and interpretation of the data. Critically reviewed manuscript and approved the final version.
References


Table 1. Comparison between treatment options among Black and White patients who were living in urban counties of Alabama and were diagnosed with cervical cancer from 2004-2013.

<table>
<thead>
<tr>
<th>Treatment &amp; Radiation Sequence</th>
<th>Age groups (in years)</th>
<th>Blacks</th>
<th>Whites</th>
<th>Age groups (in years)</th>
<th>Blacks</th>
<th>Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17-39</td>
<td>40-49</td>
<td>50 &amp; older</td>
<td>17-39</td>
<td>40-49</td>
<td>50 &amp; older</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I</td>
<td>73.91</td>
<td>24.24</td>
<td>74.07</td>
<td>13.04</td>
<td>56.72</td>
<td>17.74</td>
</tr>
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<td>42.42</td>
<td>*&lt;.0001</td>
<td>16.67</td>
<td>41.30</td>
<td>*&lt;.0001</td>
</tr>
<tr>
<td>Stage IV</td>
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<td>3.03</td>
<td>1.85</td>
<td>28.26</td>
<td>5.97</td>
<td>26.61</td>
</tr>
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<td>Radiation</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage I</td>
<td>27.91</td>
<td>83.33</td>
<td>27.12</td>
<td>73.17</td>
<td>23.77</td>
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<td>23.26</td>
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<td>Stage III</td>
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<td>Stage IV</td>
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<td>11.76</td>
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<td>22.70</td>
<td>0.00</td>
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<td>^</td>
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</tbody>
</table>

P* statistically significant difference (Mantel-Haenszel chi-square tests P-value <0.05).

Column percentages exclude those with missing data. Non-missing categories add up to 100%, except those due to rounding.

Percentage (%) = column Percentage %; Y= Yes received treatment; N= No treatment received.

^ Statistic not displayed due to fewer than 15 cases.
Table 2. Comparison between treatment options among Black and White patients who were living in rural counties of Alabama and were diagnosed with cervical cancer from 2004-2013.

<table>
<thead>
<tr>
<th>Treatment by Stage</th>
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<th>Age groups (in years)</th>
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<td>17-39</td>
<td>40-49</td>
<td>50 &amp; older</td>
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</tr>
<tr>
<td>Stage I</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y (%)</td>
<td>70.37</td>
<td>49.54</td>
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<td>N (%)</td>
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<tr>
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<td>46.67</td>
<td>46.67</td>
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<tr>
<td>p value</td>
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<tr>
<td>Stage III</td>
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<tr>
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<td>7.41</td>
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<td>Stage I</td>
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<tr>
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</tr>
<tr>
<td>N (%)</td>
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<td>9.76</td>
<td>9.76</td>
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<tr>
<td>p value</td>
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* P statistically significant difference (Mantel-Haenszel chi-square tests P-value <0.05).
Column percentages exclude those with missing data. Non-missing categories add up to 100%, except those due to rounding.
Percentage (%) = column Percentage; Y = Yes received treatment; N = No treatment received.
^ Statistic not displayed due to fewer than 15 cases.
Table 3. Comparison between treatment options among Black and White patients who were living in urban counties of Alabama and were diagnosed with cervical cancer from 2004-2013.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Surgery</th>
<th>Radiation</th>
<th>Surgery &amp; Radiation Sequence</th>
<th>Immunotherapy</th>
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<tr>
<td>Total</td>
<td>1844</td>
<td>53.09%</td>
<td>55.26%</td>
<td>18.17%</td>
<td>0.76%</td>
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<tr>
<td>OR (95% CI)</td>
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<td></td>
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</tr>
<tr>
<td>17-39</td>
<td>509</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>40-49</td>
<td>488</td>
<td>0.867</td>
<td>1.179</td>
<td>Reference</td>
<td>Reference</td>
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<tr>
<td>50 &amp; older</td>
<td>847</td>
<td>0.381</td>
<td>1.707</td>
<td>0.918</td>
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<td>0.291-0.498</td>
<td>1.311-2.224</td>
<td>0.683-1.238</td>
<td>0.061-0.884</td>
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<td>Race,</td>
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</tr>
<tr>
<td>OR (95% CI)</td>
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</tr>
<tr>
<td>Whites</td>
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<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
<td>Reference</td>
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<tr>
<td>Blacks</td>
<td>565</td>
<td>0.738*</td>
<td>1.068</td>
<td>0.899</td>
<td>2.757*</td>
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<td>0.681-1.180</td>
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<tr>
<td>OR (95% CI)</td>
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<td>0.079-0.146</td>
<td>8.488-17.068</td>
<td>0.945-1.900</td>
<td>2.648-326.297</td>
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<td>Stage 3</td>
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<td>2.189</td>
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<td>0.112</td>
<td>0.189</td>
<td>8.415-15.060</td>
<td>1.652-2.901</td>
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<td>Stage 4</td>
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<td>0.618</td>
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<td>2.224-4.127</td>
<td>0.372-0.983</td>
<td>0.917-216.545</td>
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<td>OR (95% CI)</td>
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<tr>
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<td>1018</td>
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<td>Other Rural</td>
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<td>0.880</td>
<td>0.801</td>
<td>0.783</td>
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<td>0.662-1.059</td>
<td>0.701-1.105</td>
<td>0.616-1.039</td>
<td>0.205-2.520</td>
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<td>Rural BBC</td>
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<td>1.211</td>
<td>1.243</td>
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<td>0.577-1.561</td>
<td>0.737-2.003</td>
<td>0.729-2.047</td>
<td>0.048-5.262</td>
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Logistic regression models included variables for age group, race, stage of cervical cancer and county of residence. A separate regression model was developed for each treatment option. Those missing particular treatment data were excluded from the relevant regression models. OR (95% CI): odds ratio (95% confidence interval).

*Odds ratio shows statistically significant effect (p<0.05 via logistic regression).
Figure 1. Urban, rural Black Belt and other rural counties of Alabama (Abdalla E, 2017).
Figure 2. Frequency distributions among Black and White patients living in urban counties of Alabama, diagnosed with stage I, II, III and IV of cervical cancer and had received surgery treatment from 2004 to 2013.

Figure 3. Frequency distributions among Black and White patients living in urban counties of Alabama, diagnosed with stage I, II, III and IV of cervical cancer and had received radiation treatment from 2004 to 2013.
Figure 3. Frequency distributions among Black and White patients living in urban counties of Alabama, diagnosed with stage I, II, III, and IV of cervical cancer and had received radiation treatment from 2004 to 2013.

Figure 4. Frequency distributions among Black and White patients living in urban counties of Alabama, diagnosed with stage I, II, III, and IV of cervical cancer and had received surgery and radiation sequence treatment from 2004 to 2013.

Figure 5. Frequency distributions among Black and White patients living in urban counties of Alabama, diagnosed with stage I, II, III, and IV of cervical cancer and had received immunotherapy treatment from 2004 to 2013.
**Figure 6.** Frequency distributions among Black and White patients living in rural counties of Alabama, diagnosed with stage I, II, III and IV of cervical cancer and had received surgery treatment from 2004 to 2013.

**Figure 7.** Frequency distributions among Black and White patients living in rural counties of Alabama, diagnosed with stage I, II, III and IV of cervical cancer and had received radiation treatment from 2004 to 2013.
Figure 8. Frequency distributions among Black and White patients living in rural counties of Alabama, diagnosed with stage I, II, III and IV of cervical cancer and had received surgery and radiation sequence treatment from 2004 to 2013.

Figure 9. Frequency distributions among Black and White patients living in rural counties of Alabama, diagnosed with stages I, II, III and IV of cervical cancer and had received immunotherapy treatment from 2004 to 2014.
Figure 10. Adjusted odds ratios for receiving immunotherapy treatment option, among White and Black patients who were diagnosed with cervical cancer from 2004 to 2013.
Figure 11. Adjusted odds ratios for receiving surgery treatment option, among White and Black patients who were diagnosed with cervical cancer from 2004 to 2013.
The Paradoxical Implications of Blackness and the U.S. Constitution: The Intersectionality of King’s “I Have a Dream” Speech and Educational Inequalities

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“When the architects of our Republic wrote the magnificent words of the Constitution and the Declaration of Independence, they were signing a promissory note to which every American was to fall heir. This note was a promise that all men - yes, black men as well as white men - would be guaranteed the unalienable rights of life, liberty, and the pursuit of happiness. It is obvious today that America has defaulted on this promissory note insofar as her citizens of color are concerned. Instead of honoring this sacred obligation, America has given the Negro people a bad check, a check which has come back marked “insufficient funds.”

“But we refuse to believe that the bank of justice is bankrupt. We refuse to believe that there are insufficient funds in the great vaults of opportunity of this nation. So we’ve come to cash this check, a check that will give us upon demand the riches of freedom and the security of justice.”

Martin Luther King Jr. “I Have a Dream.”

Abstract

Employing the rhetorical phraseology of a “promissory note,” dramatized in the public address of Martin Luther King Jr., during the 1963 March on Washington for Jobs and Freedom, this article historically postulates Black Americans as constitutional beggars until Reconstruction. The white framers of our Republic legislated the dehumanization and constitutional disregard of Black Americans who continuously find themselves fighting for rights and privileges granted through American citizenship. Illuminating the paradoxical implications of blackness, substantiated in anti-black policies and practices that beset educational institutions, unravels the connectedness between King’s public address and educational inequalities. Brown v. Board of Education becomes a palpable case that congeals King’s ideological usage of the term “promissory note” with educational inequalities and solidifies the ideological connectedness between blackness and schooling.
Introduction

Standing on the steps of the Lincoln Memorial, in the symbolic grandeur of Black Americans white hope (Abraham Lincoln), Martin Luther King Jr., elucidated the moral and constitutional hypocrisy of White Americans. To grapple with the complexity and intellectual sophistication of King’s address, what historians have passionately footnoted in the annals of history as “I Have a Dream,” forces readers to grapple with the ideological convergence of what may appear to be disparate ideas. The term white hope, grounded in the racial and political realities of white disdain towards blackness, alludes to the yearning and expectancy that Black Americans upheld toward White Americans to fight for racial justice and equality. The semblance of white hope becomes noticeable in the rhetorical reference of Abraham Lincoln as “a great American” (p. 1), mainly when held in comparison to Malcolm X’s contemptuous rhetoric and outlook toward White America. Several months prior, to coagulate this point, King emphasized the “interrelatedness of all communities and states” (p. 290), and clarifies what it means to be “caught in an inescapable network of mutuality, tied in a single garment of destiny” (p. 290). King’s optimistic outlook or white hope places him in a philosophical confrontation with black radicals and white conservatives who staunchly opposed integration. For King, the struggle for racial justice and equality in America had to encompass non-violent resistance, love, radical transformation, and white allies who morally aligned with racial justice and equality.¹ Unlike moderates who clench to a historically biased and romanticized snapshot of King, particularly when it comes to “I Have a Dream,” this article seeks to congeal King’s ideological usage of the term “promissory note” with educational inequalities and radiates the intellectual depth of defiance that undergirds King’s message.

The term Black America, as referenced periodically, illuminates the collective consciousness of diasporic Africans living under the tyranny of American racism. By using a capital B, this article acknowledges the inherent worth of Africans in the diaspora and the impact of race and racialization in America. As Victor Anderson (1995) posits, “blackness is a covering term that connotes categorical, essentialist, and representational language depicting black and experience” (p. 11). For the sake of this article, blackness is posteriori, contextually confined to the United States or hereafter referred to as America, and ultimately gives voice to the myriad of ways blackness manifests itself amid marginalization and exploitation. As posteriori, blackness comes through the birthing canal of whiteness and whiteness derives from American racism. Blackness has paradoxical implications. There are empirical variations, cultural distinctions, and diverse interpretations of what it means to be black in America, and how to negotiate one’s blackness in white spaces. Thereby advancing the notion that whiteness has constitutional groundings and blackness is a constitutional omission, which in the end, creates the need for Black Americans to assert themselves in the Constitution or what this article recognizes as constitutional beggars. In this regard, Black Americans fight for rights and privileges that come through citizenship but habitually disregarded in white spaces.

¹ See A Testament of Hope: The Essential Writings and Speeches of Martin Luther King Jr. (1986). James M. Washington catalogues an array of speech and writings that illuminates King’s philosophical stance on nonviolence, racial justice, love, race relations in America.
Teresa J. Guess (2006) characterizes whiteness as an ideological, sociological, economic, and political stance that normalizes racial hierarchies in America.² Whiteness is a systemic set of beliefs, behaviors, and habits, institutionalized and individualized, that repress cultural and political differences between European and African ancestry. Goodman, Moses, and Jones (2012) affirms, “definitions and boundaries of whiteness have changed throughout American history, expanding strategically from time to time usually as scientists, policymakers, and others attempted to balance nativist and anti-immigrant prejudices with the labor needs of a growing nation” (p. 44). Goodman et al. (2012) continue, “whiteness defined through European ancestry was a calculated racial solution developed by colonial leaders to the economic and physical threat of laboring-class solidarity” (p. 44). Blackness and whiteness are sociological constructs that yield legal, political, and economic benefits, or the lack thereof. Hence, to gain intellectual clarity and theoretical acuity on the connectedness between King’s public address and educational inequalities, readers must first understand the implications and contradictions of race relations in America.

bell hooks offer a poignant scene that unraveled at a predominately white dinner party, whereas the “other,” in a contentious dialogue with the “only other black person present” (hooks, 1990, para. 1), hooks found herself wrestling with the confluence between blackness and anti-intellectualism. hooks exposes how white normative discourse or what this article refers to as whiteness, precludes non-white from asserting autonomy. hooks declares, “racism is perpetuated when blackness is associated solely with concrete gut level experience conceived either as opposing or having no connection to abstract thinking and the production of critical theory” (hooks, 1990, para. 1). When Black Americans muscle up the intellectual girt to disrupt the manifestations of whiteness in American democracy, those voices become “stifled by a powerful repressive postmodern state” (hooks, 1990, para. 5).

