



A Review of Hypertension/High Blood Pressure (HBP) or Diabetics and Associative Lack of Preventive Management Treatments among Blacks/African Americans and Black Caribbean in the Islands

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ABSTRACT

The purpose of this quantitative study was to focus on a review and a comprehensive data analyses about how preventable chronic diseases such as hypertension/high blood pressure (HBP) and diabetics impact the health wellbeing of Black/African Americans in the US and US Black in the US Virgin Islands Caribbean. This study used “Social Construction of the Ideology of Reality” Theory in decisions-making processes about what almost all government uses in addressing any peace of pandemics or non-pandemics’ times nationally and internationally. This study used both a Non-Experimental research study and Quasi-Experimental research as lens of data analyses; while comparing the pretests versus the posttests data statistics. The study found that pretests’ patients posed 57.6% of dying from diastolic BPs’ readings’ related effects untimely, and pretests’ patients posed 78% of dying from heart pulse BPs’ readings’ related effects. The study conversely found that posttests’ patients posed less than 11% of dying from diastolic BPs’ readings’ related effects untimely, and posttests’ patients posed less than 14% of dying from heart pulse BPs’ readings’ related effects. This study summed that hopefully one day, the insights gained and lessons learned from this critical research study will eventually bring some POSITIVE SOCIAL CHANGES to all Blacks/African Americans and US Virgin Island Caribbean in the US and possibly beyond.

KEYWORDS: *High Blood Pressure (HBP), Diabetics, Heart Attack, Seizures, Heart Failures, Low Blood Pressure, Dizziness, Light Headed, Refusal for Treatments, Lack of Accessibilities to Treatments, Agitations about Nothing, Collapse, Forgetfulness, Failure to Comply with Everyday Activities, Refusal to go Doctors’ Appointments, Defiance, Aggravated about Nothing.*

INTRODUCTION

Generally, history has it that hypertension or high blood pressure among Blacks/African Americans originated from the Sub-Sahara region; especially from West Africa where more than 85% to 95% plus of the slaves were illegally captured, negotiated, sold, illegally shipped, and enslaved in the unknown New World. Additional information has it that majority of the slaves who were captured, negotiated, bought, and sold, and shipped to the New World by the slaves 'masters and dealers in both ends were intentionally selected for their physical appearances and abilities' overwhelming manual labors' performances, which was possibly tied to excessive sodium among others in the blood system during those dark ages. However, for more than 400 plus years Blacks/African Americans have been in the New World such as in the US and in the Caribbean, successfully managing hypertension or high blood pressure(HBP) was/is still defined and classified as chronic disease among others and minorities in general. Conversely, like other easily manageable chronic diseases such as HBP and diabetics among others, which can be effectively, efficiently, and proficiently easily treatable and managed by personal physicians and possibly a few annual specialized physicians' referrals, such chronic diseases such as HBP and diabetics have been classified assystemic and systematical form of systematic and symmetric "**DEAD SENTENCE**" when it comes to Black/African Americans in the US and Caribbean. From overall generalized viewpoints, **HPB** is defined to many as a "**The Silent Killer**"; because it always strikes without any anticipated warning, that is HBPs' effects for you all. As such, the focus of this research study was to comprehensively review and analyze the roles races' play in the treatments or lack of treatments and lack of preventive management of hypertension or high blood pressures HBP among Blacks/African Americans and Caribbean in the New World.

BACKGROUND OF THE STUDY

Studies upon studies have shown that when it comes to addressing chronic diseases such as hypertension or high blood pressure not to mention diabetes along with other chronic diseases in the US and in the Caribbean, Blacks/African Americans along with Black Caribbean were/are always kept in the back burners (see Atatah, Kisavi-Atatah, & Kpehe, 2021; Flack, 2010; Carey, 2008 for more details). As an example medical implications for Blacks/African Americans during COVID-19 pandemic between 2019 and 2022 as an example. While hypertension or high blood pressure along with diabetics are classified as simple manageable diseases in the US, Black/African Americans, and the Blacks in the Caribbean were/are always exempted from applicable manageable treatments when it comes to chronic diseases such as hypertension or high blood pressure along with diabetics' diseases. As such, this study focused on a comprehensive review and data analyses of how preventable chronic diseases such as hypertension/high blood pressure and diabetics impact the health wellbeing of Black/African Americans in the US and Black in the Caribbean Islands.

LITERATURE REVIEW

Chronic diseases are defined broadly as medical conditions that last one years or more that required ongoing medical attention or limit activities of daily living or both; hypertension and high blood pressure are some good examples of chronic diseases which are the early indicators of heart disease. Other chronic diseases like heart disease, cancer, and diabetes are the leading cause of death and disability in the United States of America (USA). While paying critical attention to chronic diseases' treatments is fundamental as to prevent guaranteed expected

preventable complications, when it comes to Black/African Americans in the US in particular, they are always left unattended until it is too late to cry. Beside the above, International Society on Hypertension in Blacks (ISHIB, 2010) indicated that simply reducing HBP in Black/African Americans in the US was not only fundamental, but it was significant to be achieved among all Blacks worldwide (see Flack et al., 2010; About Ethnicity & Diseases, 2010; Carey, 2008 for more details). Pinpointed, as stipulated by Flack et al in 2010, the **slavery hypertension hypothesis** proposes that disproportionately high rates of hypertension among black people in the New World are due to selection bias preferring individuals who retain more sodium among black slaves during the Middle Passage. Presumably about this blinded aged hypothesis, such default selections' processes could have been that Blacks in Africa were people on earth who were able to work under the hot burning sun for hours upon hours and days upon days without being tired or even complain about the exhaustion from such backbreaking "**HARD LABOR**" repeatedly.

This was/is a blind hypothesis during the dark days and possibly, such an unproven hypothesis could have contributed to the systematic development of hypertension gene which was passed down from generations to generations in Africa and exported to the New World. In addition to the above, a body of research studies has shown that there are correlations between individual geographical location with the intensities of HPB (see Kaufman et al., 2003; Thompson et al., 2004; Dubner, 2005 for more details). These studies showed a substantial correlation between geographical latitude and the CPY3A5 allele distribution, with African Americans descended from the slave trade having retained the equatorial haplotype. For example, In 2005 the thesis that black Americans who trace their immigration to the slave era experience lower life expectancy due to hypertensive disease associated with the slave trade was revisited by the distinguished academic team of David Cutler (senior health care advisor to Barack Obama), Roland G. Fryer Jr. (economist and 2011 MacArthur Fellow) and Nathan Glazer (Dubner, 2005). Another study showed that Black Americans having descended from the slave trade have largely retained the allele associated with equatorial populations, have higher sodium retention than other populations in America "(including black people who later emigrated to America after the slave trade had ended)" p. 399, and have correspondingly higher hypertensive disease (Cutler et al., 2005). Precisely, since it was originally proposed, the hypothesis has been challenged, and it has been described as a myth" Detractors argue that the hypothesis is inconsistent with historical evidence regarding salt deficiency in Africa or the causes of death aboard slave ships. Grim and Robinson responded to Kaufman and Hall, maintaining the validity of the hypothesis and its consistency with historical descriptions of slavery (see Chowkwanyun, 2007; Obasogie, 2007; Armelagos, 2005; Curtin, 1992; Grim & Robinson, 2003 for more details). The questions now become was/is HBP in Blacks/African Americans in the New World was/is due to their historic geographical heritage? Was/is the classification of HPB in Blacks/African Americans in the New World a "MYTH" or another form of discrimination or deprivation from obtaining simple medical care in the USA? In short, this study focused on a review and a comprehensive analysis of how preventable chronic diseases such as hypertension/high blood pressure HBP and diabetics impact the health wellbeing of Black/African Americans in the US and Black in the Caribbean's Islands.

THEORETICAL FRAMEWORK

This study used "**Social Construction of the Ideology of Reality**" Theory in making decisions about what almost all government uses in addressing any peace of pandemics or non-pandemics' times nationally and internationally (see Berger & Luckmann, 1966 for more details). For example, this theory assists leaderships, being public or

private leaderships, to make decisions due to the anticipated “**Social Construction of the Ideology of Reality Theory.**” As a result of the previously pinpointed issues that dealt with lack of transparencies about COVID-19 for example, races’ differences actual and accurate effects this theory fits perfectly as a lens of data analyses in this study; hence it was selected. Furthermore, Lack of transparency leads to false information, misinformation, disinformation, and intentional lying when it comes to dealing with Black/African Americans’ health efficacies’ issues for more than 400 years in the US and Blacks in the Caribbean, especially those in the US Virgin Islands. For example, HPB and diabetics among Blacks/African Americans in the US and US Caribbean have been intentionally unviewed, undermined, discounted, dismissed, degraded, undergrounded, and even underscored and classified as their inherited chronic diseases from their **MOTHERLAND** (Africa), which are untreatable in the US which is not true. These assumptions, presumptions, preconceptions, and false full preconceptions fell perfectly under one of the many unproven premises of “**Social Construction of the Ideology of Reality Theory**”; hence it was selected as the theoretical lens of analysis of framework in this comprehensive public health research study.

