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Chu Chu Onwuachi-Saunders, MD, MPH is a mother, pediatrician, and former medical epidemiologist with the US Centers for Disease Control and Prevention (CDC) where for over 10 years she was involved with issues related to children’s health and youth violence prevention. She was also a program officer at the Ford Foundation, Senior Deputy Director of Health in Washington DC and Philadelphia’s Deputy Heath Commissioner. She served as Senior Deployment/Operations Manager for the Substance Abuse and Mental Health Services Administration (SAMHSA) Katrina Assistance Project, a $12.8m federal response that offered mental health services to both first line responders and the community (especially youth) in order to reduce trauma-related stress in the disaster-affected areas of Hurricane Katrina. Dr. Saunders is currently a public health consultant and the author of various journal articles and a children’s book for girls entitled OOOPS! Dr. Saunders is also a sought after motivational speaker and conducts workshops and retreats for youth, parents, teachers healthcare professionals, and program staff.

Jedidah Murray is a first year Masters of Public Health student from Miami, Florida. Ms. Murray is a part of several honor societies including Pi Mu Epsilon (Mathematics Honor Society), Association of Women in Mathematics, Public Health Club, the National Society of Leadership and Success, and the Bioethics Honor Program. Holding an A.A. in Chemical Engineering, she intends to continue her graduate studies and complete a Ph.D. in mathematics, focusing her research on mathematical biology. As a part of her ten year plan Ms. Murray aims to become a university professor, teaching mathematics and helping other minority students in STEM research. Ms. Murray is a part of the Tuskegee University track team and International Student Association. During her leisure time, she enjoys travelling, acting and spending time with family. While her interests are broad they are deeply rooted in her community.

Latasha McCrary, Esq. is a Senior Staff Attorney for the Southern Poverty Law Center (SPLC). She currently supervises the Center’s juvenile justice work in Alabama and serves as a trial attorney in SPLC’s class action lawsuit against the Alabama Department of Corrections. McCrary formerly managed a solo practice where she focused on providing representation to clients accused of crimes in Alabama state courts. Her career is dedicated to reforming Alabama’s justice system to ensure equality is afforded to all juveniles and adults who interact with the criminal justice system and to reduce the number of persons who are jailed, detained, and incarcerated in Alabama. McCrary has authored several journal articles that focus on criminal justice in Alabama as well as articles on how to be successful as a young lawyer. She frequently serves as a panelist and lecturer on the issues of mass incarceration and criminal justice reform. McCrary is the proud mother of two children—Charisma and Jordan. Her guiding principle in life is, “Service is the price we pay for the space that we occupy.”

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...
Preface

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.

Ashanti-Ali Davis is from Stoughton, Massachusetts. He received his Bachelors of Science in Biochemistry and Molecular Biology from University of Massachusetts Amherst. He is currently completing a Master of Public Health focusing in food deserts and health policy. In 2018, he was a Public Health Ethics Fellow and presented at the Centers for Disease Control and Prevention. He intends to pursue a PhD in Bioethics & Health Policy.

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, Dr. Zekeri’s book, “Issues and Challenges of the American Rural South,” was published by Cognella Academic Publishing. He holds a PhD in rural sociology from The Pennsylvania State University.

Brandon R. Isome, D.Min., Ed.S., M.Div., M.S.E. serves 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 level. 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 and has taken continuing education courses at Emory University. Currently, he is working on his Doctor of Philosophy (Ph.D) Degree in Public Policy at Tuskegee University.
Public Health Ethics Intensive

Course Description

The purpose of the Public Health Ethics Intensive Course is to provide an academically and professionally rigorous course for physicians, dentists, nurses, other healthcare professionals and medical residents, social workers, graduate students, undergraduate students, university faculty and other leaders including health educators, healthcare administrators, and community advocates. The course will build competency in the theory and practice of various spheres of ethics, including public health ethics, healthcare ethics, bioethics and research ethics, focusing specifically on their influence on race/ethnicity, sex/gender, income and geographical local. Through various presentations and interactive discussions, the course will explore the relationship of these spheres of ethics to social justice and the needs of individuals, groups and communities locally, nationally and globally, especially vulnerable and susceptible populations. The explorations of these topics will give critical consideration to their expansive dimensions, including areas related to agro- and socio-economics, social structures, communications, human relations, health, healthcare and the humanities. The tensions that exist between these spheres of ethics and opportunities for collaborative work between them will also be discussed. These topics are explored utilizing keynote presentations, engaging responses, general discussions, and other learning venues.

Course Objectives

At the end of the course the participants will be able to:

1. Articulate how demographic constructs such as race/ethnicity, sex/gender, income and geographical local play a role in bioethics, public health ethics and healthcare ethics by honing skillsets of ethical reasoning.

2. Discuss the ethical challenges and opportunities that influence human subject research, health care delivery, and public health policy and practice.

3. Identify and discuss the narratives of scientists, faith communities, educators, ethicists and other collaborators/partners that highlight the complexities inherent in untold stories of healing that result in social justice.

4. Define health as a total human experience, (for example, as understood in the concept of Optimal Health) and describe ethics and social justice as inherent to the health and wellness of individual persons, communities and institutions.

5. Identify contemporary social justice issues that continue to challenge the Optimal Health of persons and communities across the globe while describing the signature elements common to various contextual approaches that are seeking to rectify such issues.
## COURSE SCHEDULE

**Tuesday, April 10, 2018**

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<td>Continental Breakfast</td>
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| 9:15 am - 9:25 am | Welcome
  Tejinder Sara, PH.D., Provost
  Greetings                                                   | BIOETHICS AUDITORIUM              |
| 9:25 am - 9:35 am | Chairman Louis Maxwell, Macon County Commission                     | BIOETHICS AUDITORIUM              |
| 9:35 am - 9:45 am | Lawrence F. Haygood, Jr., Mayor Tuskegee, Alabama                    | BIOETHICS AUDITORIUM              |
| 9:45 am - 10:00 am| Overview
  Rueben Warren, D.D.S., M.P.H., Dr.PH, M.Div.                   | BIOETHICS AUDITORIUM              |
| 10:00 am - 11:00 am| Opening Plenary
  Ethics and Miseducation
  Keynote Presenter
  Dr. Jawanza Kunjufu
  Responder
  Nathaniel Holmes, MTS, PhD
  Moderator
  Lenai Samuels                                                  | BIOETHICS AUDITORIUM              |
| 11:00 am - 11:45 pm| Opening Plenary Small Group Session                                 | BIOETHICS AUDITORIUM              |
| 12:00 pm - 1:00 pm| Lunch                                                                | Tompkins Hall                     |
| 1:30 pm - 2:30 pm | Ethics and Reproductive Justice
  Keynote Presenter
  Chu Chu Onwuachi-Saunders, MD, MPH
  Responder
  Randall Baily, PhD, M.Div
  Moderator
  Ja’la Brown                                                   | BIOETHICS AUDITORIUM              |
| 2:30 pm - 3:30 pm | Small Group Session                                                  | BIOETHICS AUDITORIUM              |
| 3:30 pm - 4:00 pm | Late Breaker
  Mamie Clemons
  “From our Elders”
  Moderator
  Kiersten Fluellen                                              | BIOETHICS AUDITORIUM              |
| 4:00 pm - 4:45 pm | Refreshments                                                         | BIOETHICS AUDITORIUM              |
| 4:45 pm - 6:00 pm | Tour
  Tuskegee History Center                                        |                                     |
Preface

Message from the Editor

Rueben C. Warren, DDS, MPH, Dr. P.H. MDiv
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This edition of the Journal of the Healthcare, Science and the Humanities includes selected articles from the Public Health Ethics Intensive Course (PHEI). The PHEI was a part of the Commemoration of the 21st Anniversary of 1997 Presidential Apology by William J. Clinton for the U.S. Public Health Service Syphilis Study at Tuskegee, conducted between 1932 to 1972. The Commemoration Events also highlighted the 1999 opening of the National Center for Bioethics in Research and Health Care (National Bioethics Center). The overall theme for the year’s activities was “Ethics Across Generations” The theme alludes to the importance of intergenerational trust and trustworthiness that must continue particularly, in times, such as these. There was energy, excitement and optimism among the young people who attended the activities, and the wisdom, experience, faith, as well as optimism, among the elders was palpable. The Public Health Ethics Intensive (PHEI) course attracted a cross section presenters from several different disciples working in a variety of professional areas.

The National Bioethics Center’s planned activities spanned the entire week. On Monday morning, April 9th descendant family members participated in the annual healing session, facilitated by Drs. Edward and Anne Wimberley. Later, they conducted a memorial service honoring the legacy of their fathers. That evening they hosted the 1st Annual Scholarship Banquet at the Anderson Auditorium, Washington Chapel A.M.E. Church in Tuskegee, Alabama. The PHEI began on Tuesday, April 10th. On Friday April 14, the Annual Apology Banquet and Luncheon was held on the campus of Tuskegee University. Prior to the Banquet, as one part of the four and one half-day Commemorative Events, Macon County students who attend Tuskegee Institute Middle School and Booker T. Washington High School participated in an interactive half-day session focused on Optimal Health. Over the last six years, a special guest speaker was invited to speak to the students from Tuskegee Institute Middle School on various domains of Optimal Health. This year, the topic was on optimal physical health, and Chukwudi Onwuanchi-Saunders MD, MPH, facilitated the session. Optimal Health is “the best possible emotional, intellectual, physical, spiritual and social-economic aliveness that we can attain.” Over 100 youth participated in the session.

This edition includes three articles that were presented during the PHEI and two others, one on food deserts and the other on conspiracy beliefs and antiretroviral medications for HIV/AIDS among HIV positive African Americans. The first article is co-authored by, Dr. Chukwudi Onwuachi-Saunders, Public Health Consultant/Author and Bioethics Visiting Scholar,
Preface

Que P. Dang, MPH, Director of Student Equity, Cuesta College and Jedidah Murray, BS, and first-year MPH student at Tuskegee University. The topic was addressed earlier by Dr. Onwuanchi-Saunders in the PHEI opening session on ethics and reproductive justice. Their article, “Reproductive Rights, Reproductive Justice: Redefining Challenges to Create Optimal Health for All Women” expands the scope of reproductive justice to include the complete physical, mental, spiritual, political, social, and economic wellbeing of women and girls, based on the full achievement and protection of women’s human rights. They reframed the language and realities of women of color related to sexual and reproductive health issues. Their article expands the reproductive health framework, particularly for women of color. Their article also recounts the history and challenges of reproductive health/right within the context of Optimal Health.

Latasha McCrary, JD, a Senior Staff Attorney for the Southern Poverty Law Center is uniquely positioned to address ethics and the law during her response presentation during the PHEI course. Her paper is entitled, “To Be Young, Gifted and Black, and Powerless: Disenfranchisement in the New Jim Crow Era,” explores the challenges to be young and Black, particularly if you are gifted. African American youth are at an increased risk of alienation from systems that are supposed to help them. African American youths are disproportionately low income; they often live in resource limited communities, their high school graduation rates are lower than many other racial/ethnic groups, and unemployment rates are high. Their incarceration rates are also disproportionately high, resulting in the New Jim Crow. Her article recounts some of the reasons why and what can be done to address these problems.

The article by Rueben Warren, DDS, MPH, Dr. P.H. MDiv, emanates from his presentation at the PHEI. He focuses on challenges and opportunities at ages 45-64, when the lessons learned from earlier years should provide opportunities to maximize ethics and population well-being. In the midst longstanding racial and ethnic health disparities, Optimal Health is still possible. Operational definitions for ethics, bioethics and public health ethics are discussed and individual and group strategies to maximize population health are provided.

The Ashanti-Ali Davis’, BA, a 2nd year MPH student in the Graduate Public Health Program, College of Veterinary Medicine, Tuskegee University, entitled, Synergizing Oral and Systemic Health in a Food Desert, details the importance of understanding the relationship between oral and systemic health. He argues that it is essential to synergize oral and systemic health by enhancing the availability, accessibility and acceptability of fresh fruits and vegetables, particularly in a food desert. He describes an applied research project that he conducted in a southern, rural, low income county that is a food desert. He documents the quantity, quality and costs of fresh, frozen and canned fruits and vegetables, and recommends strategies to address this public health challenge.
From the Editor’s Desk

Andrew Zekeri, PhD, Professor of Sociology at Tuskegee University, provides an intriguing article entitled, “Conspiracy Beliefs about Antiretroviral Medicines for HIV/AIDS among African American Living with HIV.” Dr. Zekeri has published several articles on HIV/AIDS and African Americans in Alabama Black Belt Counties. This article advances his work in a time when HIV/AIDS is considered a chronic disease for many, but remains an acute life-threatening condition, particularly for African American women.

Dr. Brandon Isome, the MERCK Public Health Ethics Fellow at the National Bioethics Center has work in areas of theological leadership and religious life for many years. His Commentary is timely, in that, he writes about a Professor-Pupil relationship and two very important evolutions of Liberation Theology: Black Liberation Theology and Women’s Liberation Theology. Liberation Theology grew out of a progressive movement within the Catholic Church by Gustavo Gutierrez, a Peruvian theologian and Dominican priest. Black Liberation Theology was championed by Dr. James Cone, particularly in the academy. His death in April, 2018 demands constant and continuous conversations about his work and his legacy. Some argue that Black Liberation Theology was started in Detroit, Michigan by a United Church of Christ minister, Rev. Albert Cleage, in the 1960s, when he founded the Pan African Orthodox Christian Church. Dr. Katie Cannon, an African American woman theologian and academician, who studied under Cone, draws upon her lived experiences of plausible oppressive relationships, that a liberation theology is needed to resolve. These relationships are between Black woman and: white women, Black men, and what it means to be a Black woman.

The articles provide an interesting reflections on the relationships and interactions between spheres of ethics, the law, race/ethnicity, age, sex/gender, quality of life and Optimal Health. Please enjoy the readings.
Reproductive Rights, Reproductive Justice: Redefining Challenges to Create Optimal Health for All Women

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Authors’ Note
The opinions expressed in this article are those of the authors alone. They do not reflect the official opinion of any institutions that the authors serve. The authors have no financial conflicts of interest.

Abstract
The World Health Organization (WHO) defines reproductive health as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive Justice is the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women’s human rights. While these concepts are similar, the latter was an approach that grew out of the need to better
articulate the language and realities of women of color as it related to sexual and reproductive health issues. The current U.S. reproductive health agenda is polarized to a choice or abortion issue without any alignment to other issues that predominantly impact women of color within the reproductive health framework. This article acknowledges the history and challenges of reproductive health and rights, while offering a non-polarized, more inclusive ethical course of action, using an optimal health approach with new alliances for the reproductive justice movement today.

**Keywords:** reproductive justice, reproductive health, reproductive rights, women of color, women, girls, optimal health, health justice

### Introduction

The 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing (FWCW) debated and redefined focus within the reproductive health arena. The Platform for Action and the Beijing Declaration (documents) from the conferences created an enabling national and international political environment for reproductive health. They altered the language about population and family planning issues to include human rights and intensified the interest and participation of non-governmental organizations (NGOs), governments and institutions worldwide in reproductive health issues (The First World Conference on Women, 1995).

Including NGOs made certain that strategies were derived from consistently “listening to the voices of those closest to the ground and most importantly ensuring that programming was relevant and sensitive to community conditions and cultural norms” (Seibert, Stridh-Igo, & Zimmerman, 2002).

Before attending the ICPD, a group of black women in Chicago coined the term reproductive justice, defined as the complete physical, mental, spiritual, political, social and economic wellbeing of women and girls, based on the full achievement and protection of women's human rights (Ross, 2007). This was done out of the need to better articulate the language and realities of women of color as it related to sexual and reproductive health issues and rights. Following this, in the late 90s, the Ford Foundation funded a collective of women of color –led NGOs, called SisterSong, the cornerstone for reproductive justice programming. Twenty years later, this concept or broad lens is still limited in its use to guide programming and advocacy efforts within the reproductive health arena.