This is what makes King’s public address so powerful and radical. Whiteness equates blackness with criminality and anti-intellectualism, often “dominated primarily by the voices of white male intellectuals and/or academic elites who speak to and about one another with coded familiarity” (hooks, 1990, para. 2). hooks expose how white normative discourse suppresses the voice of “others,” and thereby reinforces the normalization of whiteness. King, however, as the “other,” intellectually navigates blackness into a white space during the March on Washington for Jobs and Freedom. More importantly, King exposes the constitutional disregard of blackness in white spaces. King takes the white normative discourse, enshrined in the Constitution, Declaration of Independence, and Emancipation Proclamation, and interjects black subjectivity to illuminate the multiple manifestations of whiteness. Simply put, King exposes the moral hypocrisy of White Americans and the paradoxical implication of blackness in America. The March on Washington provided the rhetorical window and philosophical space for King

² See “The Sociological Construction of Whiteness: Racism by Intent, Racism by Consequence” (2006). This article examines the role that whiteness plays in racial inequality and sustaining the social, economic, and political privileges of those considered white. Whiteness is intrinsically woven in the ethos of America, ultimately reproducing structures and ideological stances that maintain the superiority of whiteness. Guess makes a clear distinction between racism by intent and racism by consequence. The former operates at the individual level and manifests itself in racial prejudice and discrimination. The latter operates on an institutional level and disguises itself in customs, practices, procedures, and even the law. Ian H. Lopez, in White by Law: The Legal Construction of Race, empathizes the legal construction of race and the role that law has played, though legislation or adjudication, in constructing our understand of race.
to scrutinize the legitimacy of constitutional and emancipatory promises, by citing the very documents that bolster whiteness.

**An Ideological Jump from “I Have a Dream” to Educational Inequalities**

While much attention focuses on the historical significance of King’s public address and his rhetorical cadence, scholars have said little on the intersectionality between critical race theory and educational inequalities. Intersectionality is a multidimensional framework that mitigates the theoretical and ideological collision between blackness and schooling. The term schooling references the socialization process that occurs in educational institutions where students become versed in the values, expectations, and behaviorism that sustains whiteness in public and private schools.³ Schools are social institutions that harbor anti-black policies and practices, as whiteness breathes on social institution’s ability to “school” students on acceptable social standards and practices. Such standards become synonymous with the prejudicial outlook needed to preserve the sanctity of whiteness and the exclusion of blackness in educational institutions. Educational inequalities channeled “through ideological and material manifestations of whiteness” (Goodman et al., 2012, p. 47), illustrate the suppression and exclusion of educational resources based on race. Critical race theory is a theoretical tool that meanders between race, law, and power.

The March on Washington gave voice to the social, political, and educational realities of Black America and provided the rhetorical, moral, and constitutional space for King to illuminate the moral collision between whiteness and blackness. Accentuating a sociological analysis of schooling, converging with the theory of intersectionality, promulgates the complexity of American apartheid and how this article conceptualizes King’s public address with educational inequalities. American apartheid, as identified by Douglass S. Massey and Nancy A. Denton (1998), posits that “institutional arrangements and contemporary individual actions” (p. 1) created residential segregation, economic disparities, and black ghettos. Subsequently giving way to power structures, “overtly or covertly, [that] prevent change, perpetuate, and exploit the status quo” (p. 154). American apartheid pre-determines the quality of education and educational resources that schools receive, thereby supporting the preservation of whiteness. Understandably, it is easy for listeners to find themselves mesmerized by the rhetorical mantra, “I Have a Dream.” However, it is King’s reference to the Constitution, Declaration of Independence, and Emancipation Proclamation that enthralls a discourse on intersectionality as a theoretical linchpin that illuminates King’s ideological usage of the term “promissory note” and the conceptual connectedness of such term to educational inequalities. King realized the promises, as put forth in the Constitution, Declaration of Independence, and Emancipation Proclamation had not been actualized by the March on Washington.

³ See “Notes from the Back of the Room: Problems and Paradoxes in the Schooling of Young Black Students” (2003). Karolyn Tyson explores the role that schools play in the reproduction of social inequalities. According to Tyson, schools are structured to maintain white cultural norms or what this article references as whiteness. Interestingly, Tyson examines the role of teachers in the maintenance of whiteness and identifies he role of schooling as “teaching basic academic skills and knowledge and to transmit to students particular cultural orientations, values, and attitudes” (p. 328). From this perspective, the goal of education is to teach students from the perspective of the dominant culture.
Blackness and the Constitution

For Black Americans, evaluating the efficacy of constitutional promises is cyclical and ongoing. King dramatizes the dismal plight of blackness in America, by employing constitutional language to uncover the moral hypocrisy of American democracy. During times of constitutional contention and contradictions, Black Americans have focused their attention on the Constitution, as the supreme Law of the Land (Article VI), to mitigate the excruciating pain of blackness in white spaces. Paradoxically, the same document that negates blackness has also provided negotiating space for blackness amid whiteness. As Vincent G. Harding (1987) declares,

From the outset, they [Black Americans] caught the possibility that the area of contradiction and nonalignment between the best interpretation of the Preamble and the conservative, compromising thrust of the main document (especially where slavery was concerned) provided a crucial wedge by which they might engage the struggle for the transformation of the Constitution, the nation – and themselves. (p. 721).

Black Americans have always known that “we the people,” enshrined in the Preamble to the Constitution, had nothing to do with Black Americans, as negated by the three-fifths compromise clause and supported by judicial rulings – *Dred Scott v. Sandford* and *Plessy v. Ferguson*. In his essay *The American Constitution: Its Troubling Religious and Ethical Paradox for Blacks*, Riggins Earl Jr. (2012) posits the Constitution as “America’s social contract” (p. 63) and unveils the empowering and disempowering nature of the Constitution, particularly as it pertains to Black America. Earl (2012) declares, “except for the Bible, the Constitution is for blacks the paramount symbol of authority. The faith of blacks in the authority of the Constitution has prevailed despite the unwillingness of whites to ‘contract them into’ its sacred promises of equality and justice for all” (p. 64). To further syncretize his argument, Earl (2012) continues, “blacks have never lost hope in the promissory ideals of equality and justice expressed in such documents as the Preamble to the Declaration of Independence and Abraham Lincoln’s Emancipation Proclamation” (p. 64). While the white framers of our Republic never intended for Black Americans to experience the fullness of American democracy, nevertheless, Black Americans seized such opportunities to expose the contradictions and constitutional disregard for blackness. In every generation, from black soldiers during the Civil War to black freedom fighters during the Civil Rights Movement, the manifestations of whiteness in American democracy has forced Black Americans to question their constitutional standing. Essentially, Black Americans look for constitutional language to validate their existence. King, grounded in the rich tradition of black freedom struggle in America, stands in this historical trajectory.

Vincent G. Harding (1987) illuminates the contentious struggle between blackness and the Constitution, by invoking the biblical imagery of the pugnacious account of Jacob and an unidentified man. For Harding (1987),

The children of Africa, whose freedom the Constitution makers sacrificed on the altar of a tenuous and limited white unite, become the foremost proponents of freedom and justice in the nation, demanding of the Constitution more than its slave-holding creators dared to dream, wrestling it toward an integrity that the Fathers could not
give it. And in the process, though they sustain significant wounds, they also provide opportunities for justice, equity, and hope for many persons other than themselves. Indeed, they encourage others to enter the arena with them to press the nation toward its highest possibilities. At their best they remind their fellow citizens that nights of wrestling and breakings of dawn are absolutely necessary, are never finished, in a society that aspires toward a more perfect union based on justice and liberty and committed to the empowerment of “we the people.” (p. 719).

Black Americans wrestle continuously with the Constitution in a way that exposes the foibles of the Constitution and helps to transform the Constitution into a meaningful document that aids in the black freedom struggle. The phrase “meaningful,” given the evidence of how white framers legislated the dehumanization and constitutional disregard of Black Americans, challenges the legitimacy of the Constitution. In his article *Lincoln and the Constitution*, George Kateb (2015) distinctively classifies and contends that our revered Constitution is both a document of slavery and freedom, but more importantly, “it was a constitution of freedom as racial privilege and hence only prima facie a constitution of freedom” (p. 105). According to Kateb (2015),

Lincoln (and any White American) would not have countenanced the chattel slavery of any white minority for any purpose, his revered Constitution was fundamentally a constitution of black slavery. He would not have revered for a moment a constitution that kept white people like him in any number as chattel slaves. Then we add but only secondly that it was a constitution of freedom. But even to say that much is to say too much because it was only apparently a constitution of freedom. (p. 106).

Kateb (2015) gives voice, as a White American scholar, to the quintessential strivings and struggles of Black Americans who wrestled with the contradictions and the promises of American democracy. Black Americans do not have the luxury of dismissing the Constitution, as the same document that bolstered whiteness and racial prejudice in America, also gave birth to black freedom. As Black Americans struggled with the paradoxical implications of the Constitution, Vincent G. Harding (1987) asserts,

Their demands to be citizens, their insistence on claiming the rights and responsibilities of citizenship, and their actions as agitators, soldiers, and citizen-activists were part of the mounting force that led to the Fourteenth Amendment. It was a confirmation of their truth, a response to their wrestling with the Constitution, and with White America. (p. 724).

Standing on the steps of the Lincoln Memorial, King intellectually wrestles with the legitimacy of constitutional promises, even though the “Constitution had been changed, it had not sufficiently provided for some of the most fundamental needs of the black community” (Harding, 1987, p. 726). Not sufficiently attending to the economic, political, and educational needs of Black Americans, guaranteed in the Constitution as the rights, privileges, and immunities of citizenship, meant that America had defaulted on its “promissory note.”
Emancipation Proclamation: A Joyous Daybreak for Black Exiles

Lincoln believed, as many other White Americans believed and continue to believe, it was the providential hand of God that led the framers of our Republic to assert their freedom from the tyranny of Britain. Paradoxically, White Americans who subscribe to such a view often question the civil disobedience of Black Americans, from the Civil Rights Movement to the Black Lives Matter Movement, with some going as far as characterizing Black Americans as thugs, while simultaneously revering white framers as patriots. History shows White Americans, as was the case in 1776 and at other junctures throughout American history, lashing out against any attempts to impede their progress and subjugation over blackness. White Americans often reference emancipatory language in the Declaration of Independence. However, for Black Americans, the idea of freedom did not present itself until Abraham Lincoln signed an executive order, the Emancipation Proclamation, which slightly altered the status of blacks Americans in southern secessionist states. In 1861, eighty-five years after the birth of this nation and four years after the landmark case that negated black citizenship, *Dred Scott v. Sandford*, an internal way erupted between the Union and the Confederacy, over several contributing factors. James McPherson (2014) asserts,

While the Revolution of 1776-1783 created the United States, the Civil War of 1861-1865 determined what kind of nation it would be. The war resolved two fundamental questions left unresolved by the revolution: whether the United States was to be a dissolvable confederation of sovereign states or an indivisible nation with a sovereign national government; and whether this nation, born of a declaration that all men were created with equal right to liberty, would continue to exist as the largest slaveholding country in the world. (A Defining Time in Our Nation's History, para. 1).

History shows what kind of a nation we had become. The Emancipation Proclamation was a war measure that Abraham Lincoln used to preserve the Union, not to destroy and denounce the hideous institution of slavery. From a constitutional perspective, freedom did not come until the ratification of the 13th Amendment. Even then, black codes and public lynching has restricted the economic, political, and educational mobility of Black Americans. Although limited in scope, the Emancipation Proclamation became for Black Americans, what the Declaration of Independence was to the white framers of our Republic. When Black Americans heard, “shall be then, henceforward, and forever free” (President Lincoln, Preliminary Emancipation Proclamation, 1862), they heard freedom and altered the trajectory of the war. Black Americans made the war about emancipation. Unfortunately, this becomes problematic, as Black Americans found themselves emancipated without the rights, privileges, and immunities of citizenship. The Emancipation Proclamation was a military strategy at best, but from the perspective of Black Americans, when Lincoln signed the executive order, it was as if God had finally spoken to their painful plight. In Black American, there is nothing anomalous with the confluence between the secular and the sacred.⁴

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As King declares, “the Emancipation Proclamation came as a great beacon light of hope to millions of Negro slaves who had been seared in the flames of withering justice. It came as a joyous daybreak to end the long night of captivity” (p. 1). It came as a blissful affirmation to those staring in the face of constitutional disregard and judicial disempowerment. Black Americans would come to understand the stark differences between a civil understanding of God (Constitution and Declaration of Independence) and a biblical interpretation of God (Emancipation Proclamation), as the economic, political, and educational advancement of Black Americans came to an abrupt halt during the Johnsonian administration. Just like that, White Americans seized political power and enacted legislation to override the newly acquired rights of Black Americans, sometimes leading to violent demonstrations, often initiated by White Americans. It is from this historical context, exacerbated by a blatant discontentment for blackness, that King illuminated the depth of American hypocrisy. The Constitution and Declaration of Independence granted certain rights, privileges, and immunities to White Americans through natural law and white benevolence, as seen in the signing of the Emancipation Proclamation, granted Black Americans the opportunity to interject black subjectivity and self-efficacy. White benevolence refers to acts of kindness or benevolent gestures extended to Black Americans by white allies who may or may not morally align with racial justice and equality. According to Lewis V. Baldwin (2002),

King had a very nuanced understanding of the complexities of American history and of her documents of freedom. He knew that the Declaration of Independence, the Constitution, and the Emancipation Proclamation are fraught with contradictions, but he valued the noble ideals they embodied, and they were among the sources he used to validate a movement for freedom. When it came to the Declaration of Independence and the Constitution, what mattered to King most was not the original intent of the founding fathers, but, rather, the ways in which the principles embodied in those documents could be universalized in the present and future. (p. 126).

White Americans fought to protect their independence during the Revolutionary War and sought to maintain their economic and political interests during Reconstruction. During the Revolutionary War, White Americans asserted their constitutional right to decide what worked for them, over against the economic interests of their colonizers, and Black Americans did the same during Reconstruction. Two irreconcilable forms of civilization, American freedom and American enslavement, came to a head during the Civil War, and Black Americans utilized this historical moment to assert their constitutional rights. The Emancipation Proclamation provided the legislative space for Black Americans to lay hold of the constitutional promises granted through citizenship. However, and more importantly, emancipation became a catalyst for public education in the south.

Reconstruction: Black Determination and Politics

Upon hearing about the emancipatory ramifications of the Lincolnian executive order, Black Americans fled plantations and navigated their way into Union territory, as the dawn of freedom arrived. The signing of the executive order did not guarantee emancipation for Black
Americans in southern secessionist states and never had emancipatory implications for Black Americans in states already loyal to the Union. However, Black Americans redefined the Civil War and helped to ameliorate, momentarily, the cantankerous sore of racial prejudice, legislative disdain, and judicial disempowerment. The assertive actions of Black Americans helped to solidify the birth of a new nation or what Eric Foner (2019) references as a “seconding founding” (p. xx), supposedly no longer tearing at the seams of racial injustices and economic inequalities. Thomas J. Brown (2006) offers the cautious pronouncement, “the end of racial slavery hardly created a colorblind society, but the color line would be drawn in new ways, and to different purposes, in the post-emancipation South” (p. 11). With new opportunities for economic, political, and educational advancement, blacks Americans “found that they possessed the power, not only to shape their own destinies within the society in which they found themselves, but also to change that society, at least in a limited way” (Ransom and Sutch, 2001, p. 1). Emancipation gave way to Reconstruction, thereby allowing Ransom and Sutch (2001) to conclude,

For nearly two and one-half centuries, black slave labor had been an integral part of southern life. Emancipation had destroyed the foundations of the southern economy and southern society. Freedom meant that the new economy and the new society that we constructed on the site of the old could not be patterned on the old design. Although new institutions emerged, they were fashioned in haste and in a climate of racial animosity, and as a result they emerged deeply flawed. The black had gained his political freedom, but he was soon effectively disenfranchised. He had gained his social freedom, yet he remained an outcast in white society, discriminated against because of the color of his skin. He has gained his economic freedom, but the southern economy emerged poor and stagnant, and the black man was the poorest of southerners. Blacks gained much with emancipation, but that gain represented a single step from slavery to freedom. (p. 1-2).