DESIGN AND METHODOLOGY OF THE STUDY

This study used a quantitative methodology “**Non-Experimental “Descriptive Statistics”**” research method to quantify its data statistics collections from its secondary data to analyze its statistical differences between its independent and dependent variables (see Frankfort-Nachmias & Nachmias, 2008; Creswell, 2009 for more). Since all participants were introduced to some forms of interventions, and secondary data were collected from the confidential Southwest clinic in Houston, Texas, that means that a pretest and a posttest data analysis was appropriate for the quantitative research study. That was precisely why “**Non-Experimental Descriptive Statistics**” methodology was selected over “**Real-Experimental or Quasi-Experimental**” methodologies.

COLLECTION OF DATA

This study data collection was divided into two major sections which fell into “**Pretests**” and “**Posttests**” in the study’s data analyses. Confidential seconding data was collected from a healthcare clinic in Southwest Houston, Texas for statistical data analyses. The pretests data was classified as patients who were either not treated, undertreated, for HBP or Diabetics in the healthcare clinic; while the posttest data comprises of patients who eventually receive moderate treatments due to affordability or due to having jobs that carry healthcare insurance coverage or due to buying into “**Affordable Care Act (ACA)**”, also known as “**Obama Care.**” The collected data was fed into **Statistical Package of Social Sciences (SPSS) version 27** for analysis.

DEMOGRAPHICS

All participants were Blacks/African Americans Black Caribbean from the US Virgin Islands between the ages of 20 to 75 years old.

All participants live in the Southwest Houston Harris County, Texas area; of the initial 125 participants 20 out of 125 or 16% were Black Caribbean from the US Virgin Islands with residences in Southwest Houston Harris County, Texas area.

There were 77 men and 48 females in the study which equals 125 but 100 participants were randomly selected; and their blood pressures measurements were collected for 1125 times in three months.

Their blood pressure BP measurements were randomly scheduled for during mornings, afternoons, and evenings to obtain accurate readings of their blood pressure readings in different periods of the days.

All participants resided in Southwest Houston Harris County, Texas area/s.

Some participants were either not treated, previously treated, currently under treatments, or undertreated for **HBP** or Diabetes or for other chronic diseases, just to mention a few.

All participants' social, personal, and interpersonal demographics information was kept confidential to protect the privacy of the participants.

Pretests' Selection

Of the 125 participants' blood pressures readings collected from the participants, **100 BPs' readings** out 125 PBs readings or 80% were randomly selected and fed in **SPSS Version 27** for analysis. However, pretests were taken from the participants' BP readings and analyzed, thereafter, participants were given different types of preventable treatments by using some machines and equipment at home and others that can be used in the Houston Harris County Southwest clinic for further analyses.

INTERVENTION

Participants were advised to control their fatty food intakes, take **81 mg of Aspirin daily**, along with other minor **PB medications** prescribed by their personal physicians or their cardiologists, and all participants were placed in less stress daily exercises' activities such as:

1. Climbing staircases instead of using the elevators, bicycling at an average strength levels, walking slowly at **least 3 to 4 times weekly**, to complete at least **2500 steps** a day, use steps' monitor known as "Walk Tracker" to count their actual walking steps, which can be downloaded for free of charge from their smart phones.
 - A. Start with at least 1000 steps in the first week which should take less than 25 minutes to 30 minutes to complete.
 - B. In week two, increase it to 1500 steps walk which should take approximately 30 to 35 minutes to complete.
 - C. Increase it to 2000 steps in week three which should take approximately 35 to 40 minutes to complete it.
 - D. In week four increase it to 2500 steps' walks which should take approximately 40 to 45 minutes to complete; don't rush it, take your time because evidence showed that you have not exercise in a while, just give your body some time to build up some strength systematically.
 - E. Furthermore, in week five you should complete at least 3500 to 4000 steps walks and continue to increase it gradually weekly in accordance based on your strengths' capacities.

- F. Don't walk at night and don't walk near any dip or swallow water bodies, because it can be dangerous in case of stroke, collapses, and seizures, which can be triggered due to high blood pressure, low blood pressure, or irregular uncontrolled blood pressures' readings.
- G. Don't walk when the weather is too hot; walk in the mornings or evenings when the weather is cooler and ensure that you are visible to the crowd for safety purposes.
- H. Finally, don't cook anywhere when you are home alone; don't take baths, instead take showers, don't swim, don't climb ladders or staircases when you are dizzy, and if it is possible always have at least one family member available to monitor you consistently.
- I. **STOP SMOKING**, if the patients have a history of smoking and drinking, please, **absolutely no drinking of any alcohol beverages**.
2. Jogging on the treadmill at home, and for those who cannot afford it, to join the gym such as affordable **YMCA** in Houston Harris County, Texas to accomplish the above treatment interventions. Note that YMCA is a non-governmental federation with each independent local affiliation with national organization. The YMCA was founded in 1844 and it has more 178 years of excellent customers' services record of exercises history, and it is affordable to many for less than .50 cents a day payment. **As for those who cannot afford YMCA fees, they were advised to go to a nearby parks as to meet the cardiologists' prescribed exercises' obligations, because walking in any neighbourhoods' parks in Houston Harris County, Texas is free for all; and there should be "NO MORE EXCUSES" for not exercising weekly as prescribed by the cardiologists.**
3. Participants were also advised to take their BP measurement at least twice daily (one in the mornings & one in the evenings) for three months. However, those with more chronic hearts' conditions were assigned to home **EKG** monitors, which allow the cardiologists to monitor their EKGs' readings in cardiologists' clinic.
4. In other untestable BP cases due to irregular BPs, among others just to mention a few, the participants were scheduled for heart's stress tests such the heart's treadmill stress tests, and for those who cannot sustain walking, jogging, or running on the treadmill tests as it intensifies its strength, nuclear camera tests was prescribed for them to take the picture images of their hearts **during relax mode as well as during stress mode** for analyses by the cardiologists thereafter. Finally, the obtained data statistics were fed into **SPSSVersion 27** for a new BP readings analysis for the posttests.
5. Finally, if any patients may be experiencing any medical issues that may be "**Out of the Normal**", for example having problem breathing, passing out, collapse, physical changes in their faces, or slow speech, having problems remembering every day-to-day items or peoples' names, dizziness, agitated about nothing, complains about chest persistently, unnecessarily aggressive about nothing, shows absolute non compliances about nothing especially about taking his or her prescribed medications, just to mention a few, if the above are observed by the immediate significant, family members, or caretakers, **please, don't call this clinic, please, call 911 for emergencies' medical assistance immediately.**

Posttests' Selection

Upon the completion of the cardiologists' prescribed intervention methodology after three months, participants brought their BPs' readings monitors to the clinics to be downloaded and uploaded into SPSS Version 27 for posttests' analyses after randomly selection of 100 out 125 or 80% BPs' readings which were downloaded.

Example of the High Blood Pressure (HBP) Measurement Equipment/s below

Figure 1. Heart Nuclear Camera



Figure 1. Shows an example of a heart “nuclear camera” which can scan and take pictures and images of one’s heart during relax mode and stress mode; they are available in different forms and designs (see figure 1 above for more details).

Figure 2. Blood Pressure Arm Monitor



Figure 2. Shows a classical form of Blood Pressure Arm monitor which is commonly used in clinics, hospitals, and at home; the numbers indicated above showed a near perfect BP reading (see figure 2 above for more details).

Figure 3. Blood Pressure Wrist Monitor



Figure 3. Shows a classical form of Blood Pressure Wrist monitor which is commonly used in clinics, hospitals, and at home; the numbers indicated above showed a near perfect BP readings (see figure 3 above for more details).

Figure 4. Portable Electrocardiography or Electrocardiogram (EKG) Machine

Figure 4. Shows Electrocardiography or Electrocardiogram (EKG) monitor machine is a simple heart test machine that takes a quick test that records heart's electrical activities each time heart beats, an electrical signal travels through the heart. Consequently, this continuous portable EKG monitor machine can detect if there are initially developed blockages, partial blockages, or complete blockages of electrical activities' communication blockages between the upper and the lower chambers of one's heart, which could lead to sudden death without any warning. It should be noted that in more critical cases, patients with serious or complete blockages may be scheduled for some form of surgical works to correct them, if the patients can afford it financially or if they have any insurance that will accept the procedure/s, or if they can afford the applicable copays for such surgical operation/s (see figure 4 above for more details details).