Today, the U.S. reproductive health agenda is polarized around choice on abortion issue without any alignment to other issues within the reproductive health framework. This paper highlights a brief history of reproductive rights and the challenges faced as these rights evolved into the reproductive justice movement. It goes on to encourage the reproductive justice movement to adopt an even broader framework of optimal health steeped in theories that advocate for women to embrace their feminine power, a more inclusive and ethical fit
for women’s health. This new framework will generate a new movement that will create fresh language, identify new allies, foster nontraditional partnerships and strengthen the capacity of the reproductive justice/optimal health movement so it fully reflects the voices of all women.

**Reproductive Justice Context and History**

During the 1950s and 60s, philanthropic and international development organizations focused mainly on population and reproduction. Efforts were made to better understand the causes, characteristics and consequences of the population growth trends facing developing countries. Demography was developed as an independent discipline (establishing centers for graduate study) and research was supported in reproductive and contraceptive development. Broad discussions on population policies and assistance were held to better define the design and delivery of family planning programs overseas.

The 1980s involved funding model projects to provide education and facilitate safe, affordable and effective contraceptive use and abortion services if necessary. The focus was on disadvantaged women who chose to have children safely and ensure the safe and healthy development of all children (maternal and child health programs). There was also an increased emphasis on factors influencing the demand for family planning with regard to women’s development, cultural references in developing effective population policies and increased efforts on migration/refugee issues.

The 1990s saw a conceptual shift from family planning to reproductive health and a women-centered, rights-based focus. Within this decade organizations helped emphasize the cultural and economic factors affecting reproductive health (high fertility, poor maternal health and STD/AIDS spread). They also paid special attention to disadvantaged women in developing countries through their reproductive life cycle, supported efforts against STDs/AIDS, and addressed the special needs of adolescents. The main feature of this new focus was to strengthen social science research and training to expand knowledge about the socioeconomic factors affecting reproductive health.

Funding was provided for projects that helped women articulate and act on their reproductive health needs both within the family and at the community and policy levels. This support also promoted public discussion aimed at developing ethical and legal frameworks for reproductive health appropriate to the culture and traditions of different societies. The late 1990s saw the inclusion of sexuality as integral to reproductive health.

The 1994 ICPD in Cairo shifted the emphasis from governmental aims to limit population growth to individual decision-making in reproductive health. The narrow definitions and scope of family planning programming (pregnancy and contraceptives) were expanded holistically to include an individual’s comprehensive needs (reproductive intent, contraceptive availability, client choice and satisfaction). Along these lines the inherent holistic concept of choice was reaffirmed to include freedom to decide when and whether to have
children. A woman's reproductive health was now placed within the structure of reproductive rights and empowerment i.e. accounting for power imbalances and the degree to which women’s choices are constrained. Women played a vital role in national development and had the right to control their fertility. They had the right to participate in providing direction in the formulation of policies that impacted the political, social and economic realms of their health and therefore their existence (United Nations Population Fund (UNPF), 1994).

This conference and the FWCW the following year, expounded on principles that redefined sexual and reproductive health and rights programming for all women around the globe. New principles of thought, along with altering the language around population and family planning issues to include rights, helped to intensify the interest and participation of non-governmental organizations (NGOs), governments and institutions worldwide in reproductive health issues (The First World Conference on Women, 1995).

Unfortunately, in the United States the globally endorsed action plan did not frame sexual and reproductive health and rights programming. Instead, efforts remained fragmented and unidirectional, i.e. pro-choice.

The subsequent meetings, ICPD (1999) and Beijing Plus Five (2000) discussed progress and obstacles to implementation of the initial action plans. Both conferences highlighted that action was still needed to guarantee women their human rights. Steps were required to implement much of what was written. There was still limited demonstration of the understanding of a women’s reproductive health and its link to other issues that affected her health, rights and empowerment.

The important advances resulting from the Plus Five experiences included more female activists as members of government delegations than ever before. Another was the agreement that all forms of violence against women would be treated as a criminal offense, including marital rape. Governments re-affirmed the indicators and time-bound targets on sexual and reproductive health and stated that adolescents especially girls should also have access to sexual and reproductive health services including sexuality and life skills education.

In 1997 the Ford Foundation funded an initiative on reproductive health. Sixteen (four African American, four Asian American/Pacific Islander, four Latina and four Native American) U.S. community based organizations (CBOs) led by women of color were supported in an attempt to promote research and advocacy on reproductive tract infections (RTIs) faced by women of color (SisterSong, 1997).

RTIs were chosen because of their contribution to the major health problems of women. Often undiagnosed until more severe complications arise, these preventable and treatable infections are responsible for the mortality of thousands of women each year through their association with cervical cancer, unsafe deliveries and septic abortions. The high rates of RTIs are also associated with interrelated socio-cultural, biological, and economic factors including poverty, low social status, low levels of education, racism, rapid urbanization, etc.
The synergistic effects of these factors are known to reduce women’s decision-making power over their own sexuality and constrain their ability to seek quality reproductive care, thus contributing to poor reproductive health.

The initiative called The Women of Color Reproductive Health Collective or SisterSong (Loretta Ross, Dazon Dixon Diallo leading grantees) was a three-year effort to support these organizations to identify common concerns and needs and develop a plan of action for prevention and early treatment of RTIs within their communities. It also focused on identity and ethnicity and its intersections/linkages as to how women approach health and reproductive issues. The 16 organizations represented the different facets of reproductive health programming (prevention, HIV/AIDS services, midwifery, substance abuse, human/health rights advocacy, self-help care, and reproductive rights). The Collective through shared learning served as an enhanced voice to bring awareness and action to improve the reproductive health of women of color.

The Collective highlighted the need to recognize health and reproductive health as human rights issues impacted by social, political, cultural and economic factors. This broad definition of reproductive rights was revealed at the ICPD and FWCW and had been repeatedly voiced by women of color in the U.S and globally.

This broader concept now called reproductive justice was not an opposing one to the present day pro-choice/reproductive rights movement. In fact, it was inclusive. This renewed definition served to repeatedly highlight that the health and rights of women could never be analyzed without taking into consideration the «holistic» reality of a woman’s existence.

Reproductive justice is defined as the complete physical, mental, spiritual, political, social and economic wellbeing of women and girls, based on the full achievement and protection of women’s human rights (Ross, 2007; Ross, Solinger, 2017).

The Women of African Descent for Reproductive Justice in Chicago coined this definition in June of 1994, before the ICPD in Cairo (Loretta Ross and Toni M. Bond organizers). Recognizing that the current reproductive rights movement led by middle class white women was not inclusive of minority, low income, and other marginalized women, this group of African American women started the movement of Reproductive Justice. Reproductive Justice began when the group published a statement with over 800 signatures in the Washington Post and Roll Call. Thus, acting as a catalysis for Sister Song (SisterSong, 1997).

To date, SisterSong is the only national coalition in the U.S. consisting of women of color organizations working to ensure reproductive justice for communities of color” (SisterSong, 1997). SisterSong believes that they have the right and responsibility to represent themselves and their communities, and the equally compelling need to advance the perspectives of women of color. They know that they can do more collectively than they can do individually. Headquartered in Atlanta, they are a blend of both young and experienced activists, academic and community scholars, grassroots and national organizations (SisterSong, 1997).
Recently, two additional movements that have brought attention to women’s reproductive issues are the #MeToo movement, and the Women’s March. The #MeToo movement was founded in 2006 by Tarana Burke to help survivors of sexual violence find healing, particularly black women and girls and other young women of color from low economic communities. What began as a hashtag to spread awareness became popularized when several celebrities began to use the hashtag and spread word about the movement via their social media pages. An important turning point of the #MeToo movement came when men, and members of the LGBTQ+ communities shared their experiences. The goal of the #MeToo movement is to reframe and expand the global conversation around sexual violence to speak to the needs of a broader spectrum of survivors (MeToo, 2006).

The Women’s March began on social media. Teresa Shook stated that a pro-woman march was necessary in reaction to Trump’s presidential win. In 2017, the first full day of President Donald Trump’s presidency hundreds of thousands of people gathered in the nation’s capital for the Women’s March on Washington. On the same day, many other women and supporters of the march gathered in other cities and states. The Women’s March centered around eight principles—ending violence, ensuring reproductive rights, LGBTQIA rights, workers’ rights, civil rights, disability rights, immigrant rights, and environmental justice (Women’s March, 2017).

While these movements have brought awareness to those who identify as women and those effected by women’s issues, they do not address that comprehensive reproductive health care and sexual and reproductive rights are «vital human and social assets within a broader developmental agenda to reduce poverty and injustice» (Ford Foundation, 2001). The agenda, defined by SisterSong highlighting the importance of the reproductive justice movement, is often overlooked in the mainstream media. Unfortunately, the agenda and access to these assets still are impacted by the inter-relationship of race, culture, gender, class and political factors thus the continuous neglect of women of color and others from low socioeconomic backgrounds.

Challenges

Reproductive health and rights have become a well-established field both domestically and internationally. Key national and international organizations (i.e., International Planned Parenthood Association, NARAL-Pro Choice America, Center for Reproductive Rights, National Abortion Federation) help to form a widespread network of activism that has contributed to the visibility and progress of women’s health by engaging in political advocacy, advocating for funding appropriations and demanding increased and improved reproductive health programming. Despite these well-established networks and programming efforts there are still challenges to overcome.

Leading reproductive health organizations in the U.S. have minimally or not at all incorporated reproductive justice into their programming. They have continued to not effectively engage women of color in representation, leadership development or promotion,
programmatic design, implementation or evaluation. Many of these organizations believed and argued that women of color were complacent on issues related to their reproductive health and rights. These fail to recognize that although organizing around reproductive health issues have been difficult for these women there has been long standing activism in communities of color on these issues even within the abortion rights movement. Even when women of color become involved with these organizations, they invariably fail to have a significant influence on the organizations’ agenda because it speaks to mainstream needs (Bond, 2001).

There remains institutional limitations within well-established reproductive health organizations around cultural or racial/ethnic diversity. While many of these organizations have been funded over the years to diversify and have women of color in leadership roles, there has been limited success in this effort. Many have placed their focus on board representation. This does not guarantee the adequate level of diversity on the professional staff level where programmatic focus, strategic planning, evaluation and networks are concentrated.

In order to counter the adversity of the challenges, strategies need to be derived from consistently “listening to the voices of those closest to the ground, enabling self-defined needs to guide decisions, and most importantly ensuring that programming is relevant and sensitive to community conditions and cultural norms” (Seibert, Stridh-Igo, & Zimmerman, 2002). The reasons are obvious. Those closest to the issues have the solutions and must advocate for those solutions thus creating social change. However social change can only occur through strong ethical leadership supported by strong organizations with visions, missions, capacity, strategic partnerships and alliances that reflect all members of the community.

In 2013 GuideStar (the largest source of up-to-date information on nonprofits) presented an article entitled “New Rankings Announced: Top 25 National Reproductive Health, Rights and Justice Nonprofits.” These were organizations identified as having an impact on multiple levels. Of the 25, four were using a reproductive justice lens to influence their work and four were led by a woman of color (SisterSong, National Latina Institute for Reproductive Health, National Network of Abortion Funds, and Forward Together) (Morrow, 2013).

This report also offers insights from experts on issues within the nonprofits (i.e. impact, other organizational strengths,) and how to improve them. SisterSong received favorable comments for leadership, innovativeness, networking, justice and equity. But under organizational areas of improvements, the comments included: “needs technical assistance, not stable in finances and staffing/operations.” All too familiar repeated statements made about CBOs’ capacity especially those led by women of color.

Today when using GuideStar to search for “reproductive rights” nonprofits the yield is 3,387 organizations. If the search uses the words “reproductive justice” 1,234 organizations are identified. If the exclusion criteria, “only organizations that have provided data on diversity, equity and inclusion”, is applied the results yield, 42 organizations for reproductive rights and only 12 for reproductive justice.
Today, the U.S. reproductive health agenda both nationally and locally, largely because of the efforts to overturn Roe versus Wade, remains polarized to a choice or abortion issue without any alignment to other issues within the reproductive health framework. Women of color have often voiced that the mainstream reproductive rights framework, which addresses legal issues, is mainly one-dimensional with no consideration for the broader issues within their communities (e.g. limited or no access to health services especially prenatal care, Medicaid expansion, hysterectomies, pregnancy-related deaths, poverty, interpersonal violence, STDs/AIDS, environmental injustices, mental health issues, etc.) which impact their reproductive health and rights on a daily basis.

A more recent display of extreme infringement on women’s reproductive rights and justice are the impending abortion laws adopted in multiple states such as Alabama, Georgia, Ohio, Missouri and Mississippi. Each passed abortion bans for nearly all-reproductive scenarios with limited exceptions (if the pregnant person’s life is at risk, or if the abortion is before six weeks of pregnancy (“heartbeat bills”)). While these bans are fundamentally unsound, unsafe and unethical, this extreme agenda pushed by ill-informed and buffoonery politicians disregards the entire paradigm of why women seek abortions in the first place (i.e., rape, incest, emergency life threatening conditions, etc.).

Unfortunately, many of these efforts are initially generated in states within the existing Bible Belt and extremely conservative religion theology undermines the bans. These states, and others considering adopting similar policies, have large powerful conservative religious populations and politicians. This is another clear example of how religion has been used repeatedly as a means of controlling, disempowering, and dominating women and girls for centuries.

Health is the physical, mental, spiritual and social wellbeing of an individual and access to it is a human right. Thus, services such as abortion, the method by which one can choose not to reproduce is embedded within a woman’s right to access health services and is a fundamental human right However, for it to have become the central and only theme of reproductive health represents an extremely myopic view of a woman’s human right to comprehensive reproductive health care. This approach although targeting power imbalances does not consider the degree to which women of color choices are constrained.

Bell Hooks, a black feminist, expounded on this when she wrote in 1999: “highlighting abortion rather than reproductive rights as a whole reflected the class biases of the women who were at the front of the movement.” “While the issue of abortion was and remains relevant to all women, there were other reproductive issues that were just as vital which needed attention and might have served to galvanize the masses.” ... “Ongoing discussion about the wide range of issues that come under the heading of reproductive rights is needed if females of all ages and our male allies in the struggle are to understand why these rights are important. This understanding is the basis of our commitment to keeping reproductive rights a reality for all females” (Hooks, 1999).
Today the approach termed “reproductive rights” or “reproductive justice” continues to conjure up preconceived thoughts and beliefs that have become even more polarized. Unfortunately, due to this polarization, individuals instantly take a stance for (choice) or against (prolife) this vital health issue with limited knowledge and understanding.

### A New Ethical Course of Action

The few women-led organizations that have adopted a reproductive justice framework for their programming efforts are laudable. They are more likely to develop the interventions or strategies needed to shift the continuous burden of poor health outcomes among women and girls especially those of color. Unfortunately, due to limited complete data and escalating poor health outcomes, it is obvious that they cannot keep doing the same thing nor do it alone. Women’s health and wellness is an overpowering issue.

Therefore, to minimize the effects of losing any more ground and capitalizing on the opportunities, a new course of action or promising next steps would be to broaden the reproductive justice framework and embrace and advocate for “optimal health” for all women and girls regardless of socio-cultural or economic limitations.

Optimal health defined by the late John T. Chissell, MD is the “best possible emotional, intellectual, physical, spiritual and socio-economic aliveness that one can attain” (Chissell, 1998). It is a continuous journey versus a destination. In his work, Dr Chissell offers an Afrocentric approach or playbook to achieving optimal health that is relevant today. Dr Chissell's definition of optimal health is similar to that for reproductive justice and offers an expanded focus with steps. This expanded focus can enhance the existing reproductive justice framework, amplify the language and shift the paradigm to one of total wellness while offering steps for action.

Focusing on optimal health as the next level of the women’s reproductive justice movement would eliminate polarized language, silos, unidirectional programming, selective funding efforts and the myopic focus of mainstream organizations that still haunts the reproductive justice movement. A new broadened framework will produce new dialogue, engender innovative solutions, foster new partnerships and strengthen existing ones. This new agenda termed “optimal health justice” or simply “health justice” advocates for complete wellness.