Black Americans to transition from enslavement to sharecropping, from exploitation to economic independence, from indentured servants to autonomous beings. In his essay on Black Agency After Slavery, John C. Rodrigue (2006) defines “agency as the capacity to act on behalf of one’s own interests and values. In essence, it involves the ability to remain independent, to some degree, of another’s control and to exercise a measure of free will” (p. 41). He further asserts, “to maintain that former slaves in the postbellum South exercised agency is to insist not only upon their essential humanity but also upon their ability to identify their own interests and to pursue their own agenda” (p. 42). Reconstruction shifted the perennial narrative on anti-intellectualism and uncivility aimed at Black Americans, and for a pivotal moment in American history, Black Americans truncated the ideal of constitutional beggars and became constitutional enforcers of justice and equality. Eric Foner (1987) declares,

In seeking to invest emancipation with a broad definition of equal rights, blacks challenged the nation to live up to the full implications of its democratic creed and helped set in motion events that fundamentally altered the definition of citizenship for all Americans. (p. 863).
During Reconstruction, Black Americans “took actions that helped propel a reluctant White America down the road not simply to abolition but also to a constitutional recognition of the principle of civil and political equality regardless of race” (Foner, 1987, p. 864). Albeit, history records uprisings, revolts, and deliberate acts of resistance from ships traversing the Atlantic waters to the indignation of Gabriel Prosser, Denmark Vesey, and Nat Turner. Reconstruction, however, became a pivotal era in the black freedom struggle in America, as Black Americans began to mobilize on a massive scale to demand their constitutional rights. Through constitutional amendments, Black Americans “gained a measure of political influence in southern states” (Tyack and Lowe, 1986, p. 236) and “created the world’s first biracial democracy” (Foner, 2019), p. xx). Reconstruction played an integral role in redefining American democracy and reevaluating the meaning of freedom. However, this presented many challenges. According to Ransom and Sutch (2001),

Slavery proved a poor preparation of freedom. The slave had never negotiated a contract, borrowed on credit, determined the crop mix, marketed a cotton crop, or read an agricultural journal. Slaves were universally illiterate and without the benefit of formal education. They typically possessed no skills beyond those of a field hand. Formal education for slaves was almost nonexistent. In most slave states it was actually illegal to educate a slave. Apparently such laws were passed in the 1820s and 1830s in the belief that an illiterate slave population would be more docile and less subject to revolt. The fear of black education had been intensified by the fact that the leaders of several famous insurrections and conspiracies were, in fact, literate. Denmark Vesey was a free Negro whose role in the 1822 plot in Charleston was apparently inspired by his reading of abolitionist literature. Nat Turner was also literate, and it was claimed, though never provided, that he was inspired by the writings of David Walker, another educated slave. (p. 15).

With newly acquired political power, along with the help from the Freedmen’s Bureau, Abolitionists, white philanthropy, and black contributions, Black Americans continuously wrestled with the constitutional promises of freedom, justice, and equality for all. Eric Foner (1987) states, “as Reconstruction progressed, the national Constitution took place alongside the Declaration of Independence as a central reference point in black political discourse” (p. 880). As their desire for autonomy increased, Black Americans “withdrew from religious and other institutions controlled by whites” (Foner, 1987, p. 871) and created institutions that served their economic, political, and educational needs. Public education became an essential component in helping Black Americans understand the meaning of freedom and citizenship. The federal government, through an array of constitutional amendments, resolved a series of questions “only to open a host of others” (Foner, 1987, p. 869). As Eric Foner (2019) declares, “even if we are unaware of it, Reconstruction remains part of our lives, or to put it another way, key issues confronting American society today are in some ways Reconstruction questions” (p. xi). The expansion of public education, the unconstitutionality of racially segregated schools, and the distinct view of whether public education in America constitutionally binds the federal government or becomes the responsibility of states, hinges upon Reconstruction and the Fourteenth Amendment. Whereas White Americans looked to the state in their efforts
to minimize the encroachment of the federal government on their rights and privileges, Black Americans “viewed the [federal] government as the guarantor of their rights (Foner, 1987, p. 880), particularly “when blacks had seen whites restored to local hegemony” (Foner, 987, p. 880) through racial violence.

American Education: The Emancipation and Education of Black Exiles

As the Constitution and Declaration of Independence took on new meaning during Reconstruction, the role and responsibility of education shifted as well, thereby illuminating the confluence between education and citizenship. Public education has existed since Colonial times. In *Thomas Jefferson and the Ideology of Democratic Schooling*, James Carpenter (2013) emphasizes the Jeffersonian view of education that amalgamated education and citizenship, subsequently laying the constitutional foundation for republican education. In this article, James Carpenter (2013) defines republican education, as used today, as “efforts to prepare students to be good citizens. Republican education hopes to help students know their rights and responsibilities, understand the political and historical legacy of important documents and government actions, and meet the expectations of citizenship” (p. 2). According to Carpenter (2013), “for Jefferson, education was not only instrumental in preparing citizens for their role in the new republic, but it also would serve to safeguard the United States and its citizens from the dangers posed by the British and their way of life” (p. 3). Education helped to civilize Americans from acting like the British. Furthermore, as Carpenter (2013) declares, “to ensure that the people were the best safeguard against an overzealous government, Jefferson’s political vision required an informed citizenry. Citizenship was integrally linked to power, responsibility, and freedom. It was axiomatic for Jefferson to connect freedom and responsibility, with republican citizenship” (p. 3). Such an expanded view of education as the rights of all citizens, which starkly differed from the educational norm of that time that only extended to the ruling class, buttressed whiteness as the model for American education.

Building upon the Jeffersonian view of education and citizenship, Suzanna Sherry (1995) asserts,

There is no dearth of literature of the *rights* of citizens, but it seems disingenuous (and maybe circular) to argue that one needs an education to exercise the rights of citizenship. After all, despite some claims that illiteracy is inevitably disenfranchising, one can vote – as well as earn a living, own property, raise a family, and do whatever else might be suggested as a right of citizenship – without an education. Millions do. The core of the claim that education is necessary to citizenship must instead be that education is necessary to the thoughtful or responsible exercise of citizenship rights. But focusing on how a right is exercised changes the nature of the argument. Citizens are no longer simply rights-bearing individuals. They are, rather, rights-bearing individuals with responsibilities. (p. 132).
For Sherry (1995), the rights and responsibilities of citizenship add virtue to the conversation, eventually “changing the nature of education itself” (p. 133). From this perspective, “education is no longer something merely provided by the government and consumed by the individual. It is, rather, an ongoing lesson in responsible citizenship that requires participation and dedication on the part of present and future citizens” (Sherry, 1995, p. 133). Such virtues, fundamentally immersed in whiteness, has governed American education and laid the censorious role of schooling in educational institutions, both public and private schools alike. Whiteness prohibited Black Americans from acquiring formal education until Reconstruction. Even then, the normalization of whiteness manifested itself in institutional and instructional norms that denounced blackness. James Anderson (1988) argues, “both schooling for [republican] citizenship and schooling for second-class citizenship have been basic traditions in American education” (p. 1). It is Anderson’s use of the word schooling, coupled with the notion of education and citizenship, which solidifies the connection between blackness and schooling. It does not fall in the purview of this article to chronicle the historical evolution of American education, narrate the religious instruction of Black Americans, or offer a thorough account of the educational processes and norms that governed educational institutions during Reconstruction. On the contrary, this article unravels the paradoxical implications of blackness, substantiated in anti-black policies and practices that beset educational institutions or what this article references as schooling, and how such thought connects King’s ideological usage of the term “promissory note” to educational inequalities.

The ingenuity of emancipated Black Americans is no small endeavor. W.E.B. DuBois (1935) reveals, “the eagerness to learn among American Negroes was exceptional in the case of a poor and recently emancipated folks” (p. 637). American enslavement robbed Black Americans of many things, but it did not quench their insatiable appetite for formal education. Amid anti-literacy laws and severe repercussions, Black Americans maintained a positive outlook on the transformative role of education. In *Black Reconstruction*, DuBois (1935) highlights the role that Black Americans played in erecting educational institutions that served “at the expense of the state” (p. 638). Black Americans “sought to use the authority of the state to create universal and free schools open to all” (Tyack and Lowe, 1986, p. 239). White Americans, however, used the authority of the state to sustain whiteness. Emphasizing the “obstacles to a free public school system,” seeing as how the idea of public education has existed since the Colonial Era, DuBois (1935) highlights the attitude of white property owners who believed education created challenges to exploitation and manipulation, as the first major obstacle. According to DuBois (1935), “the second obstacle was that the white laborers did not demand education, and saw no need of it, save in exceptional cases” (p. 641). On the contrary,

It was only the other part of the laboring class, the black folks, who connected knowledge with power; who believed that education was the stepping-stone to wealth and respect, and that wealth, without education, was crippled. Perhaps the very fact that so many of them had seen the wealthy slaveholders at close range, and knew the extent of ignorance and inefficiency among them, led to that extraordinary mass demand on the part of the black laboring class for education. And it was this demand
Black Americans worked tirelessly, sacrificially, and collectively to erect educational institutions and adopt liberating pedagogies that helped to foster social change. As Black Americans sought autonomy and continued to demand their constitutional rights, education became synonymous with liberation. Black Americans held to the belief that education would ameliorate the educational advantages that whiteness fortified. Unfortunately, this was not the case. To restore the South to its former state, Black Americans “fell victim to violence, fraud, and national abandonment” (Foner, 1987, p. 878). The economic, political, and educational advancement of Black Americans came to an abrupt halt. According to Tyack and Lowe (1986), “with the restoration of white supremacy, blacks in the South were forced to attend schools universally segregated and increasingly starved for funds in comparison with the white schools” (p. 239). White Americans “did not dismantle the common school systems that blacks and their allies had created, but they used those educational systems to reinforce the caste system” (Tyack and Lowe, 1986, p. 239). Schooling reinforced the values, expectations, and behaviorism that whiteness normalized, and black students became versed in the inferiority of blackness in American democracy, from educational curriculums to educational standards and instructional assessments. Carter G. Woodson would later unravel the docility of American education and how Black Americans easily succumbed to whiteness. Herbert A. Simon (1993) defines docility as “the tendency to depend on suggestions, recommendations, persuasion, and information obtained through social channels as a major basis for choice” (p. 2). In a similar manner as anti-literacy laws that prohibited Black Americans from learning how to read and white, educational institutions, fundamentally steeped in whiteness, helped to restore the docility of American enslavement. Substandard facilities, inequitable funding, denigrating narratives, and the mischaracterization of black students, along with a resurgence of black autonomy and subjectivity, gave way to Brown v. Board of Education.

The Disintegration of Blackness: Brown v. Board of Education

The ruling of the U.S. Supreme Court to desegregate public schools reinvigorated the ideal of racial justice and equality for countless Black Americans. Similarly to Black Americans living under the brute of Black Codes, Jim Crow Laws restored the racial caste system of oppression and dehumanization, in the aftermath of Reconstruction, consequently forcing Black Americans to once again grapple with the contradictions of American democracy. Reconstruction, albeit fleeting, became a joyous and celebratory period in the lives of Black Americans, no longer subject to the cruelties of American enslavement. However, as is the case with any advancements that Black Americans have collectively made in America, whiteness takes on new meanings. It manifests itself in the illusions of American democracy and the delusion

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5 See Carter G. Woodson, *The Mis-Education of the Negro* (1933). Woodson explores the indoctrination that has occurred in American schools, whereby Black Americans find themselves bombarded with the superiority of whiteness and the inferiority of blackness. Instead of knowing about the accomplishments of White Americans, Woodson posits that Black Americans should know about their history and heritage. The schooling that Black Americans receive has moral flaws and cultural deficits, in the sense, Black Americans leave educational institutions indoctrinated in the norms, customs, and practices of whiteness.
that every American has access to the same opportunities. Whiteness is institutionalized and individualized. Reconstruction ushered in a period of economic, political, and educational opportunities, however, whiteness quickly robbed Black Americans of those opportunities through the restoration of anti-black laws, policies, and practices.

Jason Jordan (2015) interrogates the role that laws and courts played in the construction of race and the maintenance of whiteness in the American legal system. Courts have played a dehumanizing and liberating role in race relations in America. In analyzing the rhetoric of Brown, Jordan (2015) unravels how the court racialized subjects as “either black or white,” and ultimately concludes that the court was “not concerned with questions of equal facilities or educational standards, but instead the issue of whether the existence of white bodies within a school is a right that must be made available to all on equal terms” (Jordan, 2015, p. 24). For Jordan (2015), the equality that the court talked about in Brown was “an attempt to fix the problem of blackness” (p. 25) in public schools, not the eradication of whiteness.

Brown v. Board of Education, though a landmark case that “struck down state-sponsored racial segregation of America’s public schools” (Patterson, 2001, p. xiii), did not eradicate the permanence of whiteness in educational institutions. If anything, Brown became the judicial catalyst for the disintegration of blackness, as the assimilation to whiteness became the antidote against blackness. Legalized discrimination has existed in educational institutions since the Colonial Era, subsequently disclosing the economic and political conditions that created inferior schools. American apartheid, as mentioned earlier, plays an indispensable role in the makeup of schools today, as zip codes determine the quality of education and instructional resources that students receive.⁶ April L. Peters (2019) pointedly asserts, “education exists in a broader system of oppression,” in which she concludes that desegregation closed Black schools, not White one, and disintegrated the impact of Black educators on their students and the communities they served” (p. 521). It is not the intent of this article to regurgitate the historical and political context of Brown, nor to offer a thorough analysis of Brown’s failures. On the contrary, this article emphasizes how Brown contributed to the disintegration of blackness, following in the historical denunciation of blackness in the American legal system, and how the dissolution of blackness has contributed to an array of challenges that beset educational institutions today.