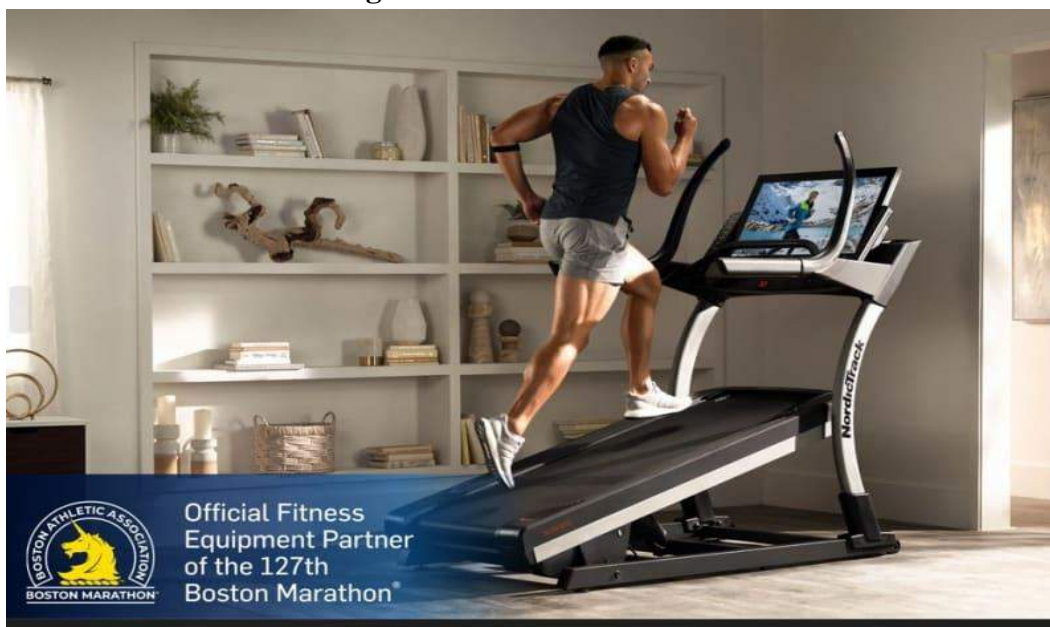
Figure 5. Exercise Treadmill

Figure 5. Shows an example of a specialized exercise treadmill which can be fitted into an independent heart's images and pictures to demonstrate the condition of one's heart during relaxation and stress modes (see figure 5 above for more details).

Figure 6. Regular Heart Monitor Camera



Figure 6. Shows an example of a regular heart monitor camera which can take the images and pictures as the patient runs on the above treadmill during relaxation and stress modes (see figures 5 & 6 above for more details).

Hypotheses

This study hypothesized two major Alternative Hypotheses:

Alternative Hypothesis 1: *H1*

1. There are relationships between races' identifications and classifications and the treatments of Blacks/African Americans and Blacks in the US Virgin Islands' Caribbean when it comes to effective healthcare treatments of **HBP** and possibly diabetics.

Null Hypothesis 1: *H0*

1. There are no relationships between races' identifications and classifications and the treatments of Blacks/African Americans and Blacks in the US Virgin Islands' Caribbean when it comes to effective healthcare treatments of **HBP** and possibly diabetics.

Alternative Hypothesis 2: *H1*

- Blacks/African Americans and Blacks in the US Virgin Islands’ Caribbean are more likely to die due to lack of effective chronic diseases’ healthcare treatments and lack of healthcare accessibilities such as **HPB** and possibly diabetics.

Null Hypothesis 2: *H0*

- Blacks/African Americans and Blacks in the US Virgin Islands’ Caribbean are less likely to die due to lack of effective chronic diseases’ healthcare treatments and lack of healthcare accessibilities such as **HBP** and possibly diabetics.

THE RESULTS AND FINDINGS OF THE STUDY

Pretests Results and Findings of the Study

Table 1. Frequencies and Statistical Data of the Pretests Results and Findings of the Study

		Statistics		
		Pretest Systolic BP Readings	Pretest Diastolic BP Readings	Pretest Pulse BP Readings
N	Valid	100	100	100
	Missing	0	0	0
Mean		169.5700	85.2500	52.2400
Std. Error of Mean		1.93397	.82037	.77618
Median		169.0000	86.5000	50.5000
Mode		165.00	89.00	45.00 ^a
Std. Deviation		19.33974	8.20369	7.76176
Variance		374.025	67.301	60.245
Skewness		-.311	-.799	.489
Std. Error of Skewness		.241	.241	.241
Kurtosis		.053	.466	-.609
Std. Error of Kurtosis		.478	.478	.478
Range		97.00	39.00	30.00
Maximum		209.00	99.00	70.00
Sum		16957.00	8525.00	5224.00

a. Multiple modes exist. The smallest value is shown

Table 1. Shows the mean of systolic BP readings of 169.6, diastolic BP readings of 85, and pulse BP readings of 52.2; additionally, it showed the range of 97, 39, and 30 consistently (see Table 1 above for more details).

Figure 7. Pretest Systolic BP Readings

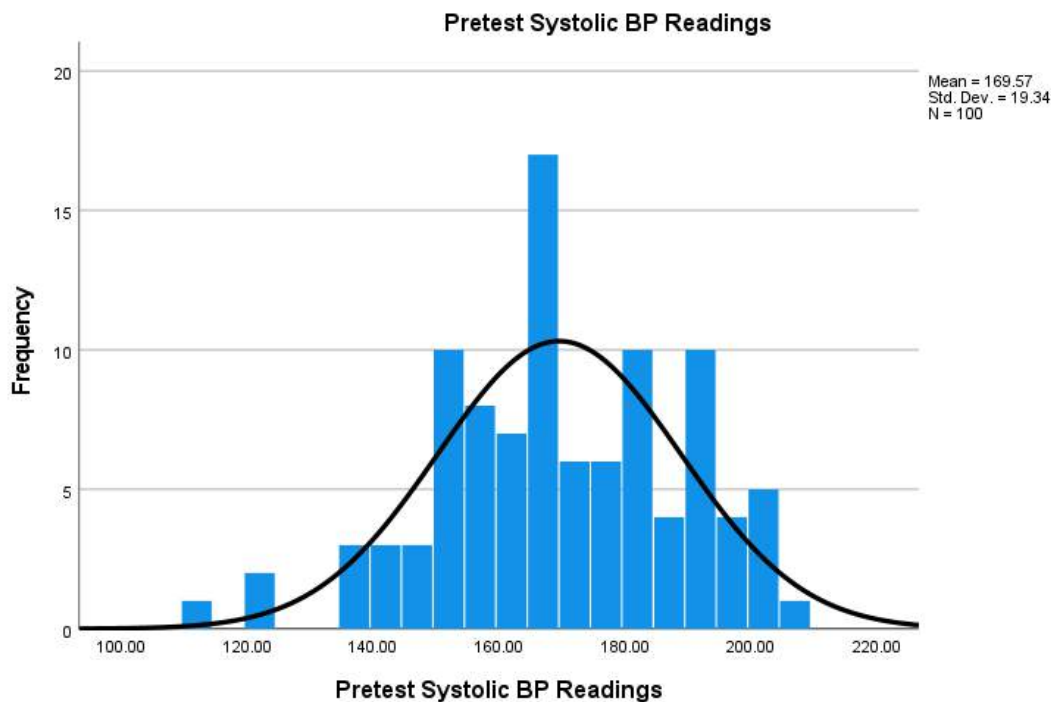


Figure 7. Shows pretest systolic BP readings mean of 169.6 and the std. dev. of 19.34 with a sway of 120 to 210 ranges which was too high (see Figure 7 above for more details).

Figure 8. Pretest Diastolic BP Readings

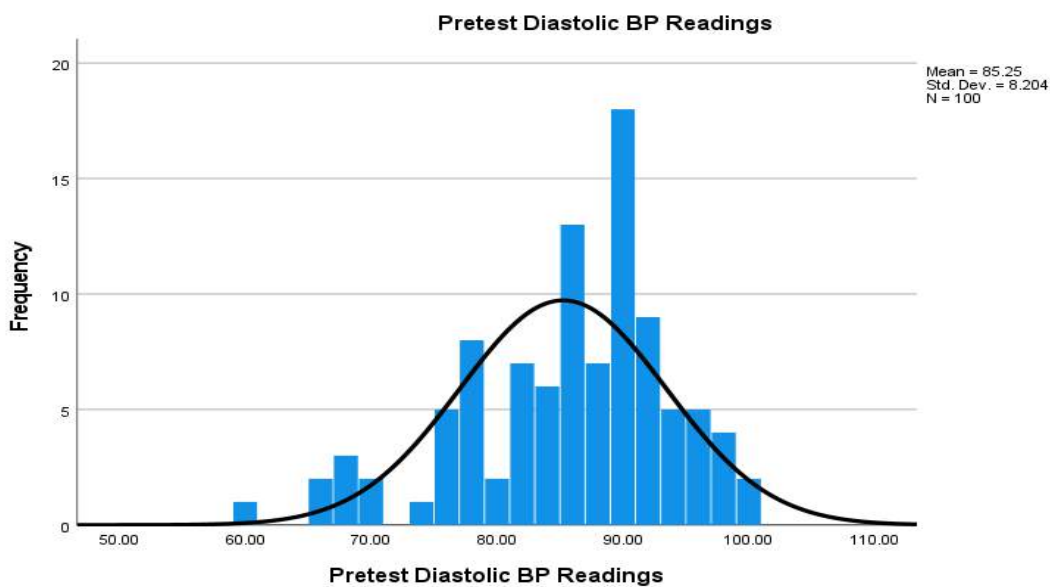


Figure 8. Shows pretest diastolic BP readings mean of 85.25 and the std. dev. of 8.2 with a sway of 80 to 110 ranges which was too high (see Figure 8 above for more details).