This framework will be grounded in two major theories. The first is Womanism. Created by Alice Walker, Womanism is defined as – “…the opposite of frivolous, the cultivation of community, the demand of love- …a woman who LOVES herself unconditionally or a form of feminism that emphasizes women’s natural contribution to society” (Walker, 1983).

The second is the theory of the “divine feminine.” The divine feminine is defined as – “one’s powerful inner energy that represents the feminine side of self or consciousness.
It is energy that is- present, loving, nurturing, creative, intuitive, kind, empathic, community focused, collaborative, flexible, sensual (in touch with feelings versus thinking or intellect)” (Cromwell, 2017).

Both schools of thought offer an innovative and even broader framework for action. Together with all women and their allies these theories will aid and sustain a movement that will target the social, political, economic, spiritual and cultural factors that perpetuate poor health outcomes among all women and girls living in the U.S.

New thoughts and frameworks nurture new partnerships. Possible new allies and nontraditional partners for sustained action of this optimal health framework is the religion and spirituality domains. Noted earlier, religion is and has been closely aligned with conservative political ideology that is often anti-choice, lacks understanding of and is non-supportive of comprehensive reproductive health care. But this new framework must consider religion and spirituality as necessary allies. Women and girls operate within these arenas and they too have poor health outcomes.

Spiritual wellbeing is an integral component of an optimal health model. The faith community, both traditional (e.g. Black Churches), and non-denominational (e.g. Buddhist, Interdenominational entities) can clearly speak in support of this new approach and not sanction opposing rhetoric or unprecedented extreme bans on essential health care (i.e. abortions). Progressive and conservative religion/spiritual voices must be encouraged and welcomed thus ensuring inclusivity, sustainability and success (Goodstein, 2007).

Visibly calling for and collaborating with males or partners in a movement targeting women and their optimal health is delicate but essential. The role of men and partners must be defined and welcomed. They may highlight missing keys to multiple insights, solutions and interventions. Women do not exist in isolation. They thrive in healthy relationships with others in communities. Having strategic input and involvement from those they are in relationships with would be innovative. Also partnering with male dominated institutions (e.g. Teamsters Union, 100 Black Men, etc.) would be even more innovative (Funk, 2007).

Other strong nontraditional partners to foster new relationships with could include 1199 Hospital Workers, Teacher Union, Social Workers, Nurses, American Medical Association (AMA), National Medical Association (NMA), Black Lives Matter, etc. Each could contribute to strengthening the movement and ensuring it is sustained and successful.

This broader framework will need a new paradigm of research involving researchers and community practitioners working in concert with the community (a Communiversity) to evaluate and support capacity building assistance within cultural contexts. Reinforcing the sustainability and institutional capacity of community-based organizations involved in this new movement will entail offering capacity building assistance that includes relationship building, board development, program implementation, linking local strategies to national efforts, evaluation, training, organizational growth/development/adaptability and funding.
Conclusion

Due to the threats to women’s health and rights under the current conservative political climate there could not be a more pertinent time to support reproductive justice efforts by broadening the focus and engaging in optimal health justice advocacy. Forging a new paradigm by embracing an optimal health approach and partnering with new and nontraditional allies (i.e., religion, spirituality, men, others) can only build and reinforce the capacity for a stronger, more inclusive and effective optimal health justice movement for all women and girls. Inclusive involvement is essential to nourish this new ethical framework, propel relevant advocacy efforts, reinforce its capacity and sustain it to ensure its success on the local, state and national levels.
References


To Be Young, Black, and Powerless: Disenfranchisement in the New Jim Crow Era

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Author's Note

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Abstract

This article examines the challenges of being young and black in America. In the United States, African Americans have historically suffered from systemic discrimination. Such discrimination deprived them of fundamental rights such as the right to vote. Although African Americans are no longer denied the right to vote based solely on race, the future of the black vote remains threatened by the criminalization of African American youth. African American youths are increasing alienated from systems that are supposed to help them. They are excessively disciplined in schools and disproportionately incarcerated, resulting in the New Jim Crow. This article recounts some of the reasons why and what can be done to address these problems.

Keywords: Jim Crow, Disenfranchisement, Powerless, African Americans, black

“Despite compromise, war, and struggle, the Negro is not free.”²

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Introduction

In the United States, Blacks have long been treated as second-class citizens. For hundreds of years, Whites viewed them as bodies fit merely for free hardened labor. They have been burned, beaten, lynched, raped, experimented upon, and feared. They have been portrayed as unworthy, unfit, and less deserving of fundamental equality. Despite perceived socio-economic and legal progress, they have been denied basic human rights based solely on the color of their skin. The story of Blacks in America is one that even progressive Whites are reluctant to tell. It is an ugly truth that renders great shame. However, what is equally shameful is America's ongoing failure to confront the truth and reverse history's course.

Throughout this country, Blacks remain victims of what Michelle Alexander termed “The New Jim Crow.” Despite the passage of the Civil Rights Act, they are denied key rights, due to criminal justice policies that were specifically designed to disenfranchise Blacks and maintain white supremacy. As Alexander puts it, “Today it is perfectly legal to discriminate against criminals in nearly all ways that it was once legal to discriminate against African Americans. Once you’re labeled a felon, the old forms of discrimination...are suddenly legal. As a criminal, you have scarcely more rights, and arguably less respect, than a black man living in Alabama at the height of Jim Crow.”³

Under current felon disenfranchisement laws, nearly 6.1 million Americans are denied the right to vote.⁴ Although once convicted of a felony, the majority of these individuals have “paid their debt to society” and completed their sentences (51 percent). An additional 26 percent have reentered society with oversight from probation or parole.⁵ They live, work, and pay taxes in our communities, yet are unable to elect the politicians who serve them. It is not surprising that a disproportionate number of these individuals are Black. In the United States, Blacks are banned from voting at four times the rate of other races.⁶ In the South, more than 1 in 5 Blacks are unable to vote due to felony convictions.⁷ But perhaps more shocking, is the fact that a significant number of these individuals were stripped of their rights before they were old enough to vote. As children, they were eliminated from the democratic process and left politically powerless.

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3 Michelle Alexander, The New Jim Crow.
5 Id. at p. 6.
7 In Alabama, Florida, Kentucky, Mississippi, Tennessee and Virginia, more than 7 percent of the adult population is disenfranchised. In Florida, Kentucky, Tennessee, and Virginia, more than 1 in 5 African Americans are disenfranchised. Uggen et. Al. 6 Million Lost Voters: State-Level Estimates of Felony Disenfranchisement 2016. The Sentencing Project 3, 10-11. https://www.sentencingproject.org/wp-content/uploads/2016/10/6-Million-Lost-Voters.pdf. In November 2018, Florida residents passed an amendment, which guaranteed restoration of voting rights for nearly all felons upon “completion of all terms of sentence including parole or probation.” However, the Florida legislature is now attempting to limit the impact of the amendment. Gary Fineout and Ursula Perana, Florida Felon Voting Rights Imperiled Amid GOP Opposition. POLITICO 3/19/2019. Given these changes, Florida’s current rate of disenfranchisement is unclear.
This article briefly examines the discriminatory intent of Alabama’s felon disenfranchisement law, the ongoing incarceration of Alabama’s black youth, and the impact of felon disenfranchisement on future generations of Black voters.

I. The Discriminatory Intent of Alabama’s Felon Disenfranchisement Law.

The origin of Alabama’s disenfranchisement law can be traced to the intent of Alabama’s wealthy to deprive Blacks and poor Whites of their right to vote. In 1901, Alabama’s constitution was drafted in response to white southerners who were disgruntled about the emancipation of black slaves and the recent adoption of the Fourteenth and Fifteenth Amendments. As W.E.B. DuBois recalled, following the Emancipation of black slaves, “[n]ot a single Southern legislature stood ready to admit a Negro, under any conditions, to the polls; not a single Southern legislature believed free Negro labor was possible without a system of restrictions that took all its freedom away; there was scarcely any white man in the South who did not honestly regard Emancipation as a crime, and its practical nullification as a duty.”

Dissatisfied with the freedom and emerging power of newly freed slaves, Whites in Alabama agreed “something must be done.” They decided to create a new constitution that would divest Blacks of political power for years to come.

The racist intent of the 1901 constitutional convention was evident from the start. In his opening address, President John B. Knox stated, “And what is it that we want to do? Why it is within the limits imposed by the Federal Constitution, to establish white supremacy in this State.” Other drafters similarly boasted about their efforts. In 1902, Dabney Palmer wrote a letter to his granddaughter stating, “I wrote my name to our new Constitution in September 1901...This will never be forgotten: we have virtually disfranchised the negro....”

With the intent to maintain white supremacy, the authors of the 1901 Constitution constructed a number of obstacles to stifle black progress. Most prevailing were their efforts to strip blacks of the right to vote. They codified voting restrictions such as the grandfather clause, poll taxes, and literacy tests. For additional security, they included a criminal disenfranchisement provision. It was “intended to provide states with ‘insurance if courts struck down more blatantly unconstitutional clauses.”

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10 DuBois, at 33.
11 Flynt, at 6.
12 Flynt, at 7.
13 Id. at 3.
14 Flynt at 9 (discussing restrictions on blacks’ social freedoms); Flynt at 16 (discussing how the constitution eliminated critical services needed by many blacks); and Flynt at 319 (discussing the constitutional prohibition against interracial marriages and its mandate for separate schools).
15 Id.
The 1901 Constitution was not the first Alabama constitution to deny voting rights to persons with felony convictions. However, the new constitution broadened its scope to include non-felony offenses (or “any crime involving moral turpitude”). In doing so, drafters concentrated their efforts on crimes that they believed were more frequently committed by Blacks. For example, the new law would deny the right to vote to persons who committed the offense of wife beating. The anticipated effect was that “the crime of wife-beating alone would disqualify sixty percent of Negroes” from voting.

The impact of the new constitution was seen immediately. Within two years of its ratification, the Black vote declined from 181,000 to less than 3,000. It would take nearly a century to undo the harm. In 1985, in Hunter v. Underwood, the U.S. Supreme Court struck down Alabama’s disenfranchisement law with regard to misdemeanors involving moral turpitude. The Court ruled that there was sufficient evidence to show that the law’s “original enactment was motivated by a desire to discriminate against blacks on account of race and the section continues to this day to have that effect.”

After Hunter, the constitution was amended to eliminate voting restrictions for persons convicted of misdemeanors. However, it continued to disenfranchise persons convicted of felonies. Because the amendment did not define “crimes of moral turpitude,” officials were left to decide how to interpret and apply the law. In 2008, misapplication of the law prevented thousands of Blacks from voting in an election involving the first Black President of the United States. The state legislature listed 15 felonies involving moral turpitude; the Administrative Office of Courts listed 70; and the Governor’s Office listed nearly 500. In 2017, the legislature finally codified a list of approximately 60 felonies involving moral turpitude.

II. The Incarceration of Black Youth in Alabama.

The injustice of Alabama’s criminal system towards Black youth is no new phenomenon. Many are familiar with the wrongful conviction of nine black boys in Scottsboro, Alabama. In 1931, nine black boys—as young as 13—were falsely accused of raping two white women, while riding a train to Memphis to find work. Within a matter of days and without
adequate counsel, the boys were tried by an all-white jury and sentenced to death.\textsuperscript{24} Today, black children in Alabama continue to face disparaging outcomes in criminal court. In 2017, Alabama’s Juvenile Justice Task Force found that “[r]acial disparities exist throughout the juvenile system.”\textsuperscript{25} The Task Force found racial disparities at all levels, but the largest disparities involved cases where children were committed to state detention facilities (DYS) or transferred to adult criminal court.\textsuperscript{26} In other words, when compared to other children within the juvenile system, black children received the harshest penalties available. Black children were frequently removed from their homes and sent to adult jails or detention facilities, while white children were offered community-based alternatives and leniency.

When examining the prosecution of children in adult court, the Task Force found that black children represented 61 percent of all charges transferred from juvenile to adult court. Similarly, black children made up 84 percent of all instances where children had their charges directly (or automatically) filed in adult court.\textsuperscript{27} The numbers are both significant and disheartening. In Alabama, the prosecutor or arresting officer (most often White) decides whether a child’s case is directly filed in adult court or initiated in juvenile court. The data shows that in cases where an impartial prosecutor or officer holds the discretion, black children overwhelmingly receive the worst outcomes. There is no legal process for reversing the prosecutor’s decision.

Harsh criminal penalties for black children often stem from inequitable disciplinary practices in schools. A study of thirteen southern states found that southern schools disproportionately suspend and expel black students. In Alabama, black students make up 34 percent of all enrolled students, but receive 64 percent of school suspensions.\textsuperscript{28} Black girls are the most severely punished. Throughout the South, black girls make up 56 percent of all school suspensions and 45 percent of expulsions.

School disciplinary rates are key to understanding the effects of the school-to-prison pipeline. Data shows that expulsions and suspensions are strongly linked to subsequent involvement in the criminal system.\textsuperscript{29} Black students are 3.49 times more likely to be arrested at school than white students and are more than twice as likely to be referred to law enforcement.\textsuperscript{30} Blacks are more likely to be suspended or expelled when teachers or officials have discretion to determine punishment.\textsuperscript{31}

\textsuperscript{26}Id.
\textsuperscript{27}Id. at 5.
\textsuperscript{29}Id.
\textsuperscript{30}Equal Justice Initiative, Latest Data Shows Black Students Disproportionately Suspended, Expelled, Arrested (2017). https://ejj.org/news/latest-data-shows-black-students-disproportionately-suspended-expelled-arrested. School-based arrests are often for minor offenses. For example, students may be charged with assault for pushing past a teacher while frustrated or battery for a student fight at school.
\textsuperscript{31}Id.
III. The Impact of Felon Disenfranchisement on Future Black Voters.

The treatment of black children in schools and the criminal justice system today bears directly upon future political power. When children are prosecuted in adult courts, there are permanent social, psychological and political consequences. Children convicted of felony offenses are stripped of their voting rights and unable to participate in the democratic process. They are denied the opportunity to become future political leaders and denied opportunities to use the political process to influence decisions that impact their families and communities. Before they have matured into adults or been afforded the privileges and liberties that make being a citizen in this country great, they are condemned to second-class citizens with no political voice or power. In effect, they are legal outcasts in their own society. Such a fate for black children is detrimental to the future of the black community. Felon disenfranchisement laws threaten to nullify decades of struggle to achieve fundamental equality at the ballot. Given current rates of disenfranchisement and practices towards black children in schools and courts, it is reasonable to expect that the majority of black voters in the next generation will be unable to cast their ballot. It is an alarming reality that must be addressed. The right to vote is critical to the health of the black community. It is the means by which Blacks ensure that their communities are not neglected and their concerns are not unheard. It is their opportunity to ensure fair representation and a proper seat at the table. According to DuBois, “the power of the ballot” is Blacks only defense against “a second slavery.”

In light of these circumstances, we cannot afford to be silent and wait with hopeful aspirations that this too shall pass. The drafters of Alabama’s disenfranchisement law made their intent clear. And for over a century, the impact of their racial animus has been realized. In addition, data evidences that when decisions about the future of black children are left in the hands of white officials, black children will not be treated with the grace extended to white children. Instead, they will be divested of any real opportunity for meaningful change.

As such, it is up to us to reverse the course. We cannot expect to undo centuries of damage overnight. However, we must be unrelenting in our efforts to demand reform in our schools and courts. If we are to sustain political power in the black community, “[w]e need to make it so that all of our kids are allowed to make mistakes and be treated with love, treated like they have a future and not discarded...we’ve got to change this narrative that some children aren’t children.”

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32 See McCrary for a discussion of the challenges of Alabama’s restoration process.
33 DuBois, at 14.
Ethics and Well-Being: Ages 45-64: 70 is the New 50

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The opinions expressed in this article are solely those of the author. They do not necessarily reflect the opinions of the institution where he is employed. The author also is grateful to the peer reviewers for their very helpful comments.