In The Costs of Brown: Black Teachers and School Integration, Adam Fairclough (2004) examine the negative stigma attached to black schools before Brown and what black schools lost in the aftermath of Brown. Amid external challenges, inequitable funding, and the prevalence of whiteness in curriculums and educational standards, black schools played an essential role “in the formation and growth of black communities during the century following emancipation” (p. 3). Fairclough (2004) continues,

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⁶ See Ann Owens “Inequality in Children’s Context: Income Segregation of Households with and without Children” (2016). Owens examines the income segregation that divides neighborhoods, ultimately contributing to the residential decisions that families make. Income determines the type of neighborhoods that families reside in, which has a direct impact on the schools that children attend. Families with more income can attend affluent schools.
There is no doubt that in shattering the legal basis of white supremacy, *Brown* opened up new opportunities for black advancement. But desegregation also abolished, or at least radically transformed, an anchor of the southern black community. It exacted costs – institutional, economic, and psychological – of which black teachers paid more than their fair share. (p. 3).

Before *Brown*, there was an affirmation of racial identity, collective responsibility, cultural pride, and dedication that prevailed in black schools. Peters (2019) highlights some of the unforeseen consequences of desegregation and sheds light on the disintegration of black education:

- “The law did not protect Black teachers and administrators from being fired and systematically pushed out of their profession” (p. 521).
- “Desegregation meant that Black students were no longer taught by Black teachers. The *Brown* legislation created an experience where Black students received instruction from teachers who often were vehemently against desegregation in the first place (p. 522).
- “Teachers were disconnected from students’ culture and way of life” (p. 522).
- “The implementation of desegregation in schools meant the closing of many Black schools, the loss of jobs for many Black educators and Black administrators, and policy changes that would restrict the growth of Black educators and Black administrators in the K-12 system that could still be seen more than 60 years after the Brown decision” (p. 522-523).

Desegregation contributed to the displacement of black educators, the dissolution of black schools, and the disintegration of blackness. Zero-tolerance policies, inequitable funding, dilapidated buildings, the criminalization of black students, obsolete teacher preparation programs, and culturally insensitive curriculums, standards, and assessments would soon stigmatize black schools after *Brown*. Following the racial indignation of White Americans, when the U.S. Supreme Court rendered its decision, John Hope Franklin (2004) declares,

The South responded by saying that it would never permit white and black children to attend the same school. Southern members of Congress drew up the Southern Manifesto that was signed by all but three senators from that region that declared that they would use all lawful means to reverse the decision. Various school jurisdictions adopted measures to preserve racially segregated schools. They pass pupil placement laws, they established busing programs, and they fled to the suburbs or wherever they could be certain that the races would be kept segregated in the schools. (p. 13).

The disdain for blackness, as history records in the aftermath of Reconstruction, created the underlying conditions of black schools today. According to Franklin (2004), “although few people at the time saw the connection between the fight that Marshall led in 1954 and the fight that Martin Luther King, Jr., led a decade later, it takes only the slightest discernment to see the dots that connect them” (p. 13). During the March on Washington in 1963, nine years removed from *Brown*, King dramatized how “America had defaulted on this
promissory note insofar as her citizens of color are concerned” (p. 1). King continued, “instead of honoring this sacred obligation, America has given the Negro people a bad check, a check which has come back marked ‘insufficient funds’” (p. 2). Although a seminal case in educational reform, Brown did not unleash the educational changes that many expected. King was cognizant of such reality. King’s “I Have a Dream” speech illuminates the educational inequalities that beset Black Americans, not White Americans. Moreover, still to this day, the constitutional promises guaranteed to White Americans have not become actualized for Black Americans, particularly when it comes to education.

King’s Dream: A Pedagogical Nightmare

It does not require an anecdotal account of American history to realize the paradoxical implications of blackness in American democracy. From the constitutional shortsightedness of white framers who legislated the dehumanization and disregard for blackness to the systematic dismantling and disdain for blackness in American democracy today. America has reneged on the constitutional promises of freedom, justice, and equality for all. While White Americans have enjoyed the rights, privileges, and immunities of citizenship, the same cannot be said for Black Americans. Gary Younge (2013), in his book The Speech: The Story Behind Dr. Martin Luther King Jr’s Dream, provides a thorough account of events that unraveled before the speech and the political context that helped position the speech. Without negating or diminishing the insights that other speakers offered on that day, the phrase “speech” specifically references King’s address and what we have come to know as “I Have a Dream.” Regurgitating a historical account of events that transpired before the speech, Younge (2013) states, “the march was held just ten weeks after [George] Wallace stood in a schoolhouse doorway to prevent Black students from going to college, and little more than two weeks before four Black girls were bombed to death in Birmingham, Alabama, during Sunday school” (p. 7). Several days before the March, intense discussions simmered around the contents of the speech, accompanied by days of editorial input and review. As King stood on the steps of the Lincoln Memorial, as the final speaker of the day, he “started by locating the demands of Black America as consistent with America’s historical tradition rather than aberrant from it” (p. 106). King understands the contradictions of American history and uses white normative discourse, enshrined in the Constitution, Declaration of Independence, and Emancipation Proclamation, to expose the moral hypocrisy of White America through palatable language. Younge (2013) captures an array of voices that conclude, “substantively, ‘I Have a Dream’ was not King’s greatest speech” (p. 6), nor does he speak in a militant tone. So, what makes this speech so powerful and persuasive?

King does not operate in a moral, intellectual, or historical vacuum. In recognizing the limitations of Brown, Herbert Lovelace (2017) postulates that “Brown gave activists, like King, a legal vocabulary to defend their struggle as constitutional, quintessentially American, and radically progressive” (p. 404). King does not speak as someone versed in constitutional law, nor had he “participated in the Brown litigation” (p. 396), but because he understood the historical significance of that moment, King used Brown to advocate for broader changes.⁷ King

had already begun to employ the U.S. Supreme Court’s decision in his attempt to extend the ruling of *Brown* to all facets of legalized discrimination and segregation in American democracy. Lovelace (2017) asserts, “*Brown* gave activists new moral, political, and legal language to negotiate the demands of civil rights leadership during the Cold War. King’s ability to connect *Brown* to Exodus built from an older tradition of black theology that blended secular and sacred concepts” (p. 397). As noted earlier, Black Americans drew strength from biblical passages in their attempts to contemporize the black freedom struggle in America, thereby aligning biblical interpretations of God with the struggle for freedom, justice, and equality in America. Hence, “*Brown* was an additional and readily available tool for [King] to argue that his position was right,” subsequently allowing King to “tie his activism to *Brown*” (p. 397). Furthermore, King utilized *Brown’s* ideals “to leverage the institutional legitimacy of the Supreme Court to appeal to government officials and everyday citizens who valued judicial review, federal supremacy, and the rule of law” (p. 406).

King, grounded in the historical trajectory of the black freedom movement in America, empathizes how America had reneged on its constitutional promises, which allowed him the rhetorical space to invoke the imagery of a bad check. America had paid Black Americans with a bad check. The imagery of a bad check highlights the depth of legalized discrimination and illuminates the role that courts played in legitimizing segregation and maintaining the validity of whiteness. Again, King comes from a long tradition of Black Americans to critically scrutinize the ideals and promises of American citizenship, but on this occasion, he does so in a digestible way. This speech and specifically the usage of the term “promissory note,” allows King to emphasize the moral and constitutional lapses of American democracy. Police brutality, housing segregation, voting rights, and educational inequalities are just a few examples of how “America had defaulted on its promissory note” (p. 1). These codified forms of discrimination all have one thing in common, the disdain and disregard for blackness in white spaces. Though intersectionality has provided an intellectual avenue to traverse different eras of American history and critical race theory has allowed readers to scrutinize the role of law, the intent of this article has remained the same. That is, to illuminate the paradoxical implications of blackness in American democracy, substantiated in anti-black policies and practices that beset educational institutions. Furthermore, to emphasize the connectedness between King’s public address and educational inequalities, which solidifies the ideological bond between blackness and schooling. America continues to default on its “promissory note” any time blackness acquiesces to whiteness.
References


Articles


Abstract

**Background:** Assuring health equity throughout the U.S. continues to challenge the public and private research enterprise. Even with some progress, racial and ethnic health disparities continue, particularly among African Americans. Health equity for African Americans is improbable unless participation in clinical trials is measurably increased.

**Method:** To inform efforts to enhance participation, interviews were conducted with three African American leadership groups from across the country to document their perceptions of why the research community is unable to engage African Americans effectively in clinical trials. The results of thirty-five interviews, conducted from three leadership groups, were analyzed and are reported in this article. The leadership groups include health/education, faith, and civic society.

**Ethical Considerations:** This research was conducted based upon the ethical protocols of the National Center for Bioethics in Research and Health Care, research ethics, and confidentiality.

**Results:** Findings indicate that trustworthiness must precede trust; both are essential in enhancing African American participation in research, especially in less understood clinical trials.

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Conclusion: Respondents agreed that the research community must demonstrate trustworthiness before trust can be established. They also indicated the importance of increasing the number of African American researchers in leadership roles. Also, suggestions were made regarding the need to develop short and long-term positive relationships between the research community and the African American population, at various levels, if increases in participation in clinical trials are expected. With the likely development of new clinical research and the attention to increasing excess deaths among African Americans, there must be representative numbers of African Americans and other underserved populations in leadership roles if health disparities are to be eliminated and health equity is to be achieved.

Keywords: Clinical Trials, African American, Trust, Trustworthiness, Bioethics, Public Health Ethics

Introduction

Health is “the physical, social, psychological and spiritual well-being of the individual and group in their physical and social environment”[1]. Optimal Health is the best possible emotional, intellectual, physical, spiritual and socioeconomic aliveness that we can attain [2]. A vision beyond health to Optimal Health is a paradigm shift, for all peoples, especially African Americans who have experienced a disproportionate burden of morbidity and mortality [3, 4]. If the goal is eliminating health disparities and achieving racial and ethnic health equity, another paradigm shift is needed. The shift does not minimize the importance of human and financial resources needed to eliminate health disparities. However, achieving racial and ethnic health equity encourages a focus on research, specifically targeting current African American health status as a baseline, rather than comparing them to other groups. Comparing racial and ethnic groups has identified disparities, but these comparisons have done little to reduce them. New thinking about persistent health challenges may result in new strategies that include considering health equity and Optimal Health.

Current conversations about health continue to be both protracted and intractable in the United States and beyond. Except for selected Asian American ethnic subgroups, people of color in general, and African Americans in particular, lead in most categories of health inequalities [5]. Seldom, if ever, are positive and/or just health and health care outcomes reported in reference to racial and ethnic minority groups (people of color). To address this problem, research must include people of color in leadership roles, as well as participants in scientific research. By involving more people of color in the research enterprise, improvements in health and health care related to minority health are possible.

This article discusses the recent literature on the need to include African Americans in health research, specifically clinical trials (CTs). Further, we discuss salient research findings from a collaboration between Eli Lilly and Company (ELC) and the National Center for Bioethics in Research and Health Care at Tuskegee University (NBC). The collaboration included a multi-phase research effort to address the longstanding challenge of enhancing participation of African Americans in CT research. This collaboration was consistent with the
Federal Drug Administration-Section 907: Inclusion of Demographic Subgroups in Clinical Trials, published in the Federal Registry for public review. The Action Plan (Section 907) thoughtfully considers public feedback, congressional requirements, and the initial report findings. The plan presents 27 action items that focused on three priorities:

1. Quality: to improve the completeness and quality of demographic subgroup data;
2. Participation: to identify barriers to subgroup enrollment in clinical trials and employ strategies to encourage greater participation;
3. Transparency: to improve the public availability of demographic subgroup data [6].

One strategy to address these priorities, and a major focus and primary interest of both ELC and NBC, was to discern the ethical problems related to historic and current challenges borne out of the lived experiences of African Americans related to clinical research and health care delivery. To explore the erroneous assumptions regarding the lack of African American participation by researchers and others, this project included a multi-phase research design to determine how to enhance African American participation in human subjects research [7]. The overall project included several components: Assessment, Advocacy, Coordination, and Evaluation. The Assessment Phase included individual interviews to elicit the perceptions of designated leadership groups about human subjects research participation. A specific focus of these interviews was to document the challenges and opportunities related to the issues of trustworthiness and trust. The study aimed to document other obstacles to participation in research, which might be crucial to the appropriate biomedical and behavioral tailoring of pharmaceutical developments to better serve populations long excluded from CTs. The collaboration of ELC and NBC had the goal of eliminating health and health care disparities that were influenced by the lack of trust between the research community and African Americans. Both institutions acknowledged the legacy of the unethical U.S. Public Health Service Syphilis Study at Tuskegee [8, 9, 10].

The main objective of the research was to inform the development of evidence-based strategies that would build relationships between African American leadership groups, their constituencies, and the research community. To accomplish this objective, in-depth interviews with a national convenience sample of leading policy, education, health, faith, and civic society members of the African-American community were conducted. These categories were selected because they represented leadership groups that historically have provided guidance through major social justice challenges [11, 12]. These leadership groups continue to advocate on behalf of African American and other vulnerable populations on all aspects of health and well-being. They serve as more than stakeholders because they have been, and continue to be, sustaining pillars for the African-American community. These pillars have survived periods of social injustice including, but not limited to, segregation, the Jim Crow era, desegregation, integration, the Civil Rights Movement, Black Power Movement, etc. [13]. These individuals and organizations continue to be the major decision-makers in the African American population. The respect they command, both in and outside of the African American community, assures a venue to translate trustworthiness into trust.
The interviews addressed three major research questions:

1) Why do African Americans not trust research conducted by the scientific community?
2) What is needed to eliminate the barriers to participation in research, while enhancing the trustworthiness among the scientific community?
3) What recourse would be available when bioethics and public health ethics violations occur?

It is important to note that a pedestrian definition of trust is insufficient to cover the various nuances associated with this research effort. Thus, we begin by teasing out these nuances and settle on a definition of trust that is more guiding and compensatory. Space would not permit an exhaustive explication of trust (and its trustworthy dialogic), but a general accounting of trust as entailed in this research, as well as trust particularized to the African American community, is helpful.

First, on a truncated general account, (one that clearly says little about the epistemology of trust but maximizes trustworthiness as a condition that would allow trust to flourish) Carolyn McLeod offers several views on what makes trust warranted (note the import of trustworthiness). She suggests, “trust is warranted, that is,

1) Well-grounded, only if the trustee is trustworthy, which makes the nature of trustworthiness important in determining when trust is warranted.
2) Justified, sometimes when the trustee is not in fact trustworthy, which suggests that the epistemology of trust is relevant.
3) Plausible, only when it is possible for one to develop trust, given one’s circumstances and the sort of mental attitude that one can will oneself to have without any evidence of a person’s trustworthiness [14].