Figure 9. Pretest Pulse BP Readings

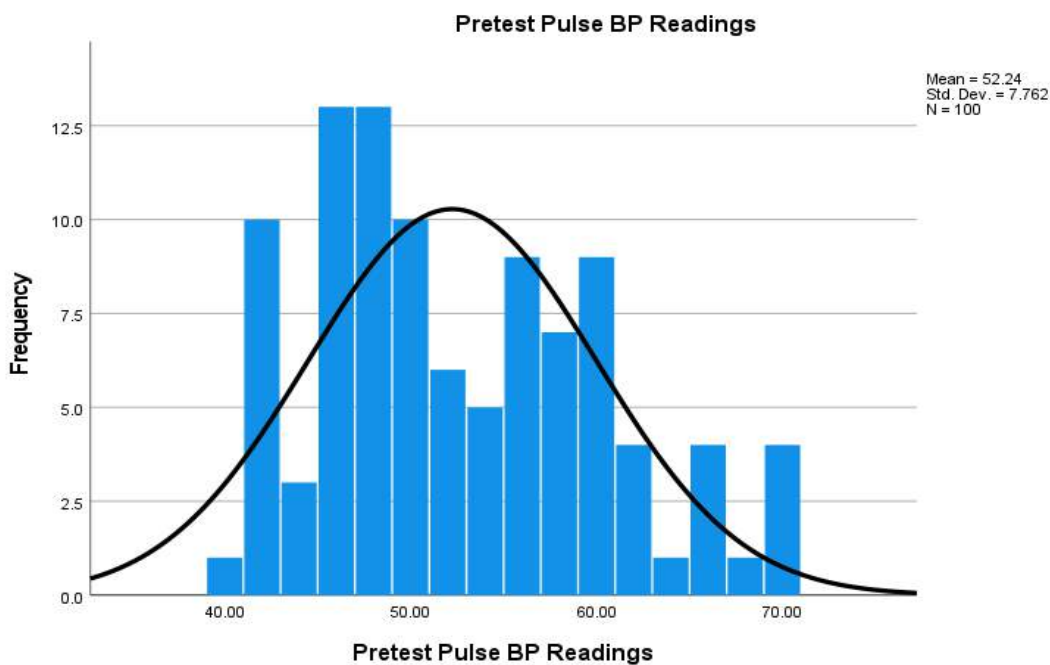


Figure 9. Shows pretest pulse BP readings mean of 52.2 and the std. dev. of 7.8 with a sway of 40 to 70 ranges which was too low (see Figure 9 above for more details).

Figure 10. Pretest Systolic BP Readings

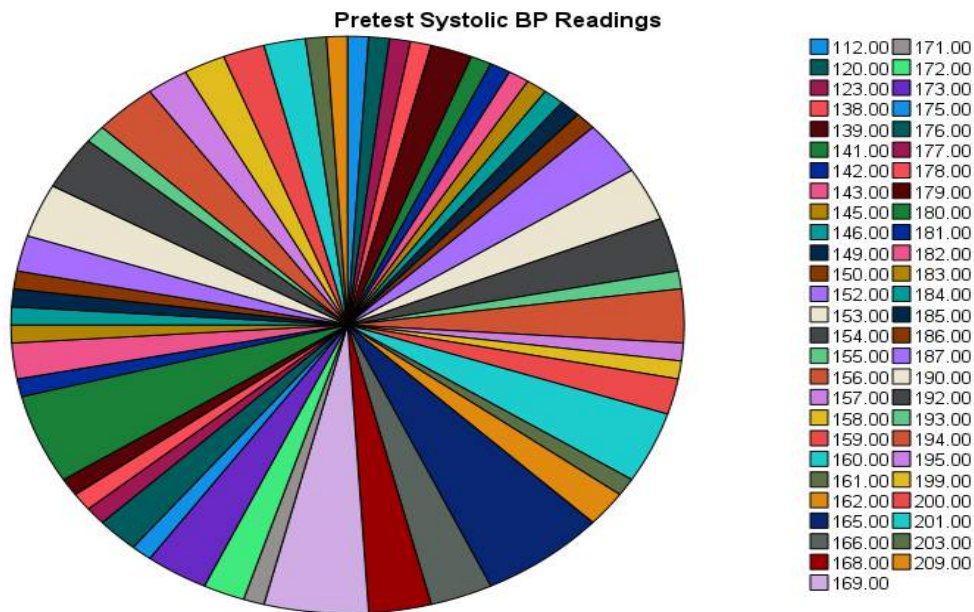


Figure 10. Shows pretest systolic BP Readings only two readings fell between 112 and 120; the remaining items fell from 123 to 203s' readings (see Figure 10 above for more information).

Figure 11. Pretest Diastolic BP readings

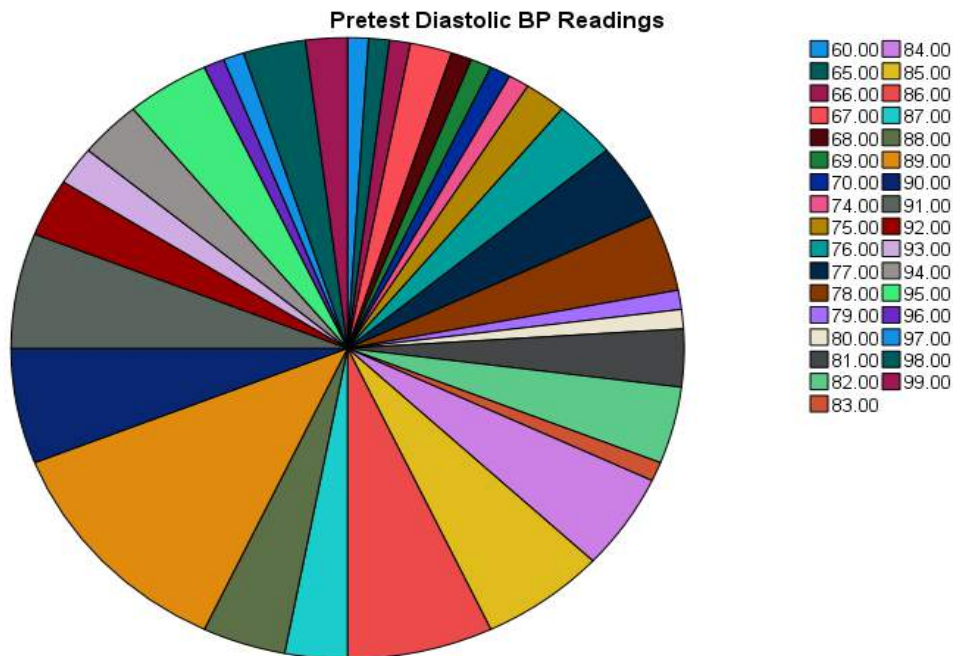


Figure 11. Shows pretest diastolic BP Readings only 14 reading fell between 60 and 80; the remaining items fell from 81 to 99 BPs' points readings (see Figure 11 above for more information).

Figure 12. Pretest Pulse BP Readings

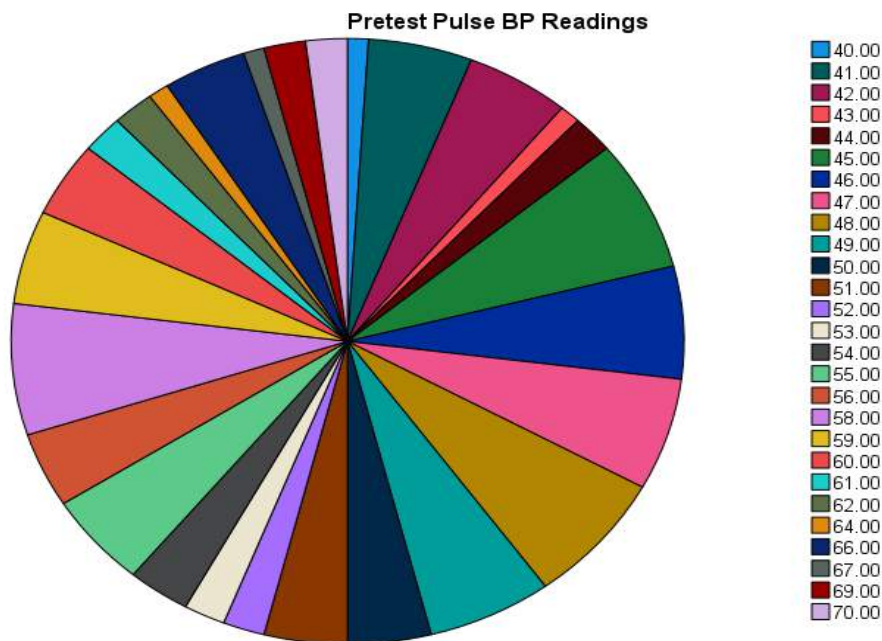


Figure 12. Shows pretest pulse BP Readings all reading fell between 40 and 70; no pulse BP reading was not up to 72 beats per minute (BPM) as medically recommended (see Figure 12 above for more information).