Abstract
The age range 45-64 covers a life-stage when ideally, health status is reasonably manageable. However, this life-stage also poses health risks, which may lead to diseases, illnesses, dysfunctions, disabilities and early death. In fact, over the last three years, life expectancy among non-Hispanic white men has decreased. The opportunity to synergize ethics, health and well-being at the individual and group/community level is also highlighted. Various sphere of ethics and how they impact on individual, group/community well-being strategically, infuses ethics into health and health care conversations. Difficult term to operationalize like well-being, health, ethics and healing are deliberated.

The phrase “70 is the new 50” reflects an importance opportunity to discuss what it means to be middle age and be healthy. There are health threats created by social and environment injustices and food deserts which are important considerations influencing health. The concept of Optimal Health, as a group strategy to advance health, particularly for people of African descent, details five group domains: optimal physical, emotional, social-economic, intellectual, and spiritual health. Optimal Health translated into individual behavior also has five health promotion principles that are detailed in the article.

Synergizing Optimal Health, at the group/community level, with the five Health Promotion Principles, at the individual level, is the ideal journey toward individual and group/community well-being. Persons ages 45-64 are poised to combine the wisdom gained from their lived experiences, with the knowledge acquired from their positive or negative interfaces with the health delivery system, are generously available to achieve Optimal Health. The article concludes by discussing the Ancient African Imhotep, True Father of Medicine, 2980 B.C.E.
Introduction

This article emanates from a keynote presentation at the 7th Annual Public Health Ethics Intensive Course during the 2018 Commemoration of the 1997 Presidential Apology for the U.S. Public Health Service Syphilis Study at Tuskegee. The theme of the Commemoration was, Ethics Across Generations.” Keynote and respondent presentations included ethics associated with topics across the lifespan starting with: ethics and reproductive health, ethics and miseducation, ethics and the law, ethics and immigration, ethics and well-being, ethics and quality of life and finally, connecting ethics across generations. This article, “Ethics and Well-Being: Ages 45-64” is a title and topic that is positive, affirming and empowering.

The age range 45-64 covers a stage in life when ideally, health status is reasonably managed, career plans and paths are well underway, economic status is expected to be predictably stable, family and other social factors that promote individual and/or community well-being are established. However, this life-stage also poses health risks, which may lead to diseases, illnesses, disability and/or other adverse conditions resulting in life changing circumstances (Murray et al., 2013). In fact, life expectancy is decreasing with this age group. In most instances, both well-being and the risks of “dis-ease” co-exist. Identifying the pathways to well-being, while learning how to maintain an appropriate balance between primary, secondary and tertiary prevention, is a reasonable and doable strategy (Espinet et al., 2019; Murray et al., 2013; Oeppen & Vaupel, 2002). These pathways to well-being ideally, are learned behaviors at each life-stage. Yet, many people are unfamiliar with evidence-based health care treatment and/or disease prevention and/or health promotion strategies. For various underserved populations, geographical or financial access to care prevents them from complying with these strategies (Batt & Bathia, 2018).

This article describes the opportunity to synergize ethics and well-being. It also discusses Optimal Health as mechanism to maximize both ethics and well-being in the midst of longstanding racial and ethnic health disparities, particularly for African Americans. It concludes by suggesting the ethical challenges/opportunities for ages 45-64 and recommends Optimal Health and five health promotion strategies that lead to individual and community well-being (Chunn, 2002). For the purpose of this article ethics is, “a set of rules, principles, values and ideals of a particular set of people. The systemic study of morals, concepts, and theories, typically in departments of philosophy” (Bayer & Beauchamp, 2007). Ethics differs from morals, in that ethics refers to how one wishes to be treated and morals are how one treats others (Mintz, 2015). In some instances, ethics of one group may conflict with the health and/or well-being of another group thus, an ethical dilemma is created (i.e., U.S. Public Health Service Syphilis Study at Tuskegee).

When recording individual health status or population health, illness, disease, disability or premature death is usually recorded, seldom are measurable indicators of health chronicles. For example, the leading cause of death in most adult life-stages is heart disease. However, in 2016, the National Center for Health Statistics reported that the leading cause of death for ages 45-64 was cancer at 30%. Heart disease was second at approximately, 20%. In
addition to cancer and heart diseases, the other conditions that result in more than 50% of the mortality in this age group include the following: unintentional injuries (7.4%), liver disease and cirrhosis (4.1%) and chronic lower respiratory disease (4.0%). As previously suggested, there is little reported on health (Kochanek, Murphy, Xu, & Arias, 2017). Instead, measures of illness, disease, disability and dysfunction are employed (Prasad, Sung, & Aggarwal, 2012).

Operationalizing health is problematic. The same challenge occurs when attempting to operationalize ethics and well-being. What is ethics; what is well-being; what is health, and what is important about these terms in the age range 45-64? The definition used for either term is neither correct or incorrect, right or wrong. The definitions selected however, are essential to appropriately contextualized, characterize and clarify to synergize future interventions.

The various spheres of ethics allow further clarification about different ethics domains such as bioethics, public health ethics, research ethics, virtue ethics, care ethics, communication ethics (Mizzoni, 2017). There are also religious ethics depending on one's faith tradition. Religion and ethics are often used synonymously, but they are not the same (Bayer & Beauchamp, 2007). While there is debate on the absolute right things to do, what “not to do” is usually, more easily discernable. For example, though shall not kill is seeming, straightforward. However, killing as an act of self-defense is legally acceptable, but is it ethical? “Just War Theory” (jus bellum iustum) is a doctrine, also referred to as a tradition of military ethics studied by theologians, ethicists, policy makers, and military leaders. The purpose of the doctrine is to ensure war is morally justifiable through a series of criteria, all of which must be met for a war is considered just (Ramsey, 1983; Walzer, 1977). As earlier indicated, communities have the right and obligation to define what is ethical within the context of their lived experiences and life circumstances. However, how a community decides about rightness or wrongness impacts on others, and should be considered before taking action. There is often tension between what is good for the individual and what is good for the group. Well-being is another difficult term to operationalize. It is however, usually included in various discussions associated with health (Cooke, Melchet, & Connor, 2016). For example, well-being integrates mental health (mind) and physical health (body) resulting in more holistic approaches to disease prevention and health promotion. Well-being is a valid population outcome measure beyond morbidity, mortality, and economic status that characterizes how people perceive their life circumstance, from their own perspective. Well-being is an outcome that is meaningful to the public and to population health. Advances in psychology, neuroscience, and measurement theory suggest that well-being is measurable with some degree of accuracy. Results from cross-sectional, longitudinal and experimental studies find that well-being is associated with self-perceived health (Haven et al., 2017). Well-being also describes longevity, healthy behaviors, mental and physical health, social connectedness, productivity, and factors in the physical and social environment (Brown, Carroll, Workman, Carlson, & Brown, 2014).

Notions of well-being are included in most definitions of health. The most commonly used definition of health is the one used by WHO, “a state of complete physical, mental, and social well-being and not just the absence of sickness or frailty” (Hellberg, & Makela, 1994). While the WHO’s definition of health is clearly defined and universally accepted, a more
broadened description of the perimeters of health may prove more helpful. In that regard, health is described as, “a dynamic relationship, a synergistic interplay between the physical, social, psychological and spiritual elements that create the well-being of individuals and/or groups in their physical and social environment” (Warren, 1998). The description of health includes several important elements: a dynamic interchange, spirituality, the individual and the group, and the physical and social environment. While these constructs in health are difficult to understand and difficult to assure, yet a consensus on the right to be healthy is growing in many parts of the U.S. and the world (Annas, 1998). The challenge is to scientifically, determine the association between health and health care and translate the elements of health into measurable health and health care strategies and outcomes. However, in the U.S only 15% of health care is attributed to health (Satcher & Higginbotham, 2008). Much work is needed to synergize health and health care.

Forty-five to sixty-four is the age range selected in this article to discuss well-being because at this life-stage, cumulative health challenges to one’s well-being such as, chronic diseases, physical and mental disabilities, and the consequences of long-term adverse environment exposures began to manifest. In earlier years, one’s physical and mental development is at its anatomical, physiological, and psychological peak. The individual is presumably able to withstand and recover from most non-life threatening health challenges (Prasad, Sung, & Aggarwal, 2012). In fact, the human body is extraordinarily able to recover from many population-based health threats. The biomedical research community is refining scientific and technological advances such as cloning, organ transplantation, xenotransplantation, neuroscience, and epigenetics (Platt & Cascalho, 2013). However, these extraordinary scientific advances have yet to replicate the exactness and efficiency of the human body (Collins, 2006).

The age range 45-64 is a period where individuals have physical, mental and even, spiritual challenges that must be reconciled. This age period is described as, mid-life, by some, and mid-life crisis by others. On the other hand, during this life-stage, many people have contributed personally and professionally in civic, social and political spheres and they are now prepared to share their contributions with a broader sphere of society. They are often in positions to influence the well-being of others at the individual, group, and community level, the nation, and even the world. During this life-stage, many people are in positions to influence domains beyond themselves. They have learned to manage many of the factors that influence their health and well-being.

Over the last three years in a row, however, the average life expectancy in the U.S has dropped. In 2017, drug overdose, in large part, was responsible for that reduction. Much of the rising mortality was among middle-aged, non-Hispanic whites (Kochanek, Murphy, Xu, & Arias, 2017). The U.S is increasing in the percentage of people of color (Phillips, 2016). Interestingly, the baby boomers, those born between 1945 and 1964, are growing in numbers, and this age group is physically and mentally healthier than in previous years; they are enjoying a better quality of life (Canizares, Gignac, Hogg-Johnson, Glazier, & Badley, 2016). The phrase “70 is the new 50” reflects the importance of this life-stage. However, while overall morbidity
and mortality rates in the U.S have improved, health inequalities, defined as racial and ethnic health disparities continue. For African Americans, sex and age morbidity, described as excess deaths, is increased (Satcher et al., 2005).

The ethical problematic is the U.S. research enterprise and health care industrial complex have the capacity to improve population health. Yet, the gap in racial and ethnic morbidity and mortality, particularly among African Americans widens, which make health equity improbably. While the scientific literature reports health inequalities in statistical language, it is also important to translate this statistical language into ethics language, so that the public can better interpret population health and well-being. The scientific language related to health and the ethical problematic associated with health disparities concur that morbidity and mortality can be chronicled by race and ethnicity and are largely, preventable. In 1985, the United States Department of Health and Human Services released the Report of the Secretary’s Task Force on Black & Minority Health. Although health disparities were previously, recorded, the Task Force Report was the first time that morbidity and mortality were chronicled by race and ethnicity (US Department of Health and Human Services, 1985).

The Task Force Report also introduced the concept of excess deaths, which is, “the difference between the number of deaths observed in the Black populations and the number that would have been expected, if the Black population had the same age-and sex-specific death rates as the non-Hispanic White population (US Department of Health and Human Services, 1985). In 1985, the data collected by the Task Force Report compared the Black population to non-Hispanic Whites and found 60,000 excess deaths (US Department of Health and Human Services, 1985). In 2002, excess deaths in the Black population increased to 83,000 excess deaths (Satcher et al., 2005). Health disparities are directly related to the historical and current unequal distribution of resources based upon prestige, hierarchy and power, minimizing the ability of disadvantaged populations to achieve Optimal Health. African Americans experience a high rate of health and health care disparities. In comparison to 10.4 percent of non-Hispanic white Americans, 17.2 percent of African Americans were uninsured in 2012 (Office of Minority Health, 2012). In 2013, African Americans were three times more likely, and Hispanic Americans were twice as likely, to die from asthma related causes as non-Hispanic whites (Office of Minority Health, 2012). African Americans have the highest mortality rate of any racial and ethnic group for all cancers combined, and for most major cancers (Office of Minority Health, 2012). In 2013, African Americans were twice as likely as non-Hispanic whites to die from diabetes, as well as African American adults were 80 percent more likely than non-Hispanic white adults to have been diagnosed with diabetes by a physician. Asian Americans and Pacific Islanders follow closely with 60 percent of the population being more likely to be diagnosed with end stage renal disease, compared to non-Hispanic whites (Office of Minority Health, 2012). African Americans have 2.2 times the infant mortality rate, are 1.5 times as likely to be obese, and are 10 percent more likely to report having serious psychological distress, compared to non-Hispanic whites (Office of Minority Health, 2012). The leading causes of death among American Indians and Alaska Natives are heart disease and cancer. This demographic is also at risk for major mental health challenges. It is an ethical challenge that populations of color disproportionately experience higher morbidities and mortalities compared to their
non-Hispanic white counterparts. Public health ethics provides a framework to address this population base concern.

A public health ethics framework has three basic constructs: community engagement, beneficence and social justice. This framework may prove helpful in rethinking, expanding, and enhancing scientific approaches to eliminate racial and ethnic health disparities. Community engagement requires public health officials and other policy makers to develop policies and programs that communities think will best meet their needs and desires. Secondly, beneficence establishes measurable evaluation criteria to determine if what was agreed upon actually is implemented. Lastly, social justice assures fair and equitable individual and population health. A public health ethics framework demands a robust conversation about the difference between health, illness and sickness and the efficacy of current health care policies and practices. All too often, these terms are not clearly distinguished; thus, resulting in policies and programs that are costly, ineffective and do not meet population needs. As previously indicated, health is a dynamic relationship, a synergistic interplay between the physical, social, psychological and spiritual elements that create the well-being of individuals and/or groups in their physical and social environment (Warren, 1998). Health care differs, in that; it includes the provision of health services by a licensed and qualified health care provider, as well as additional support from auxiliary systems. Health care also includes health education that, ideally, compliments health and health care innovation.

The literature indicates that racial/ethnic and low- income populations, regardless of their racial or ethnicity, and rural and inner-city populations bare disproportionate burdens of preventable disease, illness, disability, dysfunction and premature death. The non-Hispanic white population has greater availability, accessibility and acceptability of health care. As a result, they are measurably healthier compared to their African American, Hispanic, Native American, Alaska Native, and selected Asian American and Pacific Islanders population counterparts. To be able to discern health and health care disparities by race and ethnicity is unethical because there is sufficient scientific evidence to eliminate these disparities and achieve health equity. The challenge in eliminating health disparities and achieving health equity lies in the domain of public health ethics. Investigating and assuring health innovation, across all populations, in addition to scientific discoveries on illness, sickness, and disease are the paradigm shifts that will enhance and advance population health.

In the book, entitled, Health As Liberation: Medicine, Theology and the Quest for Justice, Alastair Campbell writes that illness describe specific adverse health conditions. Illness is a subjective experience of the individual, the awareness of ill health. Sickness is the ascription of health to a person by others, an ascription made in the absence of illness (i.e. mental health). Disease is the medical or scientific endorsement of the social role of sickness (Campbell, 1995). For example, in a May 1851 article entitled, “Disease and Physical Peculiarities of the Negro Race,” published in the New Orleans Medical and Surgical Journal, Samuel Cartwright MD, wrote about disease specific to Blacks. He described “dраМетомиЯ,” the disease of running away from slavery; and “дИезаθθεία Αθεθιπια,” “a hebetudes of mind and obtuse sensibility of body known as, rascality” (Campbell, 1995). Were the enslaved men and women ill because
they sought freedom from enslavement and oppression or were the oppressor, the white slave master or the white physicians, mentally ill for their barbaric treatment of other human beings? Another ethical problematic! The U.S. spends more money on health care than any other country in the world, with only a small percentage of those funds spent on preventing disease, and even less spent on promoting health (Etehad & Kyle, 2017).

However, outcomes/results from the money spent and the technologies employed do not match the committed financial or human resource invested in human subjects’ research and the U.S. healthcare enterprise. The U.S. is among the best places in the world for tertiary care; that is care for surgery and rehabilitation (Maypole, 2015). It is a good place to be if you are sick not, if you are healthy. However, public health threats such as environmental injustice, food insecurities and health disparities threaten U.S. population health (Institute of Medicine (US) Committee on Environmental Justice, 1999; Zenk et al., 2009). The U.S is one of the few industrialized countries that does not have national health insurance (DeMichele, 2017).