What is entailed in each of the above points is that trustworthiness is a sufficient condition for trust to flourish. However, if there is historical evidence in support of distrust, our research indicates that trustworthiness is a necessary condition for trust. Given that the one trusting is choosing to make herself vulnerable to the trustee, and furthermore, given that there are no guarantees that the trustee will keep her promise, the wisdom burden is on the one trusting to self-protect.

Second, our research goes beyond trust generally to a particularization of trust that speaks to justification (this is derived from above). Even though our research has shown that there is a justification for distrust, two thoughts should remain in the forefront: 1) “one can will” oneself to trust—but this should be measured by the number of options available. The fewer options a person or group possess, the greater the need to trust “without any evidence of a person’s trustworthiness”; 2) “racial/ethnic minorities (people of color) should not be considered inherently mistrustful, even if the mistrust can be justified by historical injustices and disparities in available, assessable, acceptable, and quality healthcare. Such characterizations may create provider bias that, in turn, create major barriers for referral and compliance in
clinical trials” [15]. African Americans are suspicious—and they have a right to be [16]. One can argue that they should prioritize their suspicion and distrust of certain systems to give themselves a better chance for quality health and healthcare. On the other hand, one can argue that those who desire to be trusted should invest in their own trustworthiness by developing an attitude and a culture of empathy, compassion and care. It is very difficult for a person not to trust someone who proves his trustworthiness.

In Trust and Trustworthiness, Russell Hardin writes of the synergy between the two terms [17]. However, he notes that discussions of trust rarely mention trustworthiness though it is often implied. L. Hertzberg writes, “Trust is always for something we can rightfully demand from others: misplaced trust, accordingly, is not a shortcoming on the part of the trustful person, but of the person in whom the trust was placed” [18]. This idea shifts the blame of a lack of trust, that is often placed on the African American community, to a lack of trustworthiness on the research community [19]. And it provides a basis for the development of an argument that fixes trustworthiness as a feature of care—i.e., a preoccupation with doing right to persons who have made themselves vulnerable.

Consequently, in this article we clarify the structure of trust and trustworthiness, and show how these specific dispositions are not merely attitudes and beliefs. Rather, we show how they represent feelings and emotions. These feelings and emotions constitute foundations for normative moral claims and judgements from both moral rationalism and moral sentimentalism. From the onset, it is not hard to discern how trust and trusting would make normative ethical sense from a Kantian (Immanuel Kant, 1724-1804), rule-based, obligatory, and deontological perspective. Trust, as a rational concept, makes perfect societal sense. Any calm, rational person, of average intelligence should not only see trust as a rational virtue, but they should see trust as an admirable disposition and the lack of trust (as opposed to a justifiable mistrust or distrust—both of which may be prudential) as perhaps having a deficiency of some sort. Trust is organic; mistrust or distrust is prudential on a rationalist account. But a sentimentalist account seems to be veridical as well.

To be sure, everything we have said about trustworthiness thus far has tremendous value in cognitivism, and certainly this is easy to see. Cognitivism asserts that ethical sentences have truth value (they are either true or false) and are, therefore, propositional (rationally and sentimentally). A trustworthy person is acting morally when she keeps her promises, is reliable, or she acts in such a way as to not compromise the vulnerability of the trusting agent. Regardless of the metaethical canopy (moral realism, moral relativism—or anti-realism), such that one can speak propositionally, sentences can be constructed in defense of trustworthiness (e.g. a doctor may say to a patient, “I am committed to maintaining the integrity of the informed consent document.” If she maintains the integrity of the document, her proposition is said to be true, therefore, in this instance, and with respect to this patient, the doctor is acting in a trustworthy fashion. She is acting morally. She is acting untrustworthily, otherwise, and therefore she is acting immorally). Trust, however, is something different and ought to be the subordinate of (and even contingent upon) trustworthiness. Trust is not a moral attitude, it is an instinctive one, genetically based and socially developed.
Infants exhibit and express trust among their first instinctive actions. They are not acting cognitively, thus morally. They are acting instinctively. One can even say that they are acting phenomenologically. It is certainly true that trust (can and likely) is a disposition that has evolved in a kind of Social Darwinian way, but this evolution doesn’t mitigate a phenomenology to trust. Other terms may be applicable (e.g., faith, confidence in, reliance, or dependence), but additional terms are simply synonymous with the phenomenology of trust. Indeed, the infant’s trust of parent, particularly if the mother is breast-feeding, is an inductive-base survival instinct—it is less of a proposition to trust and more of a non-cognitivist action that can be interpreted as trust. But phenomenologically, it is the most basic trust of instinctive, sentient creatures, of which the human infant is one. The infant could never survive without a disposition to trust. From the beginning of life, trusting is necessary, natural and universal. As the infant continues to trust, and as the parent continues to care for the infant with consistency, they represent themselves as being trustworthy, i.e., reliable and competent to the point that trusting is less of a cognitive choice [45]. Reliable and competent parents, i.e., trustworthy parents, earn the trust of their children, which has far-reaching implications for both parent and child. First, the infant instinctively and justifiably allows itself to be vulnerable to the parent or their designee because past trusts were met efficaciously. Second, because trustworthiness is established and demonstrated with consistency, the child is then justified in extending the parent’s competence from feeding to other care-competencies, like changing their diaper, protecting them from darkness or loud noises, etc. Trustworthiness, then, is contingent upon the trustee’s cognitively inculcating certain values and principles that would increase the dialogue between the trusting agent and the trustee. In short, trusting is organic and non-moral (a thief ought to be able to trust his comrade, or co-conspirators in an evil plot trusts each other). Trustworthiness, on the other hand, is virtue based. Character is essential to being trustworthy.

Would anyone trust their doctor or attorney if he or she is of questionable character? Would any child trust a parent whose character has been demonstrably unreliable? Alternatively, would African Americans or any cautious group trust clinical trials researchers? Certainly not—and the historical evidence bears this out. Trust is a great principle for the provision of (utilitarian) happiness because a society is better off having most of its citizens trusting than distrust—becoming vulnerable knowing that most people value trusting relationships is better than never becoming vulnerable, never trusting, never flourishing. Trusting, on a rule-utilitarian account is a good disposition to have, but if there is a demonstrable lack of trustworthiness in the character of those demanding trust, there can be no societal, viz, no flourishing in clinical trials. Until the last two decades, trustworthiness was historically—and unfortunately—left out of the structure of trust. Trust is dialogical with trustworthiness. There is no valid or meaningful trust if it functions, independently. Mono-logical trust has no value; it is itself vulnerable to gullibility if it is not made to be dialogical. On our account of trust (discursive trust, i.e., trust that is tied to trustworthiness), cognitive-trust and its counterpart (character-based) virtue-trustworthiness are valid and necessary for the participation of African Americans in clinical trials. This kind of dependent cognitive-trust/virtue-trustworthiness is advantageous to our present concern.
Background

Report of the Secretary’s Task Force on Black and Minority Health

In 1985, the U.S. Department of Health and Human Services released the, Report of the Secretary’s Task Force on Black & Minority Health, also known as the Heckler Report [20]. This pivotal report is the first time in U.S. history that the federal government acknowledged that morbidity and mortality could be chronicled by race and ethnicity [21]. More than thirty years later, African Americans still suffer from similar, and in some instances, worse health gaps and disease prevalence as presented in the report [22]. The US Department of Health and Human Services’ Office of Minority Health was established as an outcome of the 1985 finding [23].

Clinical Trials Participation Rates

According to Institute of Medicine, researchers failed to recruit an adequate number of subjects for clinical research 27% of the time, and 90% of clinical trials worldwide failed to enroll subjects within the allotted time [24]. Overall, the rate of participation in clinical trials is poor among certain groups and declining; however, it is poorest among African Americans. Little has been done to address or overcome recruitment obstacles for the general population.

African American Participation Rates

The recruitment and inclusion of the general population in clinical trials is difficult and in comparison, so is the rate of African American participation. In 2013, a report was drafted as a requirement by The Food and Drug Administration Safety and Innovation Act [25]. The FDASIA documented data on the participation of demographic subgroups (sex, age, race, and ethnicity) in clinical trials focused on new drugs and biological devices. African American participation in many of the studies was not representative of the US population or disease prevalence; specifically, for type 2 diabetes mellitus (T2DM). African American representation in clinical studies was less than 5%; however, African Americans make up approximately 13.3% of the U.S population and have a higher prevalence of T2DM [26]. The continual lack of participation of African Americans, disproportionately affected by many diseases, will only perpetuate the current health gaps.

Why African Americans Do Not Participate?

Retention, Protection and Reward

The literature related to African American participation in clinical trials is significant, with numerous explanations [26], but minority recruitment into clinical trials continues to be a challenge [27]. Woods et al. reported that some of these challenges include transportation, work-related and family responsibilities, fear or suspicion of researchers and the institutions that promote clinical trials, and cultural factors that ultimately influence trust and trustworthiness [28].
The United States Public Health Service Syphilis Study at Tuskegee.

The United States Public Health Service (USPHS) Syphilis Study at Tuskegee is often used as a touchstone for many African Americans’ understanding of clinical research [29, 30]. From 1932 to 1972, approximately 623 African American men located in Macon County, Alabama participated in a study to document the natural progression of syphilis in the Black population. The USPHS scientists/physicians engaged in an unethical investigation to document the adverse effects of the syphilis virus on the organs in the human system. Originally, the title of the study was the “Tuskegee Study of Untreated Syphilis in the Negro Male in Macon County Alabama” [32]. The participants were told they were being treated for “bad blood,” a local term used to describe fatigue, anemia, and malaria, among other maladies. In exchange for participation, the men were offered meals, free health treatments (not for syphilis), and ensured burial stipends after their deaths [32]. Initially there was no proven treatment for the disease. However, after penicillin was determined a cure for syphilis in 1947, treatment was still withheld from the men. In fact, a unique “surveillance system” was designed to track the men wherever they went in the U.S. to assure that they would not receive treatment anywhere for the disease. By this time, many of the men had died and some of their wives and children had been infected” [33]. The establishment of Institutional Review Board regulations to approve all human subjects research was a direct result of the USPHS Syphilis Study at Tuskegee.

Mays discusses the accepted notion that the lack of success in addressing health disparities in the African American community is attributed to skepticism towards research because of the Tuskegee Study of Untreated Syphilis in The Negro Male [27]. This belief is held despite studies that conclude that, while many African Americans may have little knowledge about the specific events associated with the Syphilis Study, there remains a “site of memory” that serves as a barrier among African Americans and other vulnerable populations about participating in human subjects’ research [32]. While willingness to participate may not necessarily be directly linked to the study in Tuskegee, there is a hesitation by many people because of myths that are associated with it. Myths influence perceptions whether they are true or false [30]. These myths perpetuate the legacy of the USPHS Syphilis Study as being the major cause of mistrust [33]. However, current bioethics and public health ethics violations continue to foster distrust in human subject research, including clinical trials.

African Americans’ Willingness to Participate in Clinical Trials

Few studies contradict the previously stated barriers to African American participation in clinical trials. Research reiterates the various themes surrounding this matter by constructing similar conclusions in varying populations [41]. Few data that link an individual’s willingness to participate in biomedical research and awareness of the study at Tuskegee. Instead, Katz and Warren suggest many other factors such as racial discrimination, health quality, and/or access to health care [30]. These current experiences result in African Americans cautious approach to research. The Tuskegee Legacy Project (TLP) Study (1992-1999; 2001-2009), addressed barriers related to the recruitment and retention of Blacks and other minorities in biomedical research studies [41].
Gaps in the Literature

While many studies examined the attitude of the subjects recruited into clinical trials, or those who chose not to participate, very few studies have focused on the perspective of clinical researchers and barriers presented in the recruitment process. Few studies consider the perspectives of trustworthiness and trust and how these two themes are interpreted and perceived by those African Americans who belong to key groups that have influenced other African Americans throughout history, such as: (a) health and educational professions, (b) faith-based leadership and (d) civic society.

Further, the current literature surrounding African Americans and clinical trial participation is limited in utility because few solutions have proposed and little has been done to rectify the lack of perceived trustworthiness of the research community.

Study Methodology

The research team assembled by the NBC included a health service research scientist/principal investigator, statistician/computer analyst, medical anthropologist, and project director. The team met quarterly to discuss the implementation of the research. We conducted thirty-five interviews among three gatekeeper leadership groups over a 12-month period. We completed a review of the literature, which identified salient topics in the recent biomedical, behavioral, public health, and bioethics literature related to clinical trials, particularly those associated with African Americans and highlighting clinical trials.

Sample

The three groups (and other key selected individuals, who did not fit into these categories, for example, Opinion Leaders) comprised the convenience sample. Individuals were identified based upon their economic, strategic, intellectual, and political positions.

Health care professionals have large patient populations that they influence in a variety of ways. They also have a large impact beyond their patient populations to include health profession students, economic peers in other professions, and members of other economic groups. Campbell explains, the physician is seen as trustworthy, as someone whose views can be respected and depended upon” [39]. Within the African American community, the role of physicians as representing authority is even more salient.

The faith community leadership has historical influence, not only with their specific congregations but also by reaching large sectors of the African American community because of the strong religious orientation of these communities. The PEW Research Center reports that 83% of Black people in the U.S have an absolute belief in God. Their White, Asian, Latino counterpart’s record, 61%, 44%, 59%, respectively [25]. The challenge for this research project was in scheduling interviews with faith leadership outside of the theological education sector.
Civic groups and other social organizations continue to play important roles in providing leadership for the African American population. While many social organizations have primary social, rather than social-action roles, most of them include civic and social responsibility within their missions. The National Association for the Advancement of Colored People and the National Urban League remain the two strongest civic organizations serving the African American population. We interviewed representatives from both organizations and the leadership from 100 Black Men, Inc.

The sample included:

• The President and two Past Presidents of the National Medical Association
• Presidents/Deans of the Black medical and dental schools
• The President of the National Dental Association
• The Presidents and/or Deans of four predominately, Black theological seminaries
• Leaders/Presiding Pastors of two major religious institutions
• Leaders of the NAACP and Urban League
• 100 Black Men Inc.
• Selected Opinion Leaders

The Director of the NBC (PI) conducted all interviews to assure consistency in the interview process. A firm was contracted to transcribe the audio and provide transcriptions to the research team.

Analysis

The transcripts from the interviews were entered into the Atlas-ti database and coded for analyses. Coding in qualitative research accommodates the exploratory nature of open-ended questions, and the complexity of textual responses obtained. Thus, the basic qualitative coding unit is a text segment, rather than a questionnaire response. Informed consent forms were discussed and signed by each interviewee and the Principle Investigator.