Table 2. T-Test One-Sample Statistics

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Pretest Systolic BP Readings	100	169.5700	19.33974	1.93397
Pretest Diastolic BP Readings	100	85.2500	8.20369	.82037
Pretest Pulse BP Readings	100	52.2400	7.76176	.77618

Table 2. Shows pretest systolic BP Readings' mean of 169.6, pretest diastolic BP Readings' mean of 85.3, and pretest pulse BP Readings' mean of 52.2; and N was 100 no missing number (see Table 2 above for more details).

Table 3. One-Sample Test

One-Sample Test						
Test Value = 0						
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Pretest Systolic BP Readings	87.680	99	.000	169.57000	165.7326	173.4074
Pretest Diastolic BP Readings	103.917	99	.000	85.25000	83.6222	86.8778
Pretest Pulse BP Readings	67.304	99	.000	52.24000	50.6999	53.7801

Table 3. Shows Sig. (2-tailed) of .000, .000, and .000, which shows a 100% correlation between dependent and independent variables (see Table 3 above for more details).

Table 4. One-Sample Effect Sizes

One-Sample Effect Sizes					
		Standardizer ^a	Point Estimate	95% Confidence Interval	
				Lower	Upper
Pretest Systolic BP Readings	Cohen's d	19.33974	8.768	7.531	10.001
	Hedges' correction	19.48781	8.701	7.474	9.925

Pretest Diastolic BP Readings	Cohen's d	8.20369	10.392	8.932	11.848
	Hedges' correction	8.26650	10.313	8.864	11.758
Pretest Pulse BP Readings	Cohen's d	7.76176	6.730	5.773	7.685
	Hedges' correction	7.82118	6.679	5.729	7.627

a. The denominator used in estimating the effect sizes.

Cohen's d uses the sample standard deviation.

Hedges' correction uses the sample standard deviation, plus a correction factor.

Table 4. Shows effect sizes of 19.3 for Cohen’s differences, 19.5 for Hedges’ correction for the pretest systolic BP readings, and 8.2 and 8.2 for the pretest diastolic BP readings and 7.8 and 7.8 for the pretests of pulse BP readings (see Table 4 above for more details).

Posttests Results and Findings of the Study

Table 5. Frequencies and Statistical Data of the Posttests’ Results and Findings of the Study

		Statistics		
		Posttest Systolic BP Readings	Posttest Diastolic BP Readings	Posttest Pulse BP Readings
N	Valid	100	100	100
	Missing	0	0	0
Mean		123.4100	80.7100	81.9300
Std. Error of Mean		.82927	.61960	.74036
Median		122.0000	81.0000	81.0000
Mode		120.00	80.00	81.00
Std. Deviation		8.29274	6.19595	7.40360
Variance		68.770	38.390	54.813
Skewness		.285	-.976	-.078
Std. Error of Skewness		.241	.241	.241
Kurtosis		-.429	5.477	-.445
Std. Error of Kurtosis		.478	.478	.478
Range		39.00	48.00	35.00
Maximum		145.00	98.00	99.00
Sum		12341.00	8071.00	8193.00

Table 5. Shows the mean of systolic BP readings of 123, diastolic BP readings of 80, and pulse BP readings of 82; additionally, it showed a range of 39, 48, and 35 consistently (see Table 5 above for more details).

Figure 13. Posttest Systolic BP Readings

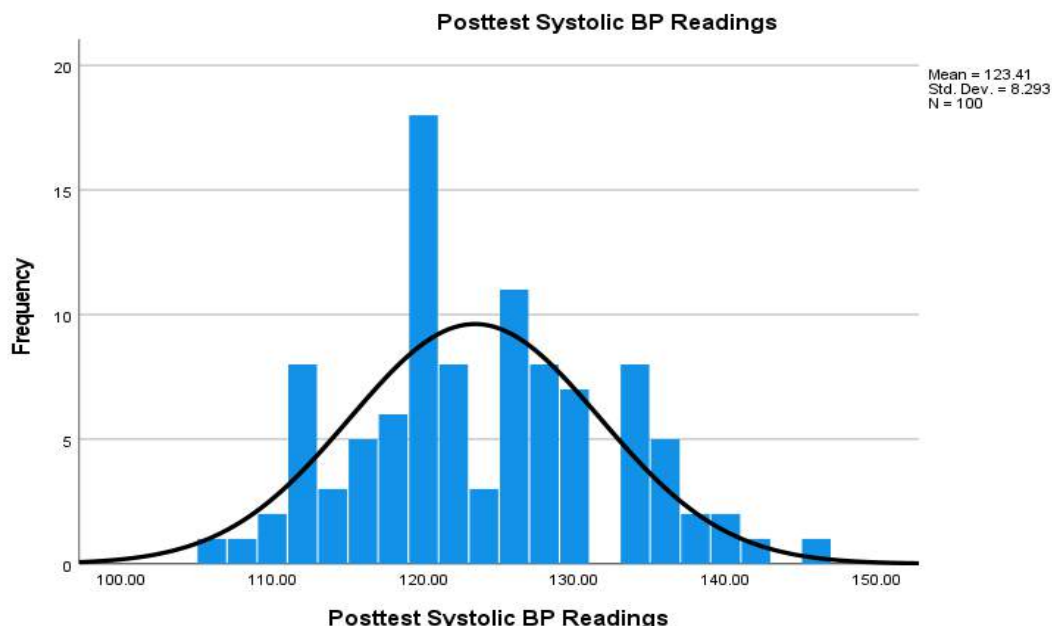


Figure 13. Shows posttest systolic BP readings mean of 123 and the std. dev. of 8.3 with a sway of 105 to 140 ranges was within normal (see Figure 13 above for more details).

Figure 14. Posttest Diastolic BP Readings

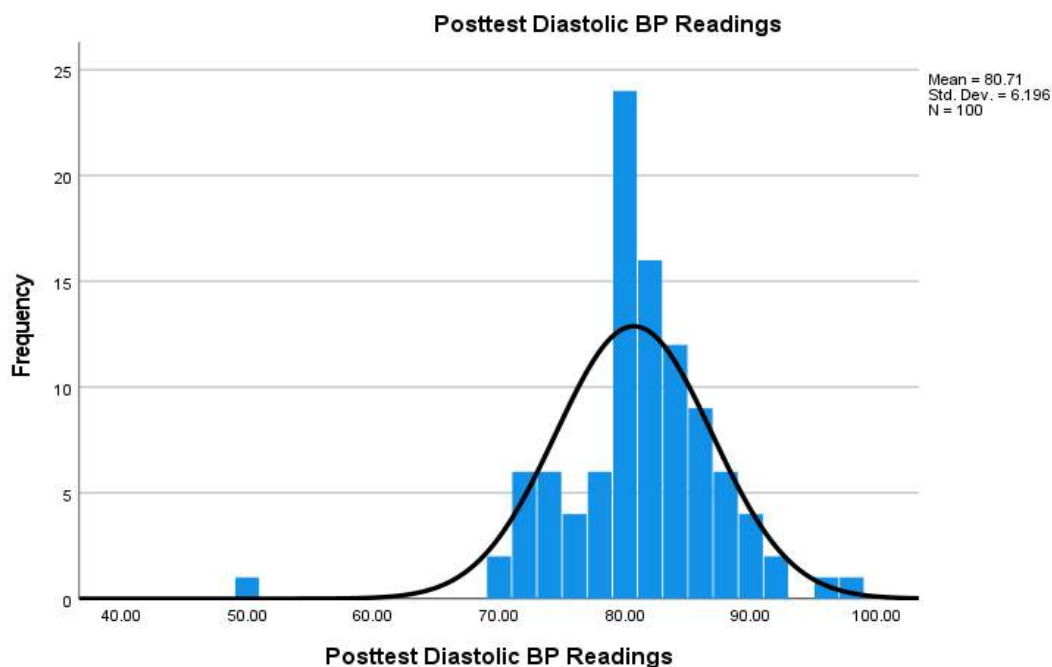


Figure 14. Shows posttest diastolic BP readings mean of 80.7 and the std. dev. of 6.2 with a sway of 70 to 90 ranges was within normal (see Figure 14 above for more details).