For example, Black people are 4-5 times more likely to live within a 5-miles radius of a toxic or hazard waste site and there is ample evidence that adverse health effects are related to environmental toxicants (Institute of Medicine (US) Committee on Environmental Justice, 1999). There are large numbers of people in the U.S. who live in food deserts. These population health challenges have, and continue to be, public health problems. However, they are also challenges in public health ethics and social justice.

One of the principles in public health ethics is to assume social justice. One way to address public health ethics is to employ domains of Optimal Health, coined by Chissell, and the health promotion principals articulated by Warren (Chissell, 1993; Chunn, 2002, & Warren, 1998). People between ages 45-64 are at increased risk for preventable morbidities and mortalities. They are also at the ideal life-stage to translate their cumulative knowledge and lived experiences to enhance, maintain and sustain their health.

The author of the concept of Optimal Health is Dr. John Chissell, an African American physician who practiced primary care in inner city Baltimore, Maryland for 30 years, before retiring from the clinical practice to conceptualize and translate into practice, Optimal Health (Chissell, 1993). In 1993, Dr. Chissell wrote the book entitled, *Pyramids of Power: An Ancient African Centered Approach to Optimal Health*. He described health as an allusive challenge for people engaged in research, education and service related to health and health care outcomes. Chissell argued that Optimal Health as “your greatest state of aliveness,” and outlines five domains: optimal physical, emotional, social-economic, intellectual, and spiritual. Chissell describes these domains as:

1) optimal intellectual health- being aware of all thoughts and actualizing those thoughts that we believe move us towards our greatest potential and highest good.

2) optimal emotional health- courageously managing the emotions we experience in such a way as to maintain joy, peace of mind and harmony with ourselves as we relate to our environment and nature.
3) optimal physical health is assuring optimal rest, nutrition, and exercise. Optimal physical, Chissell says, just feels good!

4) optimal socio-economic health requires that we change our educational system to teach everyone, from kindergarten through postgraduate education, how to choose an optimal health diet, and how to choose careers that promote social and economic health for all of us.

5) optimal spiritual health is the ability of everyone to believe in Divine Intelligence; our personal spark of the `creator that resides within each of us as our life force.

Chissell outlines Optimal Health as a journey, particularly for people of African descent who, choose to travel it. He posits Optimal Health as a journey, not a destination.

To effectively address health concerns, particularly for people of African descent, disease prevention, health promotion and healing must be considered. While these strategies overlap, disease prevention and health promotion are not the same. Disease prevention, as an ideal strategy, assumes that disease is inevitable; health promotion does not. Health promotion and disease prevention efforts may be the same but the presuppositions are different. Disease prevention presumes that individuals will inevitably be sick, and there will always be a disease to prevent. Health promotion does not presume that illness or sickness are inevitable. Health promotion is a way of living; health promotion is an everyday lived experience. Promotion health is encouraged, regardless of the threat of disease (Chunn, 2002).

Healing is another construct that may have little to do with physical illness. Healing presumes that one can be healthy in spite of the presence of physical abnormalities, that may impede one’s capacity to act, but assures a sense of control of your life, as a whole. Healing is freedom! (Campbell, 1995). Living with HIV/AIDS, in a nurturing, supportive environment, instead of dying from the disease and conditions that promote isolation, dislocation, disrespect, and despair is one example of healing and living with a disease. Healing is release not control. Some of the skill sets to promote healing are found in the complementary and alternative medicine (CAM) domain of mind-body interaction. Meditation, affirmations and prayer are included in the mind-body domain (Gage, J. A., 2004).

Optimal Health also translates in individual behavior, which also has five health promotion principles: eating the right food, taking care of your body, getting along with others, respecting and protecting the environment, and believing in a Divine Order to the universe. The literature is clear that following these principles will reduce the risk of disease and promote health. Warren describes these health promotion principles as:

1) Eating the right food (i.e., nutrition and diet)
2) Taking care of one’s body (i.e., hygiene, exercise, and rest)
3) Getting along with others (i.e., interpersonal/social skills)
4) Protecting and respecting the environment (i.e., global planning) and
5) Believing in a divine order to the universe (i.e., spiritual grounding) (Chunn, 2002).
Synergizing Optimal Health, at the group/community level, with the five health promotion principles, at the individual level, is the ideal journey toward individual and community well-being. Persons ages 45-64 are poised to combine the wisdom gained from their lived experience with the knowledge acquired from their positive or negative interfaces with the health delivery system, are ready to achieve optimal health.

In conclusion, the Ancient African Imhotep, the true Father of Medicine, was an Egypt physician; he was also a priest. He understood the importance of holistic health. He had a different notion of health, which included more than the physical being. At that time, 2980 B.C.E. most of the physicians had to be priests, before they became physicians. Understanding the social, psychological and spiritual well-being of their patients was imperative. The Egyptians understood the relationship between physical, social, psychological and spiritual well-being. They looked for ways to harmonize these various components (Mikic’, 2008). Centuries later, in 1946, Henry Surgerist, the great European medical historian stated that health is promoted by providing a decent standard of living, good labor conditions, education, physical exercise, culture and means of recreation (Terris, 1975). Booker T. Washington understood the importance of health for the full development of the African American populations. In 1915, President Washington established National Negro Health Week (Quinn & Thomas, 2001). From 2980 BCE to 2019 AD, health has been a journey, an ethic journey. The scientific literature strongly suggest that the knowledge to achieve and sustain population health is available. The challenge is translating what is known about individual and community/population well-being unto Optimal Health strategies. Public health ethics is the ideal strategy because it employs community engagement, beneficence and social justice to achieve population health/well-being and ethics. Both are important for optimal health.
References


Synthesizing Oral and Systemic Health in a Food Desert

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Abstract
Oral and systemic health constitute overall health. In recent years, dentists and physicians have acknowledged the relationship between these two areas of health. There are oral and systemic diseases that have similar risk factors. Fresh fruits and vegetables enhance oral and systemic health and the lack of these food products in the diet adversely affects both aspects of health. The availability, accessibility and acceptability of fresh fruits and vegetables were all assessed in Macon County, Alabama, using an observational research method. A Likert scale (1-4) was used to assess color, texture and smell of fresh fruits and vegetables. Within Macon County there are three grocery stores with the highest quality of fresh fruits and vegetables being in the town of Notasulga. With lack of availability, accessibility and acceptability of fresh fruits and vegetables in Macon County, residents are at a higher risk of experiencing adverse health outcomes. Strategies are needed to increase the factors that contribute to the consumption of fresh fruits and vegetables if overall health are expected to improve.

Introduction
“Let food be thy medicine, and medicine be thy food.” This quote by Hippocrates speaks many truths about modern science. Research is becoming clearer about the link between diet and overall health (Schulze, Martínez-González, Fung, Lichtenstein & Forouhi, 2018). According to the World Health Organization (WHO), health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2018). However, WHO's definition of health is difficult to translate into public health action. Health, for this paper, is described as “a relationship, a synergistic interplay between physical, social, psychological and spiritual elements that create the well-being of individuals and/or groups in their physical & social environment” (Warren, 1999). This description incorporates the spiritual element of health, the health of the group and as
well as the individual, spirituality and the physical & social environment. When discussing health, oral health is often omitted, as if oral health is separate from overall health. The 2000 Surgeon General Report “Oral Health in America” describes oral health as, “much more than healthy teeth, it means being free of chronic oral-facial pain conditions, oral and pharyngeal (throat) cancers, oral soft tissue lesions, birth defects, such as cleft lip and palate, and scores of other diseases and disorders that affect the oral, dental, and craniofacial tissues” (US Department of Health and Human Services, 2000, p.17). The description provided by the Surgeon General Report, primarily illustrates oral health as the absence of disease. Oral health however, constitutes more than just being free from disease (US Department of Health and Human Services, 2000). Oral health and systemic health are one in the same and should not be considered separate entities (US Department of Health and Human Services, 2000). If health officials and practitioners are to effectively reduce health disparities, they must acknowledge that oral health is an important component of overall health. Health disparities are systematic, potentially avoidable differences in health or in the major socially determined influences on health between groups of people who have different relative positions in social hierarchies according to wealth, power, or prestige (Braveman, 2006). Black and Hispanic populations suffer from some of the highest rates of health disparities (Baciu, Negussie, Geller & Weinsein, 2017).

One method of assessing health disparities is calculating the number of excess deaths for a particular racial/ethnic group. Excess deaths "expresses the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the White population" (Heckler, 1985, p. 63). The 1985 U.S. Department of Health and Human Services “Report of the Secretary’s Task Force on Black and Minority Health” indicated six leading causes of excess deaths in the Black population. The causes of excess deaths included, cardiovascular/stroke, cancer, diabetes, cirrhosis, infant mortality and homicide/accidents (Heckler, 1985). These six causes of death account for 80% of excess deaths for the Black population (Heckler, 1985). In 1991, HIV/AIDS was reported as a 7th cause (US Department of Health and Human Services, 1991). The purpose of this study is to assess the availability and accessibility of fresh fruits and vegetables (FFV) for residents living in Macon County, Alabama. Macon County was selected because it fulfills the criteria to be considered a food desert. This paper discusses the importance of FFV in a food desert.

According to the Centers for Disease Control and Prevention “food deserts are areas that lack access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full range of a healthy diet” (CDC, 2018). Moore, Diez Roux, Nettleton & Jacobs (2008) observed that participants that had no supermarkets near their homes were 25–46% less likely to have a healthy diet compared to participants who had a high density of supermarkets near their homes. Associations have been observed between adhering to a healthy diet and positive health outcomes. Those who have a high intake of fruits and vegetables are 30% less likely to have had a heart or stroke (Hung et al., 2004). A meta-analysis conducted in 2014 found an association between the consumption of a vegetarian diet and lower blood pressure (Yokoyama et al., 2014). A report by the World Cancer Research Fund and the American
Institute for Cancer Research stated that non-starchy vegetables and fruits “probably” have protective effects against various types of cancer (i.e. mouth, throat, larynx, esophagus, and stomach) (Wiseman, 2008). Consumption of fruits and leafy green vegetables have also been associated with lower risk of type II diabetes (Bazzano, Li, Joshipura & Hu, 2008; Muraki et al., 2013). Consumption of FFV also have oral health benefits as well. Nanri et al. A (2017) found that in their elderly sample population increased consumption of FFV was positively associated with increased oral health-related quality of life. Those who live in communities designated as a food deserts have difficulty consuming FFV, thus putting them at risk for various adverse health outcomes. Understanding the relationship between FFV, oral health and systemic health will help in creating effective disease prevention interventions.

The diseases discussed in this paper are periodontal disease, type I/II diabetes, chronic obstructive pulmonary disease (COPD), oral cancer and distant metastasis. These diseases were chosen because they demonstrate the bidirectional relationship between oral and systemic diseases. Periodontal disease was selected for this paper because it is the most prevalent oral disease in adults with 20-50% of the world population suffering from it (Albandar & Rams, 2002). Periodontal disease is a disease of the connective tissue in the oral cavity (Penn State Hershey Medical Center, 2019). Additionally, periodontal disease is an inflammatory disease which causes teeth to migrate and subsequently tooth loss. There are documented associations between periodontal disease and other systemic diseases (Kim & Amar, 2006). Cardiovascular disease, stroke and adverse pregnancy outcomes are among the systemic diseases associated with periodontal disease (Nazir, 2017).

There is a known association between periodontal disease and type II diabetes (Preshaw et al., 2011). Type II diabetes is an inflammatory condition in which the cells become resistant to insulin resulting in an accumulation of glucose in the bloodstream (Donath & Shoelson, 2011). The onset of type II diabetes has been linked to increased intake of sugar and obesity. A study conducted by Sandberg et al., 2000 concluded that periodontal disease was more prevalent in those with type II diabetes than those who were non-diabetic. Those who poorly control their diabetes tend to have more severe periodontal destruction than those who have moderately/well controlled diabetes (Apoorva et al., 2013). Uncontrolled type II diabetes can exacerbate the progress of periodontal disease. Data suggests that elderly patients with non-insulin dependent diabetes suffered more frequently from advanced periodontal disease than patients that were non-diabetic (Collin et al., 1998). The association between type II diabetes and periodontal disease has been observed even in the early life stages (Lalla et al., 2007). Lalla et al., (2007) observed that children with type I diabetes had increased gingival inflammation and higher attachment loss, which indicates greater periodontal destruction between cases and controls. These studies indicate an association between type II diabetes and periodontal disease.

Another systemic disease associated with periodontal disease is COPD. Chronic obstructive pulmonary disease is an inflammatory disease where the capillaries of the lungs become inflamed, reducing lung capacity (National Heart, Lung and Blood Institute, 2019). A proposed mechanism linking COPD and periodontal disease is that low grade chronic
inflammation from periodontal disease may have a cumulative systemic burden on a patient (Winning et al., 2019). The inflammation from the periodontal disease is suspected to be caused by the inhalation of small amounts of pathogenic bacteria from the oral cavity into the lungs (Tan et al., 2018). An increase in pathogenic microorganisms was positively associated with COPD (Tan et al., 2018). The colonization of the oral cavity and the biodiversity are linked to oral hygiene. Lack of attention to oral hygiene results in increased mass and complexity of dental plaque which can lead to bacterial infections (Parashar et al., 2018). An increase intake of sugar can lead to the proliferation of microbial growth by providing the microbes with an energy supply. Fortunately, COPD can be managed halting the disease progression. However, the damage done by COPD to the lungs is often irreversible. Another disease that can have long lasting effects on overall health is oral cancer.

Smoking and alcohol consumption increase the risk of oral cancer specifically, oral squamous cell carcinoma (OSCC) (Rosenquist et al., 2005). According to the American Cancer Society there were 51,540 new cases of oral cancer and 10,030 deaths from oral cancer in 2018 (American Cancer Society, 2019). Squamous cell carcinoma affects the thin layer of epithelial cells that line the oral cavity. Oral squamous cell carcinoma can metastasize to other areas of the head and neck by a process called distant metastasis. The broad term for these cancers is squamous cell carcinoma of the head and neck (SCCHN). Aside from smoking and alcohol consumption, missing teeth and oral hygiene are risk factors for oral and oropharyngeal squamous cell carcinoma (Rosenquist et al., 2005). Rosenquist et al (2005) observed that poor to average oral hygiene, more than five defective teeth and more than 20 missing teeth were significant risk factors for oral and oropharyngeal squamous cell carcinoma. A study by Hashim et al. (2016) assessing the risk of oropharyngeal, hypopharyngeal, pharyngeal and laryngeal cancers found that poor oral hygiene (≥5 missing teeth, tooth brushing < once/day, dental visits < once/year) and gum disease (periodontal disease and(or gingivitis) increased the risk of head and neck cancers. A study conducted by Divaris et al (2010) observed a possible modest association between self-reported tooth loss indicators and not tooth loss itself was a risk for squamous cell carcinoma of the head and neck. Poor oral health (missing 6-15) teeth increases the risk for esophageal squamous cell carcinoma two-fold (Guha et al., 2007). Lee et al (2017) conducted a population-based study in Taiwan assessing the bidirectional relationship between oral cancers and esophageal cancer. Data suggested that patients with primary oral cancer were at 10x the risk of developing esophageal cancer and patients with primary esophageal cancer were at 7x the risk of developing oral cancer than compared to the general population (Lee et al., 2017). It was observed the closer the proximity the oral structure was to the esophagus the higher the incident rate of developing cancer (Lee et al., 2017).

An aspect of cancer that leads to mortality is the ability of cancer cells to metastasize. One form of metastasis is distant metastasis (DM) which refers to cancer that has spread from the original (primary) tumor to distant organs or distant lymph nodes (National Cancer Institute). Hasegawa et al. (2015) found that in patients with OSCC multiple lymph node metastases, local region failure and the presence of extra-capsule spread were significant risk factors for DM. Data collected by Sakamoto et al. (2016) identified that a pathologically
positive neck, involvement of neck levels four and five, and local recurrence were associated with DM in patients with OSCC, with local recurrence being the strongest risk factor. The health outcomes previously mentioned have dietary implications. It is imperative that individuals have access to fresh fruits and vegetables (FFV) so that they will not have to seek unhealthy alternatives that can increase their risk for oral and systemic diseases.