Findings

Generational differences [different audiences]

The interviews identified salient perspectives on the generational and sex differences of potential CT target populations. The most pervasive theme regarding age cohorts was the difference in methods and motivation for accessing information in general, and health information specifically. As one respondent stated,

“This generation can press a remote and they get immediate feedback. We live in a world of technology whereby generations may not see the need for research because they do not fully understand the paths people have tread to get where we are today. So, I think it is a generational gap, and we need to educate them on the importance.”
Social media, as used by the younger generation, was identified as key to how they seek information, rather than personal communication with trusted persons, e.g.,

“What is Facebook saying about it? What is social media saying about it? They’re even looking for ways to participate.”

In contrast to describing the “millennials,” the older generation was called the “silent generation” by interviewees:

“We know the silent generation, the older generation, they look at things differently. Their values and their attitudes are different, and the way they perceive information is different from the millennials.”

Differences were also noted regarding the issue of trust; the younger generation was mistrusting the “system” and not necessarily separating science from government. Their mistrust was not necessarily grounded in a historical perspective:

“When you look at the younger generation, they may not have the historical perspective of the mistreatment and the ethical conduct from years past of African Americans in experiments, but their mistrust would come more from the whole system of government...”

One of the medical leaders expressed hope that the younger generation would take more responsibility for community health, clearly a message about recruitment regarding participation and the importance of tailored medications:

“Well, I would like to think that there is a new generation of people coming out who would look at the health system in a new way and see their responsibility in it, not just as patients or potential patients, but their responsibility as a part of the community to make sure that it serves the needs of the community.”

The value of reaching the younger generation was also noted, highlighting their economic power and the importance of information and education:

Understanding of Research and the Importance of Research

The leadership interviews were eloquent regarding concerns that the African American community does not fully understand what research entails, nor the importance and/or relevance of research to the health and well-being of their community. Critical was the idea that understanding the rationale for the development of population-specific drugs (epigenetics) and environmental/contextual effects/stressors such as poverty, racism, stress, and allostatic load were missing in most sectors. They saw this lack of understanding as one of the major obstacles to participation:

“I think that the lack of understanding has to be in the introduction and understanding of research and all of its dimensions. And I think that a good starting point must be...
“in our academic institutions and letting that flow out and permeate the entire Black community.”

The Quality of the Relationship between People, Groups and Institutions

Many of the respondents spoke about a fundamental lack of any relationship between the health system and the African-American community, not only the issue of medical mistrust (to be discussed following), but even the basics of protection, care and caring, and services. While doctors were the focus of the responses, the implication that the system does not serve the Black community in many ways was salient. As one respondent stated,

“I think Black people need to be convinced that the healthcare system actually does care about them and their health, and not just their disease, but about them and their health. I think that sense of caring, the sense that this is truly a health care system for Black people is missing.”

Also commented on were the obstacles presented by Pharma:

“Lack of knowledge of Pharma about the core values and cultural norms. I think dealing with our community from a point of intelligence is the way to go.”

The overall conclusion of the respondents regarding relationships and CTs was, “If people see themselves as part of a system that cares, they are more likely to participate.”

The implications of this recommendation go far beyond the focus of CT recruitment and participation and speak to the issue of health disparities and underserved/poorly served communities.

Medical Mistrust

There is a significant literature exploring medical mistrust, which demonstrates an overall distrust by the African American community of research and the research community [16, 42, 43]. The leadership interviews confirmed findings in the literature regarding the importance of understanding issues of interpersonal trust within medical/health care relationships, and issues relating to the history and current experience of individuals and groups [39, 40, 41, 42]. The importance of legitimate sources of information, which may vary by topic, was raised, as well as how legitimacy is assessed considering trust and other factors. Also emerging as important were discussions about the role of the physician in building trust and the need for more Black physicians, as well as their advocacy and education about the substance and availability of CTs. However, concern was expressed about the lack of knowledge of CTs even among physicians. As one respondent stated, “When health providers are not telling patients about clinical trials, maybe it’s because they’re not aware of them themselves.” Others questioned practitioner’s knowledge and awareness of CTs as a basis for a lack of advocacy
Suggestions for addressing medical mistrust were forthcoming:

“I think that to overcome the distrust we have is to educate people on why research and the clinical trial process is important to creating medicine and therapies that work. I don’t think a lot of people realize that the process through which medicine is created has a component of it that evaluates people and their medical profiles.”

“I also think that we know intuitively that Black people have different, differential, unique health challenges. We don’t trust that the mainstream pharmaceutical companies and the established medical profession will deal with that, but the education is that participating in the clinical trial process allows medicines and therapies to be built and designed with our challenges in mind.”

One of the most insightful comments, which addresses essential issues underlying medical mistrust, was the following:

“The health professions have to be able to show that the greater purpose of medical research, medical practice, public health, are absolutely to maximize the health and well-being of all people; and research that is conducted is not designed to sacrifice any person or group, or group of persons for the sake of everybody else.”

“...the health [professions] really have the greatest priority to be trustworthy. That doesn’t mean they are trustworthy.”

Oversight, Protections, and Consequences of Violations

One of the major objectives of the study was to understand how the leadership viewed the issues of protections for participants and what consequences they believed existed and/or should exist. Discussions about private versus public sector research elicited the opinion that Pharma was motivated by "quest for profit and reputation", rather than a commitment to health. On the other hand, many of the interviews cautioned about the African American community’s distrust of the “system” in general as well as the health care and research sectors. One of the areas of the interview focused upon the differences between the public and private sectors to better understand what issues of trust and trustworthiness might emerge, and as a segue into issues of protections and consequences.

Giving “teeth” to the protections was clearly a concern. The following views provide insight into the opinions and priorities expressed:

“Now, clearly, there has to be enough protection in the patient information that one understands the risk before going into it. And so, I think that that’s the first level of assurances.”

“To enhance the protocols in the clinical trials, the engagement really goes back to having an infrastructure that is sustainable and is longstanding that allows for the training of
people, for the education of various patients that will come through there, and the support system is there.”

“They were very big on IRB, institutional review boards, and these particular committees being composed of not just components of the people who are doing the research, but an ethical committee that encompasses several people. So, when you start to put those type of committees and those boards in place, it sorts of enhances the protection.”

Regarding policy implications, one of the leaders suggested:

“I think individual institutions and organizations that are performing clinical trials have their own set of policies. But having universal policies that are available to the public provides understanding of how clinical trials are conducted, how they're provided oversight, so things of yesteryear do not occur again.”

Others stated,

“They’re universal policies. There should be universal policies set on clinical trials and research, and those should be known at every level.”

Key Suggestions for Elimination of Barriers to Recruitment

Throughout the interviews, suggestions for eliminating barriers to recruitment and participation in research/CTs emerged. These suggestions, in general and specifically, relating to the issues of relationships, messages, trust and strategies, which address perceived obstacles to involving the African American community in research.

Trusted Sources of Information:

Faith leaders have a significant role in communication, education, and advocacy. An example of this leadership is a curriculum for seminarians to better educate them about issues of health and health care in African American populations [44]. This curriculum is an important advance already said to be underway. However, it is important to understand how difficult it may be to reach some faith leaders and clergy. African American care providers that work in the community have significant potential to promote participation by educating patients about CTs and the personal and community advantages of tailored research. The content of education and messages about research and CTs were also discussed. Health literacy was identified as an important obstacle, crucial for recruitment as well as adherence and retention in CTs, e.g., “This must be achieved at two levels, knowing about medications and an understanding of the body and disease.”

Motivation to Participate

Respondents felt that recruitment must consider the perceived motivation for participation, for example, whether individuals have a personal or family experience of
disease is often crucial to participation in specific CT research. As explained by one of the medical leadership,

“I think a lot of this with participating in clinical trials with African Americans depends sometimes on the disease, what the clinical trial is about. Getting them to participate depends on what stage of a condition they’re in.”

**Type and Amount of Reward/Incentive**

The issue of incentives for research participation was carefully considered, with differences of opinion noted, including whether to offer payment for participation. Other types of rewards and incentives were also discussed with interviewees, including the importance of altruism, and how participation can be seen as a benefit to the community:

“I think people have to see an investment, a return on investment. They have to see a need that they’re helping someone else, whether it be a family, a community, and they have to be able to have a reward to know that they made a difference by participating.”

**Recruitment Strategies**

Critical issues to consider included:

• Appropriateness of the recruiter;
• The reputation of the institution recruiting;
• The message/explanation being given;
• The need for details about what is being tested; and
• Recruitment in small hospitals and public health centers.

**Distinguish Long Term and Short-Term Goals for Participation**

Tailored strategies were needed to support participation reflecting long term and short-term goals. Long term, for example, was said to be training of Black doctors and educators in seminaries. Short term was peer recruitment; contact at support groups, information at community clinics, provision of information to community doctors and navigators, videos with explanation of CTs as well as education about the need for tailored medications.

**Conclusion**

This qualitative study is a vanguard effort because data were obtained from the leadership of the African American community in the US, regarding their perceptions of, and reasons for, obstacles to participate in human subjects research by African Americans, specifically CTs. Reaching these experienced and knowledgeable individuals in face-to-face interviews across the country was facilitated because of the reputation of the National Center for Bioethics in Research and Health Care and the respect and trust which the Director holds among his peers. The research team is confident in the validity and importance of the interviewee responses given concerns about Pharma sponsored studies.
What we have seen in these timely interviews is that trust and trustworthiness are critical issues, identified in the literature as obstacles, and in these interviews as solutions. The leadership, aware of the objective of the study, were generous in their suggestions for improving the participation of their constituencies because they understand the need for tailored medical/health interventions that will address the long-standing and unacceptable health disparities in the US. They discussed, as does the literature, the importance of the history of unethical research and the sequelae of truth and myths. They also recognized, not well addressed in the literature, that there are important generational differences in the reasons for medical/health distrust. They highlight the need for the education of the health professions community, especially Black physicians in the community and in institutions, so that there will be a better understanding of the need for such research and what it entails.

The leadership also stressed the need for reaching the faith leaders as well as the difficulty in gaining their understanding, and especially, their trust when the trustworthiness of the research community is not evident. This is true for both public and private sector efforts. Interestingly, the leadership placed emphasis on relationships between institutions, individuals, and the community as key to developing trustworthiness and trust.

The perceived pharmaceutical industry’s objective as primarily profit was seen as undermining any attempts at developing these critical relationships. “Show that you care” was a salient theme. We would say, “prove” that there is a real commitment to African American health by developing culturally sensitive strategies for informing all constituencies. Understanding the history and values of the African American populations (plural because we stress generational issues) should be paramount in promotional efforts toward recruitment and participating in clinical trails.

The conclusion that we would draw from the study’s findings is that the history of unethical research, while important, is not the predominate factor operating to limit participation. There needs to be far better understanding of what, how, and who should carry out recruitment and provide the leadership. Appropriate and effective information must be disseminated by trusted sources of information who may not necessarily be receptive to collaboration. Relationships that build trust require commitment and understanding. Motivation for participation needs to be explored and built upon, and incentives and rewards need careful consideration, not simply IRB or institutional approvals. Finally, trust, and thus participation, will not occur if the institution and its representatives are not seen as trustworthy.

\[ \text{The paradigm must change so that trustworthiness, not trust, is what is expected first.} \]

Limitations

While this study provided a unique opportunity to learn from the African American leadership in the U.S., there were clear limitations and biases which must be noted. This study was designed specifically to explore gatekeeper/expert knowledge and suggestions to enhance recruitment, retention, and reward among the African American population. The leadership
interviewed represent senior and experienced individual men and women. Thus, perspectives of their constituents and the youth populations are not represented. Although small samples are typical for exploratory, qualitative studies, the lack of a representative sample and the convenience nature of the selection of respondents, clearly limits generalizability to even these leadership sectors.

Additionally, the respondents understood that they were advising Pharma, which may have biased their discussions. Finally, the interview involved one of their peers as the interviewer, so issues of trust and confidentiality may have affected the data both positively and negatively regarding validity. Nevertheless, the insights and perspectives of these key members of the leadership should guide the development of strategies to improve recruitment among African American communities.

References


Articles


Unsilenced and Redeemed

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Abstract

This article revisits several challenges that some Black and African American women have faced exasperating to be included in the dominant society and to be deemed relevant in the world in which they live. Since there are few Black women in high places, there are limited spaces to access and have their voices and opinions on what they feel and who they really are. Overtime, white women and men have often told the stories of Black women from his or her point of view. They have gone as far as to even express to them how they feel or think about ethical issues. Plus, many white women and men have decided for Black women how they should live out their lives and what is best for them. “Unsilenced and Redeemed” sets out to bring light to this growing problem for Black women and focus on the prognosis to set the record straight in order to enhance their quality of life, to be taken serious in their plight to bring back their God given purpose, and to know what is ethical and unethical for them.

Introduction

For centuries, women of African descent have endured a great deal of scrutiny to prove their self-worth and validation as being fully human both to the dominant community of white men and women and to the community of African American men and some Black women too. No other human upon the face of the earth has suffered bigotry and discrimination at the level African women have endured. For many, the percentage of disparity falls at a higher level than any other group. The study of 1596 African American women, 18 years of age and older, conducted by Harvard TH Chan School of Public Health, reports 50% of the women said they experience institutional discrimination because they were women, 40% reported being treated unfairly in the work place with equal pay and job promotion, 22% were treated unfairly when trying to seek health care or participating in politics. Additionally, the study reports 36% of Black women who said, because they are women, they or a female family member have personally been sexually harassed and 29% have experienced violence because of race and gender. However, Black women have frequently been discussed but rarely have they been afforded the opportunity to insert their own voices in the dialogue which most times cause misrepresentation of who Black women really are. Maya Angelou said, in a Life Magazine review of Gerda Lerna’s Black Women in White America: Called Matriarch, Emasculator, and Hot Mama. Sometimes Sister, Pretty Baby, Aunti, Mamie, and girl. “She has been called unwed mother, Welfare Recipient and Inner-City Consumer. The Black American Woman has had
to admit that while nobody knew the troubles she saw, everybody, his brother and his dog felt qualified to explain her, even to herself.”

Traditionally, the images of African American women are negative unethical ones. In past years, a wealth of information about the plight of African American women was written by white women and men, depicting their point of view of how the Black women should think and respond. Today, there are many Black women writers, but not nearly enough to debunk what has been unethically portrayed about them while all the time, Black women are the very essence of the person who cared for and raised a nation. This article attempts to revisit a few negative views of others and begin a dialogue to give voice to the silent ones and redeem what the true essence of how historically, African women, both far and near, have overcome diverse atrocities.