Figure 15. Posttest Pulse BP Readings

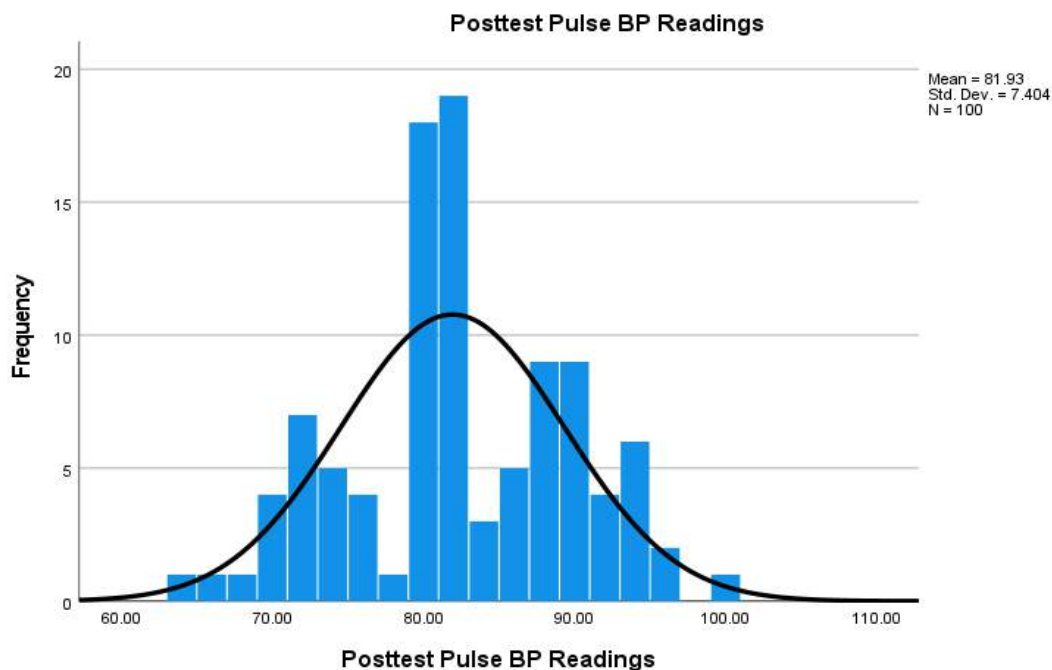


Figure 15. Shows posttest pulse BP readings mean of 82 and the std. dev. of 7.4 with a sway of 65 to 95 ranges was within normal (see Figure 15 above for more details).

Figure 16. Posttest Systolic BP Readings

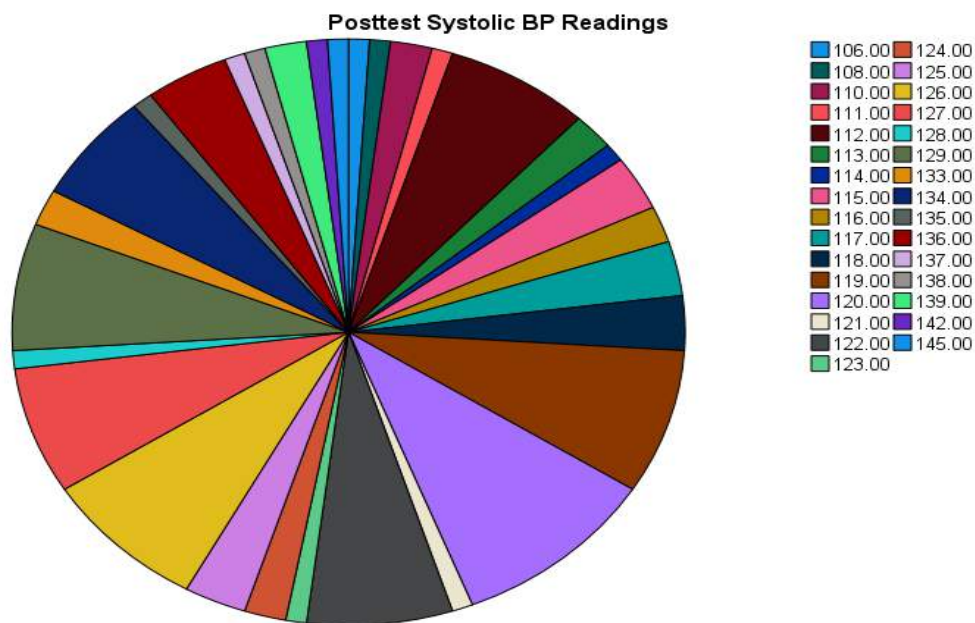


Figure 16. Shows posttest systolic BP Readings only two readings fell between 106 and 120; the remaining items fell from 121 to 145s' readings the range was within normal (see Figure 16 above for more information).

Figure 17. Posttest Diastolic BP Readings

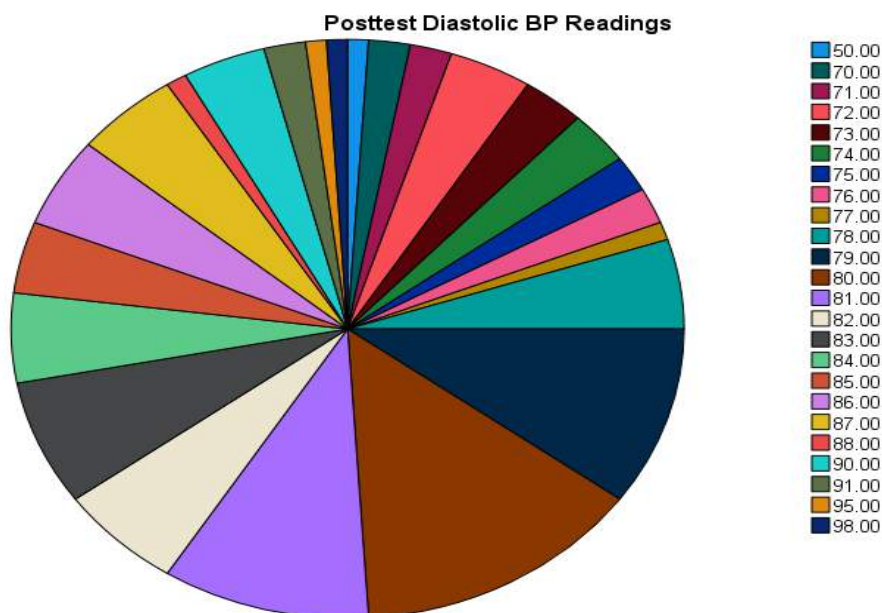


Figure 17. Shows posttest diastolic BP Readings 14 readings fell between 50 and 80; 10 of remaining items fell between 81 to 98 BPs' points readings the range was within normal (see Figure 17 above for more information).

Figure 18. Posttest Pulse BP Readings

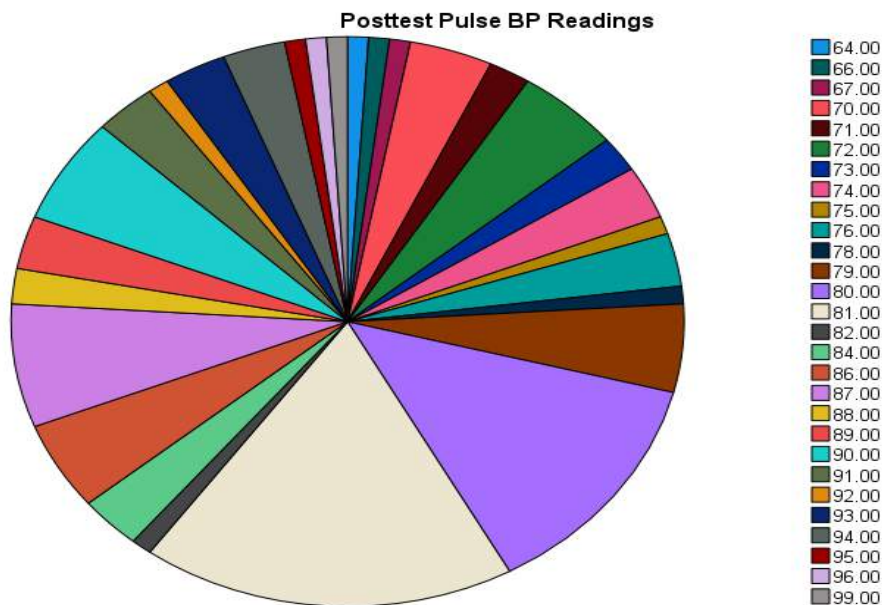


Figure 18. Shows posttest pulse BP Readings all reading fell between 64 and 99; 14 pulse BP readings were between 64 and 81 beats as recommended (see Figure 18 above for more information).

Table 5. T-Test One-Sample Statistics

One-Sample Statistics				
	N	Mean	Std. Deviation	Std. Error Mean
Posttest Systolic BP Readings	100	123.4100	8.29274	.82927
Posttest Diastolic BP Readings	100	80.7100	6.19595	.61960
Posttest Pulse BP Readings	100	81.9300	7.40360	.74036

Table 5. Shows posttest systolic BP Readings' mean of 123.4, posttest diastolic BP Readings' mean of 81, and posttest pulse BP Readings' mean of 82 in the posttests data analyses; N was 100 no missing number(see Table 5 above for more details).

Table 6. One-Sample Test

One-Sample Test						
Test Value = 0						
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Posttest Systolic BP Readings	148.817	99	.000	123.41000	121.7645	125.0555
Posttest Diastolic BP Readings	130.263	99	.000	80.71000	79.4806	81.9394
Posttest Pulse BP Readings	110.662	99	.000	81.93000	80.4610	83.3990

Table 6. Shows Sig. (2-tailed) of .000, .000, and .000, which shows a 100% correlation between dependent and independent variables in the posttests data analyses (see Table 6 above for more details).

Table 7. One-Sample Effect Sizes

		One-Sample Effect Sizes			
		Standardizer ^a	Point Estimate	95% Confidence Interval	
				Lower	Upper
Posttest Systolic BP Readings	Cohen's d	8.29274	14.882	12.801	16.958
	Hedges' correction	8.35624	14.769	12.704	16.829
Posttest Diastolic BP Readings	Cohen's d	6.19595	13.026	11.202	14.846
	Hedges' correction	6.24339	12.927	11.117	14.734
Posttest Pulse BP Readings	Cohen's d	7.40360	11.066	9.513	12.616
	Hedges' correction	7.46028	10.982	9.441	12.520

a. The denominator used in estimating the effect sizes.