Deserts and Food Insecurity

As mentioned previously the Centers for Disease Control and Prevention defines a food desert as “areas that lack access to affordable fruits, vegetables, whole grains, low-fat milk, and other foods that make up the full range of a healthy diet” (CDC, 2018). The United States Department of Agriculture define food deserts using two criteria: low income communities and low access communities (Rhone, Ver Ploeg, Dicken, Williams, & Breneman, 2012). A low-income community is a community where the poverty rate is equal to or greater than 20% or the median family income does not exceed 80% statewide (Rhone, Ver Ploeg, Dicken, Williams, & Breneman, 2012). The description of a low access community is when 500 people or 53% of the population is located more than one mile (urban) or more than 10 miles (rural) from the nearest supermarket or grocery store (Dutko, Ver Ploeg, & Farrigan, 2012). The USDA estimated that nearly 19 million or 6.2% of the U.S. population is in a food desert (Ver Ploeg & Rhone, 2018). An additional determinant that affects an individual's ability to access food is vehicle availability. It is estimated that 9.2% of households in the U.S do not have access to a vehicle and 4.2% of households in the U.S are at least 0.5 miles from a supermarket or grocery store without having access to a vehicle (Ver Ploeg & Rhone, 2018). A report released in 2017 indicated that the percentage of households with low access and low vehicle availability increased 4% from 2010 to 2015 (Rhone, Ploeg, Dicken, Williams, & Breneman, 2017). Lack of transportation affects both urban and rural communities located in a food desert. Public transportation in urban communities may help alleviate the hardships of lack of transportation however, the amount of groceries that can be transported is limited.

The residual effect of food deserts is a condition called food insecurity. Food insecurity is a state where households lack access to adequate food due to limited financial means or limited resources (Gundersen & Ziliak, 2015). Food security is defined as cases in which all household members had access at all times to enough food for an active, healthy life; low food security is defined as cases in which at least some household members were uncertain of having, or unable to acquire, enough food because they had insufficient money and other resources for food (Gundersen, Kreider & Pepper, 2011). Very low food security is defined as cases in which one or more household members were hungry, at least some time during the year, because they couldn’t afford enough food (Gundersen, Kreider & Pepper, 2011). Three factors that determine whether an individual or household is food insecure: availability, accessibility and acceptability. Availability refers to whether services and/or goods are present. Availability in terms of a food desert is whether there is a supermarket, grocery store or any other establishment that sells fresh fruits and vegetables in the community. A farmer’s market is an example of an alternative avenue residents can gain availability to fruits and vegetables in their community.
Accessibility consists of two aspects: geographic accessibility and financial accessibility. Geographic accessibility refers to the geographic location of a supermarket or grocery store and if the person can get to the location. Transportation may influence geographic accessibility. Financial accessibility refers to one’s ability to purchase fresh fruits and vegetables (FFV). Although available, lower income households may have to revert buying lesser expensive frozen or canned produce because FFV are usually more expensive. Acceptability refers to the quality and types of FFV individuals are willing to purchase. Fruits and vegetables may be available and accessible, but for, a variety of reasons, the FFV may not be acceptable resulting in food insecurity. In 2017, nearly 15 million households or 11.8% of the U.S population were food insecure at some point during the year (Coleman-Jensen, Gregory & Singh, 2017). The average percentage of food insecurity from 2015-2017 for Black non-Hispanic households was 26.1% (Coleman-Jensen, Gregory & Singh, 2017). The average percentage of food insecurity from 2015-2017 for households that were food insecure in the southern United States was 17.9% (Coleman-Jensen, Gregory & Singh, 2017). The average percentage of food insecurity from 2015-2017 for households that were food insecure in Alabama was 16.3% (Coleman-Jensen, Gregory & Singh, 2017).

Macon County is a food desert located in rural Alabama. Within Macon County there are three towns, one city and six unincorporated communities. The towns are Shorter, Franklin and Notasulga with the only city being Tuskegee. The six unincorporated municipalities are Fort Davis, Little Texas, Mount Andrew, Creek Stand, Hardaway, Warriors and Cross Keys. According to the 2017 census estimate the population of Macon County was 18,755 people. Macon County is 81.1% African American and 15.7% white non-Hispanic (U.S Census Bureau). The remaining percentages include Hispanics, Asian and Native Americans. The median household income in 2016 for Macon County was $32,390 with 30% of the population in poverty (U.S Census Bureau). In 2017 Macon County had 80.5% of the population 25 years old or older with a high school degree or higher (U.S Census Bureau). The population of individuals 25 years old or older with a high school degree or higher may be inflated due to the presence of Tuskegee University which is located in the city of Tuskegee. With students and professors living in Tuskegee the data might be positively skewed, increasing the percentage of individuals with a high school degree or higher. According to the 2015 census Macon County household income and average income for those under 25 years of age was $11,439, median income for those 25-44 years of age was $23,758, median income for those 45-64 years of age as 39,758, median income for those over 65 years old as $34,079 (U.S Census Bureau).

Despite its historical agricultural roots Macon County is a food desert. Macon county is site where Booker T. Washington who founded then Tuskegee Institute. The goal of Booker T. Washington as the first principal of Tuskegee Institute was to educate illiterate ex-slaves in the agriculture and construction. The 1893 charter revision for the university reads as follows “That the purposes of said Tuskegee Normal and Industrial Institute should be as follows: For the instruction of colored teachers and youth in the various common academic and collegiate branches, the best methods of teaching the same, the best methods of theoretical and practical industry in their application to agriculture and mechanic arts...” (Mayberry, 1989, p. 46).
The main premise was to teach the people how to better till the land, so they could thrive off the land. The way in which Booker T. Washington intended to achieve this goal was by implementing an agriculture extension program. An agriculture extension program provides informal education to farmers applying emerging scientific research and knowledge (National Institute of Food and Agriculture, 2018). The first step Booker T. Washington took in this extension program was the creation of The Farmer’s Conference in February 1892 (Mayberry, 1989). The purpose of this conference was first to assess the needs of the people and the second purpose was to educate the farmers about new agricultural techniques and sanitation (Mayberry, 1989). The first conference was attended by 500 farmers and in six years that number grew to 2,000 farmers (Mayberry, 1989). With the success of the Farmer’s Conference and the approval of the new charter there was an increasing need for a formal agriculture department at Tuskegee University (Mayberry, 1989).

To head the Agriculture Department, Booker T. Washington recruited George Washington Carver. To expand the Extension Program George Washington Carver purchased a mule drawn wagon stocked with a few tools and seed packets which was the predecessor of the more famous Jesup Wagon (Mayberry, 1989). The purpose of these wagons was to go out to the most rural parts of the county and have demonstrations showing farmers more effective farming techniques (Mayberry, 1989). By doing this, Booker T. Washington and George Washington Carver were able to drastically improve the lives of black people in Tuskegee and Macon County as a whole. To attest to the importance of Tuskegee University and Booker T. Washington in the lives of rural Black farmers, Allen W. Jones of Auburn University wrote:

“While the economically depressed white farmers of the south sought solutions to their problems in the 1880’s and 1890’s through the Grange, the Agricultural Wheel, and the Farmers Alliance, numerous industrial school and institutes were established throughout the south in an effort to help the landless, uneducated, and deprived mass of Black farmers. Founded on July 4, 1881, in the heart of the black belt of Alabama, by an act of the State Legislature, Tuskegee Institute emerged rapidly under the leadership of Booker T. Washington and his formula of self-help into a center for educating and uplifting more than 1,000,000 Black farmers in the south” (Jones, 1975, p. 252).

Given its rich agricultural history, it is surprising that Macon County is considered a food desert. A survey published by the Natural Resources Conservation Services (NRCS) and United States Department of Agriculture (USDA) in 2004 reported that in Macon County, there are 119,260 acres or 30% of the total area of Macon County is defined as prime farmland. Most of the prime farmland is used to cultivate cotton, corn and soybeans (USDA, 2004). Tuskegee University has a prominent College of Agriculture, Environment and Nutrition Sciences (CAENS), that among several objectives has the objective “to involve faculty and students in demonstration and outreach projects that help to improve communities, human health, and the quality of life for individuals and families” (Tuskegee University, 2019). Within Macon County there is no shortage of land or intellectual capital, yet Macon County is a food desert.
Methodology

An observational research method for this pilot project was used to determine if FFV were available, where FFV were located, and the quality and cost of FFV throughout Macon County. A student researcher was the principal investigator for the research. Two-experienced faculty advised and guided the student researcher. One of the faculty assisted in conceptualizing and implementing the research. The other faculty assisted with the qualitative component of the project. The quality of the FFV was measured by color, texture and smell using a Likert scale (1-4) with the quality rating being poor, fair, good and excellent. The cost of the produce was also recorded. Sodium, sugar, and cholesterol content were recorded for all frozen, canned and jarred fruits/vegetables. Initial data collection was performed on three separate occasions over three days. Supermarkets, grocery stores and convenience stores were located using a Google map search, the Maps cellular application and speaking with city/town residents. Due to the ambiguity of definitions for supermarkets and grocery stores, the definitions for supermarkets and grocery stores were used interchangeably. The National Association of Convenience Stores (NACS) defines a convenience store as “a retail business with primary emphasis placed on providing the public a convenient location to quickly purchase from a wide array of consumable products (predominantly food or food and gasoline) and services” (NACS, 2018). The North American Industry Classification System defines a convenience store as “establishments known as convenience stores or food marts (except those with fuel pumps) primarily engaged in retailing a limited line of goods that generally includes milk, bread, soda, and snacks” (NAICS, 2017). Using the REDCap Program an online survey was created to assess fresh fruits and vegetables, frozen fruits/vegetables, canned fruits/vegetables and jarred fruits/vegetables. Due to limited cellular service, the electronic survey was not used in the initial data collection. The data were later transferred from hard copy to REDCap via the electronic survey for statistical analysis. Descriptive analyses were completed to compare/contrast quality and cost were analyzed based on location. The program EpiInfo was used to calculate Chi square, odds ratio and to create a series of maps.

Results

In Macon County, there are nine stores and one Farmers’ Market that sell food items. Of those nine stores three of them sell FFV. These stores are Carmack Supermarket located in Notasulga, and Piggly Wiggly and Family Foods which are located in Tuskegee. There are four convenience stores in Tuskegee, one convenience store in Shorter and one convenience store in Notasulga. There are no supermarkets, grocery stores or convenience stores in Franklin. Of all the fruits and vegetables products assessed, 58 were FFV. There were no FFV sold in Shorter or Franklin. Of the 247 food items assessed 154 products were sold in convenience stores, equaling 62.35%. Canned fruits and vegetables account for 66.40% of the products assessed. Odds ratio for color, texture and smell were calculated using the EpiInfo program. The odds ratio for color, texture and smell were 50.75(95% CI = 6.29-390.42), 33.3(95% CI= 4.34-255.26), 31.59(95% CI= 4.12-242.15) respectively.
Table 1. Frequency of supermarkets, grocery stores, convenience stores, FFV, frozen FV and canned FV in Macon County

<table>
<thead>
<tr>
<th>Store/Food Type</th>
<th>Cities in Macon County</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tuskegee</td>
<td>Notasulga</td>
<td>Shorter</td>
<td>Franklin</td>
</tr>
<tr>
<td>Store</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supermarket</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Grocery store</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Convenience</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Food type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fresh FV</td>
<td>39</td>
<td>18</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Frozen FV</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Canned FV</td>
<td>129</td>
<td>40</td>
<td>31</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>197</td>
<td>63</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

*FV = Fruits and Vegetables

Table 2. Quality frequency of FFV assessed in Macon County

<table>
<thead>
<tr>
<th>City/Town</th>
<th>Quality Measure</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuskegee</td>
<td>Color</td>
<td>8</td>
<td>19</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Smell</td>
<td>8</td>
<td>15</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Texture</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Notasulga</td>
<td>Color</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Smell</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Texture</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td>29</td>
<td>44</td>
<td>86</td>
<td>14</td>
</tr>
</tbody>
</table>
Macon County has limited FFV available or accessible to its residents. Moreover, FFV are only available in the city of Tuskegee and the town of Notasulga. Thus, it is increasingly difficult for residents of the county to get FFV unless they travel out of the county to purchase them. With only three stores and one farmers’ market where FFV are sold, there is limited access FFV, particularly when these products are geographically and/or financially inaccessible to a population of 18,755, over an area of 608.89 square miles. Two of the three stores that sell FFV are centrally located in Macon County however, due to the size of Macon County these stores are still geographically inaccessible. For individuals that live outside of this concentrated region it may be difficult to travel ten miles or more to buy FFV. Within Macon County, there is limited public transportation for individuals to get from the fringes of county to Tuskegee or Notasulga. Individuals must either own a car or have access to a vehicle in order to go grocery shopping. The poverty rate in Macon County is 30.6% showing that there a possible difficulty with financial access to FFV.

If one can navigate the two barriers of availability and accessibility, they would then have to deal with the barrier of acceptability. The lack of quality food can severely restrict the diet of individuals and have adverse health outcomes. Fruits and vegetables that are spoiled are a health risk for the community. It was observed that the small business grocery stores had a higher quality of FFV than the supermarket FFV. We hypothesize the difference in quality could be attributed to the flexibility of that small business grocery stores may have when selecting where to purchase FFV. The store with the highest quality of FFV was Carmack in
Notasulga. Accessibility is the main issue with Carmack, it is located far in the north part of the county. The location of Carmack makes it only accessible to individuals that own or have access to a vehicle. Demographics may possibly contribute to which areas have quality FFV. The population of Notasulga is 52.2% non-Hispanic white and 47.8% Black (American FactFinder, 2018). Conversations with local residents revealed that racial/ethnic make-up of the town may be directly related to the observed improved quality of FFV in Notasulga. Further research is needed to assess if the racial/ethnic make-up of a city/town influences the quality of FFV.

Availability, accessibility and acceptability are major factors in determining an individual's diet. These factors can have serious implications not just on residents’ diets but their overall health as well. The lack of available FFV, essentially forces residents to buy canned foods which contain high levels of sodium and sugar. Diets with a high intake of sodium and sugar have been shown to lead to an increased risk of cardiovascular diseases, obesity and type II diabetes (U.S. Department of Health and Human Services and U.S. Department of Agriculture, 2015). Diets high in sugars have been observed to increase the risk for cavities and periodontal disease (Moynihan, 2005). It has been observed that an increase in fresh fruits and leafy green vegetables results in a decreased risk of developing type II diabetes (Li, 2017). The areas that have low availability and accessibility to FFV also have a high prevalence of type II diabetes (Centers for Disease Control and Prevention, 2019; United States Department of Agriculture, 2019). The highest rates are observed in southern states and counties within the Appalachian mountain range (Centers for Disease Control and Prevention, 2019; United States Department of Agriculture, 2019). Individuals living in a food desert are subjected to an abundance of unhealthy food options, usually high in sodium and sugar but also, have low availability/accessibility to FFV which further leads to adverse health outcomes. These individuals are at risk of being undernourished which has negative effects on oral and systemic health. The severity of oral mucosal and periodontal disease are exacerbated by undernourishment (Moynihan, 2005). In the case of periodontal disease, a deficiency in vitamin C & E can play a role in the progression of periodontitis. Being undernourished at the developmental stage in life can have a significant affect on one’s oral health (Moynihan, 2005). Deficiencies in vitamin D & A have been associated with enamel hypoplasia and salivary gland atrophy (Moynihan, 2005). Enamel hypoplasia is a defect in the formation of the teeth resulting in thin enamel and has been associated with an increased risk in the formation of cavities (Moynihan, 2005). For optimal health to be obtained the relationship between diet and health must be emphasized especially in the context of food deserts/insecurity.