Observing antiquity, African women have had to bear the humiliations of being sold as chattel, sexually abused, forced into labor as slaves and servants, and used as human dairies. Through these humiliations, which are well documented and expounded upon is where the quest for inclusion begins. The first group of Blacks that entered America were considered indentured servants, who after some time could regain their freedom and purchase land. Anthony Johnson was the first African American to finish his indentured servanthood and purchased land on the Eastern Shores and own slaves himself. Even though African Americans bought land, it was land that no one else wanted, which led to the Bacon’s Rebellion. This protest was against Sir William Berkley, the Governor of Virginia for his discriminatory practices. It was not until 1654 that an indentured servant, John Castor, in Virginia, was sentenced to slavery. Anthony Johnson claimed him as his slave for life. Thus, the beginning of chattel slavery. This practice in America differed from slavery in other countries because it allowed for people to be legally sold and owned forever. Chattel slavery was a known practice in America and eventually became law that all Blacks were chattel for life up until the 1865 Emancipation.

However, the status as chattel remained for women in America on either side of the racial divide. Women and everything they owned at marriage were then owned by their husbands. Marriage was a complicated issue in America for Blacks because of chattel slavery. Even though slaves could marry, they and their offsprings belonged to the slave master. Many times, at birth, babies were snatched from their mothers’ arms and sold. Then, the mother was forced to go back to the fields to work or carry on her daily chores as though nothing had happened. Since she had just delivered a baby, oftentimes she was made to nurse white women’s children, turning her into a “human dairy”. To the slave masters, she was not sanitary enough to eat from the same plates nor drink from the same drinking glasses; the question is, when did she became sanitary enough to be made to nurse their suckling from her breast. This practice was known by many slave owners as “wet nursing.” According to Emily West,

Wet-nursing is a uniquely gendered kind of exploitation, and under slavery it represented the point at which the exploitation of enslaved women as workers and as reproducers literally intersected. Feeding another woman’s child with one’s own milk constituted a form of labor, but it was work that could only be undertaken by
lactating women who had borne their own children. As a form of exploitation specific to slave mothers, enforced wet-nursing constituted a distinct aspect of enslaved women’s commodification. The evocative image of an enslaved wet nurse, carefully holding a white child to her breast in order to provide sustenance through her own milk; therefore, holds much resonance for historians interested in gender, slavery, and relationships between Black and white women in the antebellum South. Yet ultimately, white women used wet-nursing as a tool to manipulate enslaved women’s motherhood for slaveholders’ own ends.⁵

African American women have pressed toward a higher calling knowing that this degradation was neither ethical nor what God wanted for them. In spite of these atrocities and injustices, Black women have kept their eyes on the prize of one day being respected equally by women of other cultures and men in general. Unfortunately, just when many African American women thought that they had reached their goals, they found that there were still more obstacles for them to overcome, mountains to climb, and more burdens for them to bear.

Not only have Black women in slavery in America suffered devastations at the hands of the other, it would be a travesty to silence the voice and the experiences of the South African woman, Saartjie Baartman, when looking at the suffering and silencing the voices of African American women. The atrocities of Saartjie’s lived experiences as a Black woman, are prime examples of gross oppression and it gives validity to how Black women have suffered degradations for so many years at the hands of the other. Sheila Lloyd, an Associate Professor of English at the University of Redlands explained, young Saartjie was an orphaned Khoisan girl born in 1789 on the eastern frontier of Cape Colony and she was smuggled to London at twenty-one years old. She was forced to experience many mortifying acts impossible for women of any race.⁶ Additionally, noted by Lloyd, Saartjie was a small, beautiful woman with an irresistible bottom, and strangely elongated labia. Rachel Holmes, author of The Hottentot Venus: The Life and Death of Saartjie Baartman said, “You have to remember that, at the time, it was highly fashionable and desirable for women to have large bottoms, so lots of people envied what she had naturally, without having to accentuate her figure.”⁷ To the western European eyes of that time, Saartjie was extraordinary. Her physique caused many people to ponder over how it was possible for someone to be shaped with such an amazing figure.⁸

At a young age, men convinced Saartjie on the idea that she had a lucrative potential as an entertainer in England and she would become rich and famous. Believing this promise, Saartjie agreed to leave her homeland to seek for riches with hope of someday returning. Never the less, she fell into the hands of human traffickers, where they used her in circuses all over England. Her first performance was September 24, 1810. She was dressed in a tight-fitting body suit with beads and feathers, with fur cloaked from her neck to her feet, as she wore petrifying face paint and suggestive curly hair. It further noted, Saartjie’s imagery was a fantasy made flesh to the London audiences. She was ordered to sing, dance, as she played her tin guitar, while being poked and caressed by onlookers. In no time, London was taken over by the Saartjie mania. She went from being a mysterious immigrant to the city’s most talked about celebrity.
Her image became omnipresent on bright posters and penny prints while being revered for cartoons and caricature.⁹

The British Empire abolished the slave trade in 1807, but not slavery itself. As a result, campaigners were appalled at Saartjie’s treatment in London, and took her employers to court for holding Saartjie against her will. In court, Saartjie was asked if she preferred to attend bible school and then return home or stay in England and perform on contract with a salary. Saartjie said, “Stay here.” Unable to prove she was performing against her will, the case collapsed. Saartjie’s choices were limited. Who wanted to live in a poor, colonized, South African country where there were no opportunities for women at all? Again, Saartjie believed in, and had no other choice but to work for people that meant to exploit, use, and abuse her. Surely, the show owners would live up to their agreement to place Saartjie under contract and salary in a free country. Nevertheless, they did not, the show went on and she experienced more humiliation.

In the spring of 1815, Saartjie posed for three days as a live model for Europe’s leading scientist, naturalist and staff painters at the Museum of Natural History where her entire body was gazed upon and examined in public. Artists produced delicate portraits of her body that became collectible popular art, copied and sold in great quantity. The same year Saartjie died at age 26 and more indignity followed her death. Georges Cuvier, the father of comparative anatomy and paleontology, conducted the post-mortem examination. Within 48 hours, her bones were boiled, and her brain and genitals were bottled.¹⁰ According to Ora Williams, an African literary scholar and bibliographer, “It is often said the Black women are the ones on whom medical experiments are first tested.”¹¹ Once Saartjie’s whole body was examined and an autopsy performed, sculptors and artists were allowed to make plastered casts of her body, polished the mold with turpentine, skinned and painted it, and the whole body varnished. For more than two centuries, the relics of Saartjie’s body were kept in the Museum of Natural History on display. Her violated body became Europe’s most analyzed specimen. It was not until 2002 that President Nelson Mandela demanded that Saartjie’s body released to give her a proper burial.¹²

It is evident that Saartjie’s body was subjected to indignity and exaggeration. However, through lack of recognition of the works and examination of George Cuvier, the father of comparative anatomy and paleontology, Saartjie has influenced modernist female form and will forever live on in the fields of Medicine, Ethics, and the Arts. The experiences of Saartjie in early modernity is symbolic of the alienation and degradation that women have experienced oftentimes in life, be it the expropriation of female labor, sexuality or economic exploitation. Though filled with irony, historically, like Saartjie, many American Black women have inherited great attributes, wisdom and strength from the experiences of oppression and hardship. Just as Saartjie wanted to obtain wealth in hopes of one day leading her people to a better life, so do other Black women in our world today. Leadership and decision making have been engrained in American Black women’s memory, from managing the plantation, rearing off-springs (their own and those of the plantation owners), and as confidants. African American women too have suffered and experienced a lack of recognition for their contributions to a nation and institution that literally cleaved to her breast.
African American women have measured up to the humane abilities and have surpassed some men and other women. According to Angela Bonner Helm, a journalist and journalism teacher at City College in New York, “African American women are the most educated group in America, but we are still along way from equal pay.”13 Even though in 2009, President Obama signed the Lilly Ledbetter Fair Pay Restoration Act, there is still a disparity in equal pay for African American women. Unfortunately, they make up only 8% of private sector jobs and earn 64 cents to the white man’s dollar, 78 cents to the white women’s and 74 cents to the Black man’s dollar. According to Stacy Floyd-Thomas, “Black women are only relevant to explain, legitimate, or ensure the logic of men’s and other women’s lives, security, comfort, and success. Black women have no meaning for themselves outside of the utilitarian end. Simply put, for them to be relevant is for them to be useful. Plus, they are still counted as irrelevant and many doors closed in their faces if they are not subservient or if they reject employer’s expectation to serve in humbleness.”14 Ironically, many entities cannot survive without the Black woman. It is important to note that dialogue is crucial for African American women to be completely unsilenced and redeemed. The stories of the past are ways that African American women issues can be recalled and respected as authentic voices while remembering the hidden secrets that caused them to be silenced, and to begin to correct those issues that have held many Black women down and silenced them for ages.

For over six hundred years that the United States has been in existence, she has had an issue with finding value for her African American citizens, especially the African American women. James Cones, the founder of Black Theology, saw the Black woman not as a special specimen of womanhood, rather as a Black woman given less protected and burdensome positions in society.15 As, Michelle Wallace, a Black feminist author, pointed out, “this has resulted in the myth of the superwoman, which is not a description of the Black woman but, rather, a measure of the difference between what is regularly expected of white women and what is essentially required of Black women.”16 It is true, Black women are expected to endure atrocities in life that cannot be endured by neither men nor white women. She is known to give birth in the morning and tend the fields in the afternoon, all while nursing someone else’s child. Therefore, as Cones puts it, “the value that Black women have derived for themselves and have offered as an option to the Black community as well as the members of a broader, dominant society cannot be understood or adequately explained apart from the historical context in which Black women have found themselves as moral agents.”17 Cone further explained, moral values that Black women have provided as a legacy to the Black community traditions have been irrepressible in redeeming and transforming an entire human environment.18

Retrospectively, there were not very many occasions, during turbulent times, when a Black woman was not present to “save the day”. She has rebelled against oppressive institutions, led communities, and triumphed in the face of adversity. Yet, none can live without her, but many find the need to silence her. As Katie Cannon, an American Christian theologian and ethicist, explained, “The Black woman has been placed under a double injunction. She has to face a critical jury, particular white and male, that makes claims for gender neutral and value free inquiry as a model for knowledge. She has little opportunity to expand her creative energy or
concentrates on searching for universal truth unhampered by so-called incidental matters such as race, sex and class differences. If the Black woman engages in this type of abstract moral discourse, she runs the risk of being misunderstood, misinterpreted and frequently devalued.” Canon went on to argue that, Black female scholars accepted canonical methods of moral reasoning contain deeply biases that make it exceedingly difficult to turn them to the service of the best interest of Black women and universally does not include many of the Black woman’s experiences.

Finally, because a wealth of Black women have experienced a great deal of scrutiny to prove their self-worth in mainstream society, the need for dialogue among them is virtually pertinent. It will call for those women who feel that they have been or are under the auspices of oppression and silencing, to be unsilenced and redeemed. First, the fear of each other and colorism must cease. In order for them to communicate with each other and hash out their barriers, it is imperative for Black women to come to grip with the ancient dilemma forced on them, to understand themselves and to learn to appreciate the women they are purposed to be. If this cannot be accomplished, they will forever be taken for granted, overlooked, and the cycle of being the silent ones with lack of redemption will continue.

Over the years, many men and white women became to voices for black women all over the world. Some explained how Black women should feel, think, and how they should live their lives. Many have gone as far as to decide what is ethical or unethical for Black women. Steve Harvey’s book, *Act Like a Lady, Think Like a Man*, took Amazon bookstore by storm. First, his implied title gives the impression that there is a difference between a lady and woman. Its aim was to instruct Black ladies or women how to think like a man regarding relationships. I am sure that Harvey meant well in writing and promoting his book, but Black women and men are wired differently when it comes to our chromosomal makeup. There is no way that a woman or lady, as he puts it, can ever think like a man when she has a different hormonal balance, and a man cannot begin to know the secrets of a woman’s brain to tell her how to think. A coming together for dialogue will alleviate many of these lifelong issues that led to a “hush” in the Black women in the first place. Of course, inclusiveness of the genuine opinions of Black women are increasing, nevertheless, there are not enough Black women taking a seat at the table of inclusion to voice their opinions about themselves or the issues they face. A *Sankofa* effect is in order; that is reaching back and reclaiming the voices of the past. This can become a way for many Black women, who are experiencing silencing, to come to a state of a better understanding of their past and themselves. Then, it is possible for them to move forward toward redemption, so they will be able to run the race and finish the course.
Commentary

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I. General Information

The Journal of Healthcare, Science and the Humanities (JHSH) publishes a wide variety of articles intended to enrich and advance the knowledge of health and healthcare, science and the humanities, as well as the art and science of healthcare delivery and the health professions.

Program or project summaries/exemplars, formal case studies, or case scenarios are acceptable, but must be carefully constructed to avoid any subtle commercialization or politicization. Authors are free to submit academic manuscripts that present differing or alternative views to current issues and debates. The Editor will make final decisions regarding these issues after consultation with the members of the Journal Executive Leadership, including Intellectual Property Counsel if so required.

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JHSH encourages authors to choose from a wide range of subject matter categories. Authors may explore various categories and possibilities with the Senior Associate Editor, who will subsequently discuss with the Editor. The Editor has responsibility for final decisions in this area. The following are representative categories.

a. Research papers, theoretical investigations.

b. Scholarly critiques and commentaries on various topics.

b. Scholarly critiques and commentaries on various topics.

c. Formal case studies and program/project reports.

d. Reaction papers and editorials.

e. Book, film, media, law, education or other reviews.

f. Other academic or professional articles related to the JHSH interdisciplinary mission.

g. Creative work, including poetry and short fiction relevant to the JHSH mission.
Author Requirements

III. Submission Review Processes

Submissions undergo a four-stage process of rigorous review, discernment, evaluation, and approval. The Editor may adapt these processes to meet specific circumstances.

Stage 1:
Authors submit full manuscripts or manuscript concept proposals to both the Editor and Senior Associate Editor. The Editor, Senior Associate Editor, and Associate Editors will conduct a preliminary assessment for relevance to the JHSH mission. The Senior Associate Editor will provide guidance to the corresponding author about shaping the manuscript for JHSH readers. All manuscripts, including all figures and graphics, must be formatted correctly and comply with JHSH Author Requirements before manuscripts will be allowed by the Editor to progress to Stage 2. Compliance with this requirement is mandatory. Exceptions will not be granted.

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After the Senior Associate Editor determines that all Stage 1 requirements are met and that all manuscript and graphics/figures formatting is in compliance, the Senior Associate Editor forwards the manuscript to the Chairs of the Academic Review Committee (ARC) for rigorous peer review. Also, at the time of Stage 2 submission, all authors must submit their completed Author Agreements and Copyright Release Forms. No article can be published unless this requirement is met by all authors. All Journal peer reviewers have executed non-disclosure agreements and conflict of interest declarations to protect an author’s rights and academic property. Peer review routinely results in manuscript revision. The first author and the ARC Chairs work together to address matters stemming from peer review and to ensure that the manuscript is revised accordingly.