Cohen's d uses the sample standard deviation.

Hedges' correction uses the sample standard deviation, plus a correction factor.

Table 7. Shows effect sizes of 14.9 for Cohen's differences, 14.7 for Hedges' correction for the pretest systolic BP readings, and 13 and 12.9 for the pretest diastolic BP readings and 11 and 10.98 for the posttest of pulse BP readings in the posttests data analyses (see Table 7 above for more details).

INTERPRETATIONS OF THE RESULTS AND FINDINGS OF THE STUDY

Based on this research study's overwhelming data analyses of the pretests versus posttests comparison analysis, the study found that posttests data outcomes profoundly outweighed and overly performed pretests' efficacies' outcomes (see Tables 1 to 10 and Figures 1 to 7 for more details & Tables 1, 2, 3, & 4 & Figures 7, 8, 9, 10, 11 & 12 for more details as well). The study also found that if the pretests data participants remain unchanged for a reasonable period time, the patients in this avenue (pretests) are more likely to die from such chronic diseases such as HPB and diabetics' effects such as heart attack, stroke, heart failure, dead progressive parts of body limbs such as legs and arms, and many other, just to mention a few. For instance, Table 1. Shows the mean of systolic BP readings of 169.6 but as high as 209, diastolic BP readings of 85 but as high as 99, and pulse BP readings of 52.2; but as low as low as 38 beats per minute (BPM) in the data analyses. Additionally, it showed the ranges of 97, 39, and 30 consistently (see Tables 1, 2, 3, & 4 & Figures 7, 8, 9, 10, 11 & 12 above for more details). Practically speaking, pretests posed pretests' patients 90.5% of dying from systolic BPs' readings' related effects untimely, pretests' patients posed 57.6% of dying from diastolic BPs' readings' related effects untimely, and pretests' patients posed 78% of dying from heart pulse BPs' readings' related effects.

Conversely, Table 5. Shows the mean of systolic BP readings of 123 but as low as 105, diastolic BP readings of 80 but as low as 60, and pulse BP readings of 82 but as low as 64 beats per minute (BPM) in the data analyses. Additionally, it showed a range of 39, 48, and 35 consistently (see Tables 5, 6, 7, & 8 & Figures 13, 14, 15, 16, 17 & 18 above for more details). Reversely, posttests posed posttests' patients less than 1% of dying from systolic BPs' readings' related effects untimely, posttests' patients posed less than 11% of dying from diastolic BPs' readings' related effects untimely, and posttests' patients posed less than 14% of dying from heart pulse BPs' readings' related effects. Above all, it should be that noted that diabetics' effects was not measured or analyzed in this study, however, it should be known that diabetics are the micro cousins of High Blood Pressures or Low Blood Pressures (HPB or LBP), if not treated immediately. For example, whenever diabetics such as excess blood sugar levels A1C are not treated or controlled immediately, the patients face higher risks of dying from stroke, heart attack, heart failure, dead parts of the body which normally lead to amputations and many other diabetics' effects just to mention a few. While diabetics' effects was not analyzed or measured in this study, there was a similar relationship between HBP's effects and dietetics' effects because HBP and diabetics are the "Silent Killers" micro cousins.

ANALYSES OF THE HYPOTHESES" INTERPRETATIONS OF THE STUDY

Alternative Hypothesis 1: *H1*

1. There are relationships between races' identifications and classifications and the treatments of Blacks/African Americans and Blacks in the US Virgin Islands' Caribbean when it comes to effective healthcare treatments of **HBP** and diabetics.

The study found that the two-tailed data analyses showed a profound statistically significant difference of .000 which showed a statistical relationship between the dependent and independent variable. As such the study accepted the **Alternative 1:H1** hypothesis and rejected Null1: **H0** due to the results and finding of pre-tests versus post-tests in this study(see table x for more).

Alternative Hypothesis 2: *H1*

1. Blacks/African Americans and Blacks in the US Virgin Islands' Caribbean are more likely to die due to lack of effective chronic diseases' healthcare treatments and lack of healthcare accessibilities from **HPB** and **diabetics**.

Based on the results and findings of this study, the study concludes that if the patients in the pretests data remain untreated, continue to lack healthcare accessibilities, or marginally treated for a reasonable period, a large number of them are more likely to die from chronic diseases such as HPB or diabetics effects such as heart failure, congestive heart failure, stroke, seizures, and many others just to mention a few as compared to the patients in the posttests data. Above all, confidential healthcare evidence-based methodologies showed that 3 out of 4 or 75% of people hospitalized with heart failure may die in 5 years or less. Therefore, the patients in the pretests section data in this study fell perfectly within the parameter of the confidential evidence-based life expectancies' conclusion about people with heart failure. As such, the study accepted the **Alternative hypothesis** (correlation & relationship

between dependent and independent variables) and rejected the **Null hypothesis** (no correlation & no relationship between dependent and independent variables). According to confidential information received from the clinic, if the patients in the pretests section of this study are not treated, marginally treated, or continue to lack healthcare accessibility, 3 out of 4 or 75% of them may die within 5 years or less, due to heart failure issues in general (see table x for more).

INTERPRETATION OF THEORETICAL FRAMEWORK CONFIRMATIONS AND DISCONFIRMATIONS

This study used “**Social Construction of the Ideology of Reality Theory**” in making decisions what any government use in addressing any peaceful times or pandemics times (Berger & Luckmann, 1966). This study investigated decision making processes of public health and private health treatment of HPB and diabetics among Blacks/African Americans in the US and Blacks in the Caribbean and found the followings:

1. Blacks/African Americans and Blacks in the US Virgin Islands’ Caribbean are less likely to be treated for HPB or diabetics due to the decisions made by public or private health decisions’ makers due to lack of insurances’ coverage.
2. Blacks/African Americans or Blacks in the US Virgin Islands’ Caribbean are less likely to receive any effective, efficient, or even proficiently affordable healthcare treatments, due to assumption, presumption, and preconception that their current chronic health condition/s about HPB or diabetes were inherited from their Motherland (Africa) and not in the US.
3. The theoretical framework used in this study showed that such decision-making processes means that Blacks/African Americans and Blacks in the US Virgin Islands’ Caribbean are more likely to die from easily manageable and treatable chronic diseases such as HPB and diabetes due to intentional lack of treatments.
4. The study found those simple treatments’ methodologies of HBP and diabetics can improve the health wellbeing outcomes of Blacks/African Americans and Blacks in the US Virgin Islands’ Caribbean.
5. Finally, the study confirmed that disinformation, misinformation, discriminations, unproven assumptions, presumptions, preconceptions, lack of transparencies, intentionally blockages to healthcare accessibilities, and simply lying to Blacks/African Americans and Blacks in the US Virgin Islands’ Caribbean served as a fundamental yardstick in making public and private healthcare treatments and accessibilities in the USA.

Based on the results and the findings of this study, that means that the study confirmed that when it comes to chronic manageable and treatable diseases such as HPB and diabetics effective or ineffective treatments, decision were/are primarily made based on the races of the victims rather than those who actually needs treatments or who does not, which fits perfectly fine with the decisions-making processes as defined by “**Social Construction of the Ideology of Reality Theory**” premises. As such, the study confirmed that “**Social Construction of the Ideology of Reality Theory**” fitted perfectly with the theoretical framework selected for this comprehensive research study.

IMPLICATIONS OF THE STUDY

This project showed several significance and implications to participants, researcher/s, healthcare practitioners, public policies makers, and others in several ways.

1. This study used a singular comparison of data statistics collected from one clinic only in Southwest Houston, Texas which showed to participants that it is possible to eliminate chronic diseases such as HBP and diabetics with simple treatments.
2. It shed some lights that HBP and Diabetics not to mention COVID-19 experiences have no financial status, economic status, social status, or racial barriers, when it comes to chronic diseases such as HPB and diabetics and possibly of dying from it if not treated eventually.
3. It also shed some lights that misclassifications, assumptions, misconceptions, misinformation or lying about the actual paradigms of HBP and diabetics and causes of deaths can not only be misleading, but there can also and will always be counterproductive to all Americans eventually; especially to Blacks/African Americans in the US and US Virgin Islands' Caribbean.
4. It further shed some lights that vulnerable populations in the US such Blacks/African Americans in the US and US Virgin Islands' Caribbean should and must be self-educated to find proactive and workable applications as to sustain HBP and diabetics' side effects and complications.
5. It exposes the historic systemic racism of US leaderships against Black and Brown especially against Blacks/African Americans in the US and US Virgin Islands' Caribbean for more than 401 plus years.
6. This study shed some visible lights about inequalities, inaccessibility, differences, and indifferences in healthcare treatments when dealing with Black and Brown; especially when dealing with Blacks/African Americans in the US and US Virgin Islands' Caribbean in particular.
7. The study showed that Blacks/African Americans in the US and US Virgin Islands' Caribbean were/are still suspicious and uncomfortable with any of treatments such as medications and injections of vaccines in general and especially about any types of medical treatments in the US.
8. This study exposed the institutional racism against Black and Brown especially against Blacks/African Americans in the US and US Virgin Islands' Caribbean which is historic.
9. This study shed some lights that polarization and actual social scientific facts and evidence-based outcomes do not mix.