In order for physicians and other health professionals to effectively address health disparities, such as type II diabetes, a synergistic relationship needs to be formed with dentists. Physicians should be aware of the association between oral and systemic health and make appropriate oral health referrals. Just by doing this there will be an increase in the effectiveness of treatment and prevention of severe disease progression. In terms of the food environment factors public health interventions need to be taken to increase the availability, accessibility and acceptability of FFV in Macon County. The food environment in which the residents of Macon County live has put restrictions on their diets. It is unethical that the residents do not have the autonomy to decide if they want to engage in healthy eating behaviors that can help reduce the risk of adverse health outcomes.
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Articles


Conspiracy Beliefs about Antiretroviral Medications for HIV/AIDS among African Americans Living with HIV

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Author Note
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Abstract
The purposes of the present analysis are twofold: 1) to assess the extent to which African Americans that are living with HIV subscribe to conspiracy beliefs about antiretroviral medications for HIV/AIDS; and 2) ascertain the differences, if any, between men, women and educational attainment regarding these beliefs. Findings indicate that over one-third (36.6%) somewhat or strongly agreed that “people who take the new medicines for HIV/AIDS are human guinea pigs for the government,” while 28.8% somewhat or strongly endorsed the statement that “the medicine that doctors prescribe to treat HIV is poison.” One quarter of all the respondents endorsed the belief that “the medicine used to treat HIV causes people to get AIDS” (25.3%). Patients who were high school or beyond high school graduates were less likely than their peers with less education to endorse belief about HIV treatments. The calculated effect sizes confirm education’s effect is meaningful in this sample. There are no gender differences in belief about HIV treatments.

Keywords: Conspiracy beliefs, HIV/AIDS, African Americans, Antiretroviral Medication
Introduction

In the United States, HIV infection is increasing fast in the south and particularly among racial and ethnic minorities. HIV and AIDS rates are much higher among African Americans than any other racial groups in the United States. Mistrust of health care providers and the medical system is also prevalent among African American (Zekeri, 2015). Much commentary on HIV prevention has emphasized the need to take into account conspiracy beliefs among African Americans when designing culturally-relevant interventions to increase safer sexual behavior (e.g., see Clark, 1998; Herek & Capitano 1994; 1997; Herek& Glunt 1991; McGary, 1999; Smith, 1999; Thomas & Quinn, 1993; 1991). However, limited studies exist that examine beliefs in conspiracies among HIV-positive African Americans living in the rural south. Except for the work of Zekeri and Diabate (2015; 2014), no study has been found dealing with factors associated with beliefs in conspiracies about HIV/AIDS. Instead the focus has been on documenting the prevalence of such beliefs in the African American community.

Several researchers have noted that a significant percentage of Americans hold conspiracy beliefs regarding HIV/AIDS, and that such beliefs are more prevalent among African Americans than among Whites (e.g., Crocker, Luhtanen, Broadnax, & Blaine, 1999 Herek & Glunt 1991; Herek &Capitano 1994). Herek and Capitano (1994) found in their telephone survey that 20% of African Americans agreed with the statement “The government is using AIDS as a way of killing off minority groups” compared to 4% of Whites. In addition, 43% of African Americans and 37% of Whites agreed that “A lot of information about AIDS is being held back from the general public.” Thomas and Quinn (1993) reported that between 17% and 38% of their respondents believe that there is some truth in reports that the AIDS virus was produced in a germ warfare laboratory. Between 15% and 35% of their respondents also agreed that AIDS is a form of genocide against African Americans. In a similar vein, Parsons et al. (1999) surveyed parishioners of 35 churches in Louisiana. They found that almost 70% of respondents did not believe that the government was telling the truth about AIDS, and over 25% agreed that AIDS was “intended to wipe Blacks off the face of the earth.”

One understudied area in this realm are the conspiracy beliefs about antiretroviral medications for HIV that have been noted in the popular press. These conspiracy beliefs include the belief that the drugs used to treat HIV/AIDS can kill patients (France, 1998), and that people who take the medications are human guinea pigs for the U.S. government (Richardson, 1997). No research has documented conspiracy beliefs regarding these medications in a systematic fashion. Given that African Americans are less likely than whites in the United States to adhere to HIV treatment and to participate in clinical drug trials for HIV medications, research is needed to assess whether conspiracy beliefs about HIV treatments exist and contribute to racial/ethnic differences in HIV treatment behavior.

As an extension of previous work (Zekeri et al., 2009; Zekeri & Diabate, 2014; 2015), this study examines factors associated with belief in conspiracies about HIV/AIDS treatment among African Americans living with HIV in rural Alabama. It is important to document factors associated with belief in treatment conspiracies about HIV/AIDS because...
such belief can lead African Americans to be distrustful of HIV/AIDS related information and intervention efforts. The purposes of the current analysis are to assess the extent to which African Americans that are living with HIV/AIDS subscribe to the conspiracy beliefs about antiretroviral medications for HIV/AIDS and to ascertain the differences, if any, between men, women and educational attainment regarding these beliefs.

Method

The present study was part of a larger longitudinal project examining HIV/AIDS in Alabama’s Black Belt. The self-administered survey started in summer of 2005 at an AIDS Outreach Organization in Alabama that provides medical and social support services to HIV-positive persons who live in a 23 county area in Southeast Alabama including the Black Belt. Participants were patients attending two clinics within the organization. The clinics provided complete primary health care that includes physician visits, laboratory tests, case management, food bank, transportation, vouchers and emergency assistance to approximately 1,100 low-income individuals living with HIV/AIDS. All the respondents are African Americans currently taking antiretroviral medications.

For confidentiality purposes, only the staff of the AIDS Outreach Organization informed the patients of the opportunity to participate in the study. The Adherence Nurse gave the questionnaire to interested patients and they completed the self-administered survey on a voluntary basis in a private room at the agency after obtaining verbal informed consent. Each participant was given a $15 Wal-Mart gift card after completing the questionnaire. All study procedures were reviewed and approved by the Tuskegee University Office of Research Compliance prior to the collection of any data.

Measures: HIV/AIDS Treatment Conspiracy Beliefs

The primary study variables are treatment related conspiracy beliefs and demographic characteristics of the patients. Participants were asked to report the extent to which they agreed or disagreed (1 strongly disagree; 2 = slightly disagree; 3 = neutral; 4 = slightly agree; 5 = strongly agree) with three statements about HIV treatments: “The medicine used to treat HIV causes people to get AIDS,” “The medicine that doctors prescribe to treat HIV is poison,” “People who take the new medicines for HIV are human guinea pigs for the government.”

Control Variables

Respondents were asked questions to identify or select their gender, marital status, educational attainment, age, annual household income, cohabitating with a partner, and employment. Gender is sex of the respondent (1 = male and 2 = female). Marital status was measured on four levels: (1) single, (2) married, (3) separated, and (4) divorced. Educational attainment was measured by four categories: (1) did not graduate from high school, (2) completed high school, (3) some college or vocational school, and (4) completed college. Education was dichotomized into “no high school” versus “high school and college graduates.” Age was dummy coded as young (18-34) and old (35-63). Annual household income was
measured as (1) less than $30,000 and (2) more than $30,000. Employment was measured as (1) working and (0) not working.

**Statistical Analysis**

Frequency distributions and descriptive statistics provided information about patients’ respondents and beliefs about HIV/AIDS treatment conspiracy. To estimate the relation of education with conspiracy beliefs, crosstabulations were made, then percentages were calculated. Values of chi-squared statistics were calculated to test the statistical significance of the distributions by educational groups. \( p = .05 \) was considered significant.

**Results**

*Socio-demographics*

The sample is heterogeneous in terms of socio-demographic characteristics (see Table 1). Of the 225 respondents, more than half (57.6%) were male, 42.4% were female. Age ranged from 18 to 63; more than half were 35 or older. More than half (52.7%) were single, while only 17.6% were married. About 23% had no formal education up to high school while 31% completed high school. Only 15% had a four-year college degree.

| Table 1. Characteristics of patients (n = 225) |
|---------------------------------|---|
| **Gender** | % |
| Male | 57.6 |
| Female | 42.4 |
| **Marital Status** | | |
| Single | 52.7 |
| Married | 17.6 |
| Separated | 10.0 |
| Divorced | 21.7 |
| **Educational Attainment** | | |
| Did not graduate from High School | 22.9 |
| Completed High school | 30.7 |
| Some College or Vocational school | 31.2 |
| Completed College | 15.1 |
| **Age** | | |
| 18-34 | 39.0 |
| 35-63 | 61.0 |
Endorsement of Conspiracy Beliefs about Medication

As shown in Table 2, one quarter of all the respondents endorsed the belief that “the medicine used to treat HIV causes people to get AIDS” (25.3%). Some African Americans that are HIV-positive endorsed the belief that “the medicine that doctors prescribe to treat HIV is poison” (28.8%) and “People who take the new medicines for HIV are human Guinea pigs for the government” (36.6%).

Table 2. Treatment Conspiracy Beliefs Endorsed by HIV-Positive African Americans

<table>
<thead>
<tr>
<th>Belief</th>
<th>% Agreeing Somewhat or Strongly</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medicine used to treat HIV causes people to get AIDS</td>
<td>Overall: 25.3, Male: 24.6, Female: 26.4, X²: 4.76</td>
</tr>
<tr>
<td>The medicine that doctors prescribe to treat HIV is poison</td>
<td>Overall: 28.8, Male: 28.0, Female: 29.8, X²: 0.54</td>
</tr>
<tr>
<td>People who take the new medicines for HIV are human Guinea pigs for the government</td>
<td>Overall: 36.6, Male: 38.1, Female: 34.5, X²: 0.67</td>
</tr>
</tbody>
</table>

Significant values are based on X² tests between women’s and men’s frequency distributions of the 5 category responses to each item (disagree strongly, disagree somewhat, no opinion, agree somewhat, agree strongly), df = 4.

The relationship between gender and endorsing conspiracy beliefs was assessed. The chi-square statistics presented in Table 2 show that gender of the respondents is not significantly associated with conspiracy belief about antiretroviral medication.

Impact of Educational Attainment

The next question addressed in the analysis is whether educational attainment has impact on endorsing specific conspiracy beliefs. Data presented in Table 3 indicate that educational attainment is related to endorsing some specific conspiracy beliefs about antiretroviral medication. Respondents with formal schooling of high school and beyond were less likely than their non-educated peers to endorse the conspiracy beliefs that “The medicine used to treat HIV causes people to get AIDS,” “The medicine that doctors prescribe to treat HIV is poison.” and “People who take the new medicines for HIV are human Guinea pigs for the government.”
Table 3. Relationship of education to conspiracy beliefs

<table>
<thead>
<tr>
<th>% Agreeing Somewhat or Strongly</th>
<th>No High School</th>
<th>High School and Beyond</th>
<th>X^2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medicine used to treat HIV causes people to get AIDS</td>
<td>42.6</td>
<td>20.3</td>
<td>13.96*</td>
</tr>
<tr>
<td>The medicine that doctors prescribe to treat HIV is poison</td>
<td>51.9</td>
<td>24.8</td>
<td>14.58*</td>
</tr>
<tr>
<td>People who take the new medicines for HIV are human Guinea pigs for the government</td>
<td>64.5</td>
<td>29.6</td>
<td>23.83*</td>
</tr>
</tbody>
</table>

*Significant values are based on X^2 tests between no high school and high school and beyond frequency distributions of the 5 category responses to each item (disagree strongly, disagree somewhat, no opinion, agree somewhat, agree strongly), df = 4.

Conclusions

What can be concluded conspiracy beliefs about medications for HIV/AIDS among African Americans living with HIV/AIDS? These data suggest that, conspiracy beliefs about medications were endorsed. Among African Americans living with HIV/AIDS, education is associated with beliefs regarding medications for HIV/AIDS. Though there were high levels of belief about HIV treatments, belief were not associated with gender.

The present analysis supports the utility of continuing to explore the link between belief about HIV treatment and education among African Americans living with HIV/AIDS. In this study, there was evidence of a positive relationship between educational attainment and belief about HIV treatments. Many questions, however, remain unanswered. Do the relationship found for this sample of African Americans living with HIV/AIDS, who spent at least part of their youth in rural Alabama, hold for other groups in the general population? Do these associations between belief of HIV treatments and educational attainment differ by age, income, geographic region, ethnic group, or rural-urban residence? Additional research focusing on other ethnic groups, age groupings, and other geographic areas is needed to address these questions. Certainly, further research is needed to arrive at a clear understanding concerning the relationships between education and conspiracy beliefs about antiretroviral medications for HIV/AIDS.
References


Commentary

The Professor and the Pupil: The Hermeneutical Connectedness and Theological Contributions of James H. Cone and Katie G. Cannon

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“It is my contention that Christianity is essentially a religion of liberation. The function of theology is that of analyzing the meaning of that liberation for the oppressed so they can know that their struggle for political, social, and economic justice is consistent with the gospel of Jesus Christ. Any message that is not related to the liberation of the poor in a society is not Christ’s message. Any theology that is indifferent to the theme of liberation is not Christian theology. In a society where persons are oppressed because they are black, Christian theology must become black theology, a theology that is unreservedly identified with the goals of the oppressed and seeks to interpret the divine character of their struggle for liberation.”

– James Cone, A Black Theology of Liberation

“When I turned specifically to readings in theological ethics, I discovered that the assumptions of the dominant ethical systems implied that the doing of Christian ethics in the Black community was either immoral or amoral. The cherished ethical ideas predicated upon the existence of freedom and a wide range of choices proved null and void in situations of oppression. The real-lived texture of Black life requires moral agency that may run contrary to the ethical boundaries of mainline Protestantism. Blacks may use action guides which have never been considered within the scope of traditional codes of faithful living. Racism, gender discrimination and economic exploitation, as inherited, age-long complexes, require the black community to create and cultivate values and virtues in their own terms so that they can prevail against the odds with moral integrity.”

– Katie Cannon, Black Woman Ethics

Abstract

This article elucidates the hermeneutical and theological contributions of James H. Cone (Professor) and Katie G. Cannon (Pupil), by analyzing their methodological critiques of Christian theology, which failed to consider black experience in mainstream (white) America. Thereby unraveling distinct (black liberation and womanist theology) theological categories that addressed the marginalization of African Americans within mainstream America, while simultaneously debunking the hegemonic and patriarchal norms of Evangelical Christianity (slaveholding religion) that seeped into African American churches, under the guise of tradition. It is essential to delineate the dichotomy between Christian theology and evangelical Christianity, as both house the tents of white supremacy. A detailed topic later explored in this
reflection. Recognizing the indelible impact that both theologians had on Christian theology and the black church, this article builds upon the imagery of Professor and Pupil, pays homage to the hermeneutical and theological ingenuity of Cone and Cannon, calls readers attention to a liberating hermeneutic, while exposing cantankerous practices and interpretations that persist in African American churches. It is also important to note the interchangeable nature of the terms Black and African American.

**Keywords:** black experience, hermeneutics, theology, methodology, tradition, womanist theology, black liberation theology, slaveholding religion

### Introduction

Several years ago, Murali Balaji chronicled the seminal relationship between W.E.B. DuBois and Paul Roberson, through a literary analysis of the social and political (e.g., colonialism, capitalism, racism, classism) circumstances that philosophically forged their friendship and activism. Tragically, their commitment to social justice and the upward mobility of African Americans, in the aftermath of their political awakening, solidified their internal alienation from mainstream (white) America, which also had an alienating effect among African Americans. The Professor and the Pupil relationship did not begin and end with Dubois and Roberson. As we continually mourn the extinguishment of their mortal lives (Cone and Cannon) and deaths sweet repose, the Professor and Pupil analogy provides an existential hope for readers to traverse systems of oppression. From the argumentative skills of the Athenian philosopher, Socrates, the metaphysical world of Plato, shrouded with Forms, to the syllogistic discourse of Aristotle. From the black nationalist teachings of a former sharecropper, Elijah Muhammad, to the explosive, Pan-African views of the social agitator, Malcolm X. From the architect that served as a spiritual incubator for the civil rights movement, Howard Thurman, to the systematic theologian that articulated a moral blueprint that illuminated the hypocrisy of American democracy, Martin Luther King Jr. History regurgitates a plethora of philosophical relationships, though distinct and divergent that intersected at critical moments in human history to form a philosophical, hermeneutical, and theological bridge that academicians attempt to navigate. This article navigates the intersectionality of James H. Cone (Professor) and Katie G. Cannon (Pupil), exploring the categories of hermeneutics that shaped their theology and the institutional structures that housed oppressive ideologies, many of which still exist in African American communities and churches.