Stage 3:
After successful peer review and revision, the ARC Chairs send the revised manuscript to the Chairs of the Manuscript Editorial Committee (MEC) for rigorous editorial and formatting review, revision, and critique of actual content and language. This also includes careful review of all figures, graphics, and other related elements for compliance with requirements. The MEC also reviews, critiques and recommends minor formatting needs. The author and the MEC Chairs process and finalize the manuscript. When this process is completed, the MEC Chairs send the final manuscript back to the Senior Associate Editor as certified ready for final review.

Stage 4:
Upon receipt from the MEC Chairs, the Senior Associate Editor sends the final edition of the manuscript to the Journal Associate Editors for a final qualitative review. Any additional changes required are completed between the author and the Senior Associate Editor. Upon successful final qualitative review by the Associate Editors, the Senior Associate Editor sends the final edition to the Editor for final review and approval. If all items are in order, the Editor formally approves and accepts the manuscript for a future edition of JHSH. The Editor notifies the author of final acceptance.

Note: The Editor may make further determinations regarding requirements or revisions to manuscripts. In the event of circumstances, the Editor may disapprove a final edition.
IV. Style Requirements

**APA Style Requirements:** JHSH has adopted the publication style manual of the American Psychological Association (APA). Copies are available in most public and university libraries or through most university psychology departments. Reference information: Publication Manual of the American Psychological Association (6th Ed., 2010), Washington, DC: American Psychological Association.

**APA Style Web Resources:** The URL links below provide additional information and assistance for APA style requirements.

http://owl.english.purdue.edu/owl/resource/560/01/
http://www.apastyle.org/elecref.html
http://www.psychwww.com/resource/apacrib.htm

**Formatting Specifics:**

In addition to meeting APA style requirements, articles must be organized according to the format below. All papers must be divided into appropriate, titled sections and subsections based on subject matter.

a. **Introductory Material.** Each manuscript must begin with the title, name of author(s) with current title(s) and institutional affiliation(s). With the exception of creative essays pre-approved by the Editor, manuscript titles shall be consistent with the scholarly and professional nature of the Journal. Informality, a casual tone and colloquialisms must be avoided. When using degrees after an author’s name, periods are omitted. (e.g., PhD, not Ph.D). Contact information for the corresponding author is to be included, either in the introductory material or as part of the Author Note. Authors are to provide complete, precise information for themselves and each co-author, to include street address, phone, fax and e-mail address (see example below):

Mary Smith, MD, PhD, CPI
Chair, Department of Surgery
University of Smithville
301 Smithville Road
Smithville, MD
Tel: (301) 456-1234
Fax: (301) 456-1235
Email: Mary.Smith@smithville.edu

b. **Author Note.** Immediately following the title and author information, each manuscript must include a brief, un-indent ed paragraph containing important preliminary and/or disclaimer information. This paragraph, called an Author Note, will state the source of the subject material (e.g., preliminary presentation or doctoral dissertation). If the work was supported by a grant, contract, or similar instrument, proper credit must be given. In the Author Note it is required to place the information about IRB and IACUC review and approval with relevant protocol identification numbers and dates of approval or determination. The Author Note should include any required institutional disclaimers. The author/authors must declare any and all financial conflicts of interest (or lack thereof) in the Author Note. The Author Note shall include information regarding contributors.
Author Requirements

See Section VII below concerning requirements for designating authorship as opposed to contributors. Acknowledgments are placed in the Author Note.

c. Abstract. Immediately following the Author’s Note and without any page break, all articles will have an abstract of approximately 200 words. The abstract is a single, unindented paragraph of plain text without bullets or subsections. The abstract must use key information from the text to provide a clear, concise and unbiased summary. Review Articles or Creative Writing submissions do not have an abstract.

d. Keywords. Immediately following the abstract and without any page break, list at least three key words to facilitate electronic searches of the manuscript. The choice of key words will depend on the subject matter. Review Articles or Creative Writing submissions do not include key words.

e. Introduction. Immediately following the Keywords and without any page break, the text must begin with a section entitled “Introduction.” In the Introduction the author should preview what is about to be presented, and may chronicle the past history of the subject under discussion with appropriate use of references from the literature. Both the content and length of the introduction will vary according to subject matter. Review Articles and Creative Writing must include an introduction explaining the intent and providing important background to what follows.

f. Middle Sections. Based upon subject matter and methodology, the middle portion of the manuscript is to be divided into appropriate sections and subsections, each of which must be appropriately titled. See Section V for the formatting of section and subsection headings.

g. Conclusion. This section provides a concise summary of the materials previously presented, and points toward future or practical implications and/or implementation. Review Articles and Creative Writing should include a conclusion that points out the benefit of what has been presented to the reader and to the JHSH mission.

h. References. For those manuscripts requiring them, references will be listed on a separate page following the text. Accuracy is the responsibility of the author; references will not be validated in editorial review. The APA publication manual provides detail on the correct format for references. Review Articles do not require references, unless deemed by the Editor as essential. However, if useful Review Articles, Commentaries, Academic Reflections and other non-research presentations strictly speaking may offer Select Bibliographies or listings of works as For Further Reading.

V. Manuscript Preparation Requirements

Manuscripts must be submitted (including tables and figures) in single spaced copy. Standard American or UK English usage and spelling are the norm, the latter for authors from UK English-speaking communities. Except for clearly stylistic conventions that can be reasonably justified in an academic and professional publication of this nature, authors are to avoid overly informal compositional style and language. Similarly, to maintain the highest level of academic quality, the use of the first person singular or plural is normally not accepted in JHSH research-oriented works. However it can be used in commentaries, reviews, and creative works and in those categories where its usage mirrors the style of academic/scientific papers in
scholarly publications. Contractions are not to be used except for intentional style purposes or within quoted materials. For all tables and figures, see the Graphics Section below for detailed instructions. All manuscripts must use one-inch margins throughout. Authors are to submit all material in electronic format compatible with MS Word for MacOS and Windows. It is the author’s responsibility to ensure software compatibility of both text and graphics. Manuscripts should not contain any specialized formats, automatic styles, or other features not easily translated between computing platforms or any content that cannot be shaped by desktop graphics technicians at the publishing house. For example, the use of references must not require editing or graphics personnel to obtain commercial notation software. Such editing must be able to be accomplished within MS Word. It is the responsibility of authors to require with this matter. Submission that do not comply will be returned until the matter is resolved.

**Bullets**

Bullets are not permitted within the text. Numbered or lettered lists are acceptable.

**Electronic Submission**

All manuscripts are to be submitted to the Editor and the Senior Associate Editor as an e-mail attachment. All manuscripts must be submitted in MS Word format for MacOS and/or Windows (.doc or .docx format). Do not send manuscripts using the pdf or webarchive format. Such will be returned. See Section VI regarding graphics. Authors may wish to review examples of previously published articles as guides. These can be made available upon request.

**Headings**

Each manuscript must be subdivided into relevant sections as discussed above. Sections may be further subdivided to enhance the discussion or for other editorial reasons. Major sections should use Level 1 headings. Subsections should use headings for Levels 2 through 4. Directions for formatting Headings follow:

- **Level 1:** *Helvetica* 14pt Centered Uppercase and Lowercase Heading [Bold]
- **Level 2:** *Helvetica* 11pt. Centered, Italicized, Upper and Lowercase Heading
- **Level 3:** *Helvetica* 14pt Flush Left, Italicized, Uppercase and Lowercase Heading
- **Level 4:** *Helvetica* 14pt Indented, italicized, lowercase paragraph heading and ending with a period.

Authors who do not have Helvetica font may substitute Arial.

**Typeface**

Except for headings as listed above, Times New Roman 12pt font is required for the body of the manuscript and references. Do not use bold or underlining for emphasis. Italics are allowed provided they fit APA style guidelines.

**Headers and Footers**

Headers or footers (including footnotes) are not permitted in the manuscript.

Pagination is allowed at the bottom center or bottom right for review purposes only. Page numbers will be removed from the final versions of manuscripts.
Author Requirements

Length

Articles are typically approximately 15-25 pages single-spaced (approx. 9,000 – 15,000 words), not including references, tables, graphics, or other appendices.

For lengthier articles, authors may arrange with the Editor for the publication of companion manuscripts in back-to-back editions of the Journal.

Review and other similar works are limited to 10-15 pages single-spaced, including references.

Punctuation

The Abstract and Author Note are single, unindented paragraphs. Indent all remaining paragraphs. Use a comma between elements and preceding the conjunction (and, or) in a series of three or more. Use a semicolon to separate elements in a series that contains commas. Use a colon between a grammatically complete introductory clause and a final clause. Do not use a colon to introduce an incomplete sentence. Avoid the overuse of double quotation marks for words. Introduce a key or new technical term in italics.

References

The APA publication manual provides detail on the correct format, including the hanging indent for the second and subsequent lines of the reference. Double-space between references. A brief list of common citation types follows. Use Arabic numbers throughout the references unless a Roman numeral is part of a title.

Book (author):
Hewlett, L.S. (1967). Title of work. Location: Publisher.

Book (editor):

Chapter in an Edited Book:

Journal Article (print):

Journal Article, more than seven authors

Journal Article (electronic):
Newspaper Article (print):

Newspaper Article (electronic):

VI. Special Manuscript Preparations
JHSH regularly includes sections dedicated to special types of manuscripts. Such sections include:

- Book, Film, or Other Reviews
- Special Technical Reports, Scholarly Reflections, or Professional Summaries
- Literary Works

Manuscripts for review and reports generally must follow all author requirements. However, such manuscripts require careful adaptation depending upon the nature of the manuscript, its intention, its place within the JHSH edition, and other factors. The adaptation of requirements for reviews and reports is subject to the direction and approval of the Editor. The Editor may delegate the same to the Senior Associate Editor.

Literary works submitted for publication must meet the highest standards for each specific literary genre. The requirements for literary works are subject to the direction and approval of the Editor. The Editor may delegate the same to the Senior Associate Editor.

VII. Graphics Requirements
All graphics must be submitted within the individual manuscript at the end of the manuscript itself. With each figure or graphic, a short, explanatory caption must be provided. The caption is to be placed appropriately.

Where they are to be placed within the manuscript are to be indicated in a centered directions such as:

Figure 1 inserted here.

In addition to placing the graphic at the end of the manuscript, each is to be sent as a separate file in high resolution as a JPEG, TIFF, PNG etc. If the graphic is a Table created in MS Word, it is to be provided additionally as a separate graphic file that ensures that text and other elements are spaced and formatted correctly. During publication processes, first authors are to remain available for the publishing house to contact them for additional refinements for graphic elements. JHSH Editorial Leadership and the publishing house are not responsible for errors in graphics that should have been overseen and corrected by the actual authors.
Author Requirements

VIII. Authorship

The naming of authors must conform with the “Ethical Considerations in the Conduct and Reporting of Research: Authorship and Contributorship” of the International Committee of Medical Journal Editors (http://www.icmje.org/ethical_1author.html). Authorship may only be ascribed to those individuals who personally, actually and substantively contributed to the actual writing of a manuscript, its design, conceptual development, or its academic or professional scholarship. Honorary authorship by virtue of one’s position within one’s institutional organizational structure (e.g., Department Chair) is not permitted at any time or for any reason. Authors are permitted to list other individuals as contributors in the Author Note when relevant and appropriate. However, information about contributors must be brief and relevant.

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IX. Responsible Conduct of Research Standards

Authors must adhere to all standards regarding research integrity and the responsible conduct of research. JHSH strictly adheres to requirements regarding research misconduct, namely falsification, fabrication, and plagiarism. Any allegation of research misconduct is immediately referred to the Editor, who will immediately refer the matter to the JHSH Intellectual Property Counsel. JHSH will support all requirements and processes for such matters to their conclusion.

Articles involving human subjects or animal research must indicate appropriate IRB or IACUC protocol determinations, reviews and approvals with dates. Authors must cite the approved protocol numbers. Any information relative to these important areas must be placed within the Author Note. When there may be questions regarding whether data/materials are determined to involve either human subjects research or research exempt from human subjects regulations, the text must clearly indicate who has made such determinations and the date of determination. It is the right of the Editor and Senior Associate Editor to ensure that all such matters comply with requisite ethical standards, regulations, laws and requirements.

Similarly, authors must disclose relevant conflict of interest information where applicable (or the lack thereof). Any information relative to this area also must be placed within the Author Note.

All questions regarding these areas and other matters related to academic, research, or professional ethics are to be referred directly to the Editor or Senior Associate Editor.

X. Intellectual Property Information

JHSH is a peer reviewed publication of international renown. As such, it upholds and complies with all requirements regarding the protection of intellectual property and copyrights as applicable. JHSH adheres rigorously to United States norms for publications and responsible authorship. JHSH furthermore honors the academic standards and expectations of other international peer reviewed publications.
When an author’s manuscript is accepted for publication, authors must sign author agreements and comply with JHSH directives. One such area is to ensure that the JHSH respects the work of authors especially if it is derived from previous efforts. Therefore, all authors must disclose such factors and work with the Editor and Senior Associate Editor for the preservation of all intellectual property and copyright issues. JHSH will not publish any materials whose authors have not completed author agreement and copyright release requirements.

The following underscores information summarized previously. Questions concerning the information below and its applicability to specific cases are to be referred to the Editor and Senior Associate Editor.

Once an author submits a manuscript, the author is not permitted to have that work under simultaneous consideration by any other publisher or organization. Similarly, if an author submits a proposal for future manuscript development and the proposal is accepted, then the proposal and its subsequent manuscript cannot be submitted elsewhere. If by chance an error has been made in these regards, the author must obtain from the other publisher or publishers a clear release and submit this to the Editor and Senior Associate Editor for consideration. If an author wishes to have a previously submitted manuscript or already accepted proposal published by another organization, the author must submit a formal request to the Editor. Permission is needed before finalization.

In addition, unless there is clear justification and only with the written permission of the previous publisher, JHSH will not accept manuscripts that have been published elsewhere, or that will be published prior to appearing in JHSH. Authors must inform the Editor and Senior Associate Editor of such matters at the time a manuscript is submitted. Such matters must be acknowledged in the Author Note.

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XI. Contact Information

Manuscripts and/or concept proposals for articles are to be sent directly to dhodge@tuskegee.edu.

If needed, call the Tuskegee University National Center for Bioethics in Research and Health Care at (334) 724-4554.
2020 Public Health Ethics Intensive and Public Health Ethics Forum are available on our Tuskegee University website and on YouTube.com