LIMITATION OF THE STUDY

This study showed many limitations and due to the endless lists of the limitation's items, a few limitations were addressed below.

1. One of the most visible limitations was inconsistencies of data statistics which made it challenging to agree or disagree with the collected data statistics from the participants' outcomes in this Southwest Houston Clinic.
2. Only one clinic in Southwest Houston, Texas participated in this clinical research study which yet poses and generalization inability to other clinics in the Houston areas and beyond.

3. Only Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US participated in this study which poses limitation to generalized about the results and findings of this study to other areas the state of Texas and to other areas in the US in general.
4. Federal, states, counties, districts, and cities data statistics also showed overwhelming inconsistencies with the misguided data statistics' information about the originates of HBP and diabetics when it comes to dealing with Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US
5. A singular Case Study was used in this study which poses another limitation for this study due to again another possibility of data statistics inconsistency which cannot be compared to other statistics.
6. Regional internal and external intervals statistical insignificance data reports indifferences also posed another limitation for this study. For example, that Blacks/African Americans in the US and US Virgin Islands' Caribbean inherited HBP and diabetics' conditions from Africa and it cannot be successfully treated or managed in the US, which is not true, but a **MYTH** that led to false assumptions.
7. Finally, chronic historic institutional systemic racism against Black and Brown especially against Blacks/African Americans in the US and US Virgin Islands' Caribbean poses a profound limitation to this study.

SIGNIFICANCE OF THE STUDY

This study showed several significance and implications to participants, researchers' healthcare practitioners and others in several ways.

This study opened the US and the world to see and understand the long history of systemic racism in the US when dealing with minorities in general; especially when dealing with chronic diseases such as HBP and diabetics' ineffective treatments among Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US.

This study highlighted the ways public policies decisions making process were/are implemented in the US in general especially when these decisions' efficacies were/are made about the health well-beings of minorities in general; especially whenever if they deal ineffective treatments of chronic diseases such as HBP and diabetics among Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US.

This showed that whenever it comes to any written public policies on the paper, there were/are always differences whenever it comes to the races of the victims in general; especially whenever it comes to assisting Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US

This study showed that when it comes to public or private polices the implementations of the written policies were/are always double or even triple folded when dealing with Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US.

This study further showed that the possibilities of any minorities especially Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US from dying from simple illnesses such as Flu, common cold, or even HBP and diabetics are imbedded into the systems' structural racism in the US.

Finally, this study showed some well-designed health care institutional racism against minorities in general; especially when dealing with Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US.

RECOMMENDATIONS

This research study has limited recommendations for Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US when dealing with HBP and diabetes chronic conditions.

1. Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US should find ways to sign into ACA or Obama Care for their primary or family healthcare physicians' managements; because it is not as expensive as previously assumed by many.
2. Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US should find ways to retain family or person physicians whose primary healthcare goals and objectives begins with HBP and diabetes measurements.
3. Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US should and must obtain an annual physical examination, which sets the tone for individual diagnosis about ones' healthcare wellbeing and prognosis' outcomes.
4. Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US should navigate the healthcare facilities in their areas in Southwest Houston, Texas and possibly beyond; because there are many healthcare facilities that are ready to treat some minorities for free of charge, but paid for by wealthy philanthropists' supports.
5. Finally, Blacks/African Americans in the US and US Virgin Islands' Caribbean in the US should tap into and navigate themselves into their healthcare maps, as to find ways of addressing their healthcare wellbeing issues especially when dealing with HBP and diabetes conditions; as an aged saying goes, **“If you wait for other people to do for you whatever you can singularly do for yourself, nothing will be DONE for you at any time.”**

CONCLUSION AND DISCUSSIONS

There is no doubt that whenever it comes to positive healthcare treatments of Blacks/African Americans and US Virgin Island Caribbean in the US when dealing with High Blood Pressures (HBP) and Diabetes in the US, this critical black population have been left alone or behind for more than 400 plus years. On one hand, many non-black scholars have argued that HBP and Diabetes were inherited by Blacks/African Americans and US Virgin Island

Caribbean in the US from their “Motherland” AFRICA and they are untreatable in the US which is not true at all. This study has practically demonstrated that Black/African Americans and US Virgin Island Caribbean with chronic diseases such as HBP and Diabetes in the US can be successfully treated in the US regardless they where they originated. For more than 400 years in the US Blacks/African Americans and the US Virgin Island Caribbean have been mistreated, undertreated, underscored, misguided, dismissed, and even disregarded when it comes to any healthcare issues and assistance. For example, during hurricanes’ flooding in the US and Caribbean more Black/African Americans along with Blacks in the Caribbean were the ultimate victims as expected. Generally, discrimination of any kind is a historic way of life in America previously and today (see Atatah., Kisavi-Atatah., Kyle., & Ngenge., 2022; Kisavi-Atatah., Atatah., & Kyle., 2022; Kisavi-Atatah., & Atatah., 2022 for more details). Discrimination is nothing new in America whenever it comes to chronic healthcare issues such as HBP and Diabetes treatments’ efficacies is yet another good example of who gets treated fairly, and who is not treated at all, based on the color of their skin. It should not be as such; but that is AMERICA for you previously and today; millions upon millions of Blacks/African Americans and US Virgin Islands’ Blacks have died due to lack of treatments, denied treatments, and possibly lack of accessibility to any form of treatments in the US.

In addition to above, this research found that it is possible to tackle and treat HBP and Diabetes was inherited by Blacks/African Americans and US Virgin Island Caribbean in the US successfully with minimum healthcare interventions. For example, the study found that that if the patients in the pretests data remain untreated, continue to lack healthcare accessibilities, or marginally treated for a reasonable period, a large number of them are more likely to die from chronic diseases such as HPB or diabetics effects such as heart failure, congestive heart failure, stroke, seizures, and many others just to mention a few as compared to the patients in the posttests data. Above all, confidential healthcare evidence-based methodologies showed that 3 out of 4 or 75% of people hospitalized with heart failure may die in 5 years or less. Also, according to confidential information received from the clinic, if the patients in the pretests section of this study are not treated, marginally treated, or continue to lack healthcare accessibility, 3 out of 4 or 75% of them may die within 5 years or less, due to heart failure issues in general. Conversely, the study found that posttests posed posttests’ patients less than 1% of dying from systolic BPs’ readings’ related effects untimely, posttests’ patients posed less than 11% of dying from diastolic BPs’ readings’ related effects untimely, and posttests’ patients posed less than 14% of dying from heart pulse BPs’ readings’ related effects. However, the only commonality in this research study was the color of ones’ skin which is historic in the US when dealing with overall healthcare outcomes’ wellbeing. For example, during COVID-19 pandemics in the US misinformation and disinformation about the tallies of the cause of deaths for Blacks/African Americans and US Virgin Island Caribbean in the US were counted as underlying conditions instead of dying from COVID-19 pandemics’ implications. Furthermore, even mental illnesses that were created due to COVID-19 pandemics were tied to underlying health conditions; and above all, lack of vaccines confidences’ trusts with the US which were directly tied to races’ differences. In every sectors in the US decision making processes are tied to racial indifferences between Blacks/African Americans and US Virgin Island Caribbean in the US and white Americans (see Atatah., Kisavi-Atatah., & Odesuwa., 2021; Redden-Louis., Atatah., Kisavi-Atatah., Kyle., & Redden-Louis., 2021; Atatah et al.,2021; Redden-Louis, Atatah., Kisavi-Atatah., & Kyle., 2021 for more details).

In conclusion, besides the above, evidences upon evidence from this study have shown in the US in general that whenever it comes to including any minorities especially Blacks/African Americans and US Virgin Island Caribbean in the US during any kind of supports or assistances the rules always change. Also, whenever it comes to

including any minorities especially Blacks/African Americans and US Virgin Island Caribbean in the US during any healthcare accessibility's supports or assistances the rules become exclusive rather than inclusive. For example, during the collection of the raw data for this critical HBP and Diabetes research study, evidence showed that approximately 3 out 50 or 0.06% heart related Blacks/African Americans and US Virgin Island Caribbean in the US were in the cardiologists waiting room for some forms of scheduled heart related treatments. This practically underscored and demonstrated that Blacks/African Americans and US Virgin Island Caribbean in the US were intentional deprived left behind from having any benefiting healthcare accessibilities or treatments; because the residences' population in this Southwest clinic in Houston, Texas were made up of more than 66% minorities and about 48% of them were Blacks/African Americans and US Virgin Island Caribbean in the US. **This study summed that hopefully one day, the insights gained and lessons learned from this critical research study will eventually bring some POSITIVE SOCIAL CHANGES to all Blacks/African Americans and US Virgin Island Caribbean in the US and possibly beyond.**

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CONFLICT OF INTERESTS

We share no conflict of interests in this study

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