The hermeneutical complexity of interweaving theological geniuses into one article does a grave injustice to both theologians. A simplistic analysis of the depth of their connectedness cannot unravel the methodological framework that gave way to black liberation theology and womanist theology. Likewise, a scholarly reflection does not fit within the narrow constraints of a journal, yet we have the treasure of their labors in literary vessels. This is one of those literary vessels. As a rigorous inquiry into the lives of Cone and Cannon, this article begins with a brief, historical overview that kindles what we later categorize as black liberation theology and womanist theology, by considering the differentiated realities of Cone and Cannon. The duality of what it means to be black and how to negotiate one’s blackness in
Commentary

a mainstream (white) America, looks different from one person of color to the next, thereby explicating the contrasting views of Cone and Cannon. Blackness is a term that encapsulates and speaks to the suffering of African Americans. After exploring the existential experiences of both theologians and the potent questions that evangelical Christianity failed to address, as a slaveholding religion, this article elucidates the theological and hermeneutical foundations that became an academic enterprise and challenged Christian theology. After which, readers explore the relevance of Cone and Cannon to Christian theology and the practical measures that African American churches can employ to address the marginalization of African Americans in mainstream America, while also exploring how such ideologies seeped into African American churches (evangelical Christianity). Thereby forcing African American churches to reexamine practices and interpretations that ostracize, rather than liberate.

Hermeneutical Foundations

Werner G. Jeanrond (1991) offers a historical narrative on the development of hermeneutics and the praxis of hermeneutical reflection, as a “bridge between two realms, the realms of a text or a work or art and the people who wish to understand” (p. 1). According to Jeanrond (1991), “every exeget acts on hermeneutical foundations, whether he or she is aware of it or not” (p. xiii). This article begins with this premise, as a methodological framework from which to understand Cone and Cannon. In analyzing their writings, both theologians introduce readers to their “texts.” To understand Cone and Cannon is to actively engage the “texts” that shaped their hermeneutic and to view those “texts” as an extrapolation of a reality that validates their epistemology. The limitations of what Cone saw (blatant disregard for the black experience) and the limitations of what Cannon saw (blatant disregard for black women), launched by the tidal wave of white supremacy, authenticated their hermeneutic. Experience is the text of authority that both theologians read. According to Jeanrond (1991), “we never read a text ‘objectively’ or ‘neutrally’. It is always we who read and that means that it is through the application of our very particular perspectives that we allow a text to become real for us” (p. 2). Experience conditions their hermeneutic and become an epistemological barometer that Cone and Cannon utilize to debunk oppressive ideologies. For Cone, truth is speaking to the black struggle in America, and for Cannon, truth upholds the realities of black women.

In God of the Oppressed, Cone identifies “the black church experience and the sociopolitical significance of white people” (p. 1), as the texts that shaped his reality (hermeneutic). Through the black church, Cone experienced “the beauty and joy of black life and how to deal with the contradictions of black life” (p. 2), particularly in a world that sought to denounce the black experience. It was the preaching, praying, and presence of and to a liberating God that enabled Cone, and other African Americans alike, to negotiate systems of oppression. In regurgitating his earlier experiences, Cone asserts,

To be put in one’s place, as define by white society, was a terrible reality for blacks in Bearden. It meant being beaten by the two cops and spending an inordinate length of time in a stinking jail. It meant attending ‘separate but equal’ schools, going to the balcony when attending a movie, and drinking water from a ‘coloured’ fountain. It
meant prepared to leave town at the precise moment of your rebellion. You had no name except your first name or ‘boy’; and if you were past the age of sixty-five, you might attain the dubious honor or being called ‘uncle’ or ‘auntie.’ (p. 2).

For Cone, “this is why Black Theology differs in perspective, content, and style from the western theological tradition transmitted from Augustine to Barth” (p. 3). Due to differences in our experiences (White Americans and African Americans), black life and existence forced African Americans to raise questions that white America and evangelical Christianity, imbued with the ideology of white supremacy, failed to address. How could African Americans expect white churches and communities to sympathize with the plight of blackness when historically, white churches controlled the religious narrative and thereby used religious instruction to sanction their dehumanization? It was slaveholding Christianity, which for this article is synonymous to evangelical Christianity, that becomes appetizers to the Christian faith. In drawing upon their own experiences, enslaved Africans cultivated a liberating hermeneutic that enabled them to see the God of Scripture, the God of the Oppressed. In allowing experience to shape his hermeneutic, Cone systematizes what Emerson B. Powery and Rodney S. Sandler, Jr. (2016) classifies as “a black biblical hermeneutic” (p. 21) and coins the term Black Liberation Theology. At the heart of his hermeneutical discontentment, lied systematic theologians (e.g., Ludwig Feuerbach, Friedrich Schleiermacher, Karl Barth, Reinhold Niebuhr), the pietistic implications of evangelical Christianity, and the complicity of African American churches. Whereas, Cone denounces white supremacist ideologies that imbued white America and infiltrated African American churches, the limitations of his own experience (African American male), causes him initially to overlook the marginalization of African American women. So now comes the pupil, Katie G. Cannon.

In her Forward to Katie’s Cannon: Womanism and the Soul of the Black Community, Sara Lawrence-Lightfoot (1995) recalls a similar experience of negotiating systems of oppression, for “blacks were not allowed to go to the library, eat at the restaurants, sit downstairs at the movie theater, or swim in the local pools and ponds” (p. 12). She continues,

In Kannapolis, the home of the Cannon Mills, Black women had three choices. They could work as domestics, do hard labor in the mills, or a tiny, elite group could do the dignified life-giving work of teaching. Katie saw the barriers, witnessed the violence and oppression, and felt the triple-barreled threat of her poverty, her Blackness, and her femaleness. (p. 12).

Attempting to escape this triple threat, Cannon left Kannapolis and visited various parts of the world, but quickly discovered the ubiquitous effects of white supremacy. Whereas, Cone identifies two texts that shaped his reality (hermeneutic), Cannon, as an African American woman, draws upon her own experiences and utilizes three texts that speak to her reality (white women, black men, and what it means to be a black woman). The coining of the term womanism by Alice Walker provided Cannon with the hermeneutical space to “challenge inherited traditions for their collusion with androcentric patriarchy as well as a catalyst in overcoming oppressive situations through revolutionary acts of rebellion” (p. 23). Womanism,
just like Black Liberation Theology, begins with experience. Unlike Cone who begins in the black church, Cannon commences her narrative in a “folklore sanctuary” (p. 27), listening to her mother regurgitate historical stories and events. Acknowledging the dehumanizing status that American slavery had on enslaved Africans, Cannon illuminates the trappings of evangelical Christianity, as a slaveholding religion, while also expounding upon the cultural inheritance and expressions (e.g., folklore, spiritual, prayers) of enslaved Africans. Enabling Cannon to “unmask the hermeneutical distortions of White Christians, North and South, who lived quite comfortably with the institution of chattel slavery for the better part of 150 years” (p. 38). At the time Cannon wrote, the institution of chattel slavery had existed for 376 years, not 150 years.

Theo-Ethical Bankruptcy

There is no universal hermeneutic. There is no one way or “right” way to read and interpret the Bible. James Cone, the Professor, understood this better than anyone. It was his “Bearden experience” (Cone, 2013, p. 4), a hermeneutical extrapolation of his reality that enhanced his theological perspective and validated his epistemology. Experience substantiates his knowledge and challenges the authenticity of knowledge, by its sensibility to the black experience. As a systematic theologian, Cone understood the philosophical, hermeneutical, and theological constructs of western philosophers and their impact on Christian theology, but he also recognized the theological insignificance of such thoughts to the black experience. The insignificance speaks to the theological bankruptcy that African Americans experienced, trying to draw morality from white constructs of the Christian faith. As Cone says,

What could Karl Barth possibly mean for black students who had come from the cotton fields of Arkansas, Louisiana and Mississippi, seeking to change the structure of their lives in a society that had defined black as nonbeing? What is the significance of [Nicea] and Chalcedon for those who knew Jesus not as a thought in their heads to be analyzed in relation to a similar thought called God? They knew Jesus as a Savior and a friend, as the ‘lily of the valley and the bright and morning star’ (p. 5).

Seeing as how there are different sources of interpretations (e.g., experience, tradition, and bible), Cone embraced the idea that “scripture and existence had to be exegeted simultaneously” (p. 8). Cone declares,

To be an exegete of Scripture means that the theologian recognizes the Bible, the witness of God’s Word, as a primary source of theological discourse. To be an exegete of existence means that Scripture is not an abstract word, not merely a rational idea. It is God’s Word to those who are oppressed and humiliated in this world. The task of the theologian is to probe the depths of Scripture exegetically for the purpose of relating that message to human. (p. 8).

In failing to address pertinent questions relevant to the black experience, Christian theology gave way to evangelical Christianity, a slaveholding religion of the Christian faith that normalized whiteness and denounced blackness. Earlier this article spoke to the delineation
of Christian theology and evangelical Christianity, as one can still embrace the Christian
tradition, as Cone and Cannon did, with an intense level of scrutiny and hermeneutical
suspicion. Especially, when to accept such interpretations is to deny the essence of one’s self.
Hence, one can be a Christian, using experience as an interpretative framework, and consciously
deviate from the hegemonic and patriarchal norms of evangelical Christianity, which black
liberation theology and womanist theology did successfully. For Cone, the omission of the
black experience and for Cannon, the oversight of black women became the hermeneutical
justification that both theologians needed to challenge the theological failings of Christian
theology and the slaveholding teachings of evangelical Christianity. Cannon pushes further.

As a black womanist ethicist, Cannon calls a different level of scrutiny into existence,
by illuminating the hermeneutical and ethical distortions of evangelical Christianity that justified
the dehumanizing acts inflicted upon enslaved Africans and the susceptibility that black women
encountered. In doing so, Cannon recognized how “using theo-ethical language, concepts, and
categories White superordinates pressed their claims of the supposedly inherent inferiority
of Black people by appealing to the normative ethical system expressed by the dominate
slaveholders” (p. 42). Enslavement radiated the ethics and ethical values of white Christians or
as Cannon says, “they conformed their ethics to the boundaries of slave management” (p. 46).
From the economic profits of enslavement, white Christians, in their efforts to maintain social
control, “gave to charity, paid pastors, maintained church properties, supported seminaries, and
sustained overseas missionaries” (p. 46). Abused, raped, and sexually coerced, the black woman
“was answerable with her body to the sexual casualness of stock breeding with Black men and
to the sexual whims and advances of White men” (p. 49). In a constant state of struggle and
survival, womanist theology allowed black women to reaffirm their dignity and provided black
women with a voice to combat the unethical dealings and interactions of white (Christian)
slaveholders. For Cannon, “the assumptions of the dominant ethical systems implied that the
doing of Christian ethics in the Black community was either immoral or amoral” (p. 58). Cannon
noticed a dichotomy between the ethical values and ideals of whites that did not prove successful
for black women because evangelical Christianity housed white ethical norms. Why would we
expect anything different, “as long as powerful Whites who control the wealth, the systems, and
the institutions in this society continue to perpetuate brutality and criminality against blacks”
(p. 59). Again, as was the case with Cone, experience substantiates knowledge and challenges the
authenticity of knowledge, by its sensibility to black women.

As a black womanist ethicist, Cannon understood the ethical, hermeneutical, and
theological constructs of western philosophers and their impact on Christian theology, but
she also recognized the theological insignificance of such thoughts to black women. The
insignificance speaks to the ethical bankruptcy that black women experienced, trying to draw
ethical values and virtues from white constructs of the Christian faith. Cannon begins her
ethical considerations as a black woman to “explain the community’s socio-cultural patterns
from which ethical values can be gleaned” (p. 59). However, such values derive from whiteness.
In her analysis,
Black women are the most vulnerable and the most exploited members of the American society. The structure of the capitalist political economy in which Black people are commodities, combined with patriarchal contempt for women, has caused the Black woman to experience oppression that knows no ethical or physical bounds (p. 60).

Womanist theology enables black women to “live out a moral wisdom in their real-lived context that does not appeal to the fixed rules or absolute principles of the White-oriented, male-structured society” (p. 60). Womanist theology challenges white ethical norms, whereby black women become cognizant of the moral and ethical authority that lies within their reasoning and experiences. In Cannon’s view, “the concepts used by the majority of White male ethicists to discuss moral agency implicitly devalue Black women’s contribution” (p. 124). As a black womanist ethicist, the epistemological dilemma deepness, as black women confront the normative ethical system of whites, demonstrating a level of intelligence and sophistication in a masculine world, while also embracing the realities of black women. It is transcending blackness and femaleness, though simultaneously debunking the ideologies that reduce such things to a category of nothingness. Cannon illuminates the blatant disregard and devaluing of black women in society, scholarship, and now we turn our attention towards cantankerous practices and interpretations in African American churches.

**Hermeneutical Privileges of the Marginalized**

This reflection has illuminated the intersectionality of Cone and Cannon, by drawing upon their hermeneutical approaches to Christian theology, exposing evangelical Christianity as a slaveholding religion, and unveiling distinct (black liberation theology and womanist theology) theological categories and differentiated understandings of what it means to be black. There is no universal hermeneutic within marginalized communities, as there is an array of contributing factors that lead to marginalization. Cone and Cannon help us understand this. Both theologians drew upon their experiences and black historical artifacts (e.g., spirituals, storytelling, preaching, church traditions) to wrestle with biblical interpretations. It is aberrant to suggest that African American churches have not embraced a universal way of reading the Bible, particularly when one considers the consistent forms of marginalization that occur within those settings. Take for instance the various forms of gender discrimination that occur within African American churches, regardless of denominations. Cone was Baptist and Cannon was Presbyterian, yet gender discrimination crippled both denominations. Cone critiques Christian theology for its failure to include the black experience and Cannon for its refusal to include the realities of black women, yet it was not Christian theology within itself that created theological and ethical discomfort, but the white ethicists, philosophers, and theologians that interpreted (eisegesis) biblical passages. Evangelical Christianity and its emphasis on personal piety, morality, and salvation, became the dominant theology in African American churches, and there are few, if any, theological and ethical distinctions between White Americans and African Americans.
Cone and Cannon challenged the theo-ethical discourse of African American churches and illuminated the oppressive ideologies and slaveholding interpretations that did not reflect the God of Scripture. African Americans had every right to reinterpret biblical passages that sought to maintain the social control and constraints of slavery but doing so would require African Americans to ask probing questions of institutional traditions, on the congregational and denominational level, that housed domination, subordination, and subjugation. Some African American churches readily accepted the critiques of Cone and Cannon, understanding that both theologians come from a history of those (enslaved Africans) who embraced a liberating hermeneutic, while some African American churches remained loyal to the teachings of their ancestors. In those churches, biblical passages supported and sanctioned the marginalization of individuals on the sole basis of gender, class, disabilities, and sexual orientation. On the contrary, those churches who embraced a liberating hermeneutic have sought to reverse the constraints of evangelical Christianity, by reexamining ecclesiastical traditions and interpretations that divinely sanction marginalization. Sometimes tradition and experience, as sources of interpretations are the same, and there are times when the two are antithetical. Cone and Cannon sought to align tradition and experience with the Bible, thereby forging a liberating way of reading the Bible that allowed the marginalized to interpret biblical passages through the lenses of tradition and experience.
References


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 health care, science and the humanities, as well as the art and science of health care 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.

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

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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 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

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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):

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XI. Contact Information

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