

**A PROVIDER'S HANDBOOK  
ON  
CULTURALLY  
COMPETENT  
CARE**



**AFRICAN AMERICAN POPULATION  
2<sup>ND</sup> EDITION**

*Kaiser Permanente National Diversity Council  
and the Kaiser Permanente National Diversity Department*



**KAISER PERMANENTE.**

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# African American Handbook

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# INTRODUCTION

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**K**aaiser Permanente is committed to improving the quality of care provided to our increasingly diverse membership. Ensuring that members' cultural needs are considered and respected at every point of contact is integral to providing a culturally competent system of care. This commitment is aligned with Kaiser Permanente's mission to provide personalized care and to improve the overall health of the communities we serve.

This handbook is the second edition of the Provider's Handbook on Culturally Competent Care: African American Population. This revised edition includes updated information throughout and a new section on lupus. The term "culturally competent care" is the delivery of health care services that acknowledges and understands cultural diversity in the clinical setting, respects members' health beliefs and practices, and values cross-cultural communication. Increasingly, health care organizations are being evaluated by consumers and regulatory authorities for their ability to provide such care.

**Incorporating cultural sensitivity in meeting our current and potential members' needs is an important strategy in:**

- Enhancing quality of care
- Expanding our markets
- Maximizing retention rates
- Realizing our mission to improve the health status of the communities we serve
- Cost containment

This handbook is one in a series of targeted initiatives in Kaiser Permanente's overall strategy to address diversity as a business imperative and a way of maintaining a competitive quality advantage. Our goal in creating this handbook for Kaiser Permanente's health care professionals is to provide an overview of the cultural and epidemiological differences that characterize the major ethnocultural groups which comprise our membership. It focuses on the characteristics of each group that affect health care utilization. It does not, by any means, suggest that we stereotype our members or patients by groups. Rather, the handbook presents the general background information and health care statistics that can help our providers become even more sensitive and knowledgeable about our diverse membership. Culturally competent care, the acknowledgment of the underlying genetic, environmental, psychosocial, and behavioral factors that shape human experience, is critical to altering the prevalence, incidence and the successful management of disease in all populations.

The data reported in this handbook comes primarily from three sources: (i) articles published in medical and other health-related journals, (ii) state and federal publications on health, and (iii) Kaiser Permanente providers. In addition, national efforts to improve the timeliness and quality of vital statistics have resulted in access to information via the Internet. Most of the data were gathered or reported in the last decade. An editorial board comprised of Kaiser Permanente physicians and staff reviewed all materials. Data sources are placed in the reference section at the end of the handbook, which is divided by topic.

*Kaiser Permanente National Diversity Council 2003*

# DEMOGRAPHICS

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## Introduction

In this handbook, we have chosen to refer to people of African descent who reside in the United States as African Americans. We use the term African Americans interchangeably with the term Black, which is used most frequently in scientific literature. The term “African American” refers to persons who are descendants of peoples from the continent of Africa. The majority of African Americans are descendants of persons brought from Africa to the Americas between the 17th and 19th century. The enslaved Africans consisted of a range of ethnic groups of primarily West and Central African origin; hence, the parent populations were culturally and genetically diverse. The present African American population is formed from a genetic mixture across African ethnic groups and other racial groups, primarily European and American Caucasians, as well as Native Americans. It is clearly not a homogeneous population.

African Americans comprise 34 million or slightly over 12% of our nation’s population. The African American growth rate during the 1990s (15.6%), exceeded that of the nation as a whole (13.2%). However, as with Whites, African American population growth came primarily from natural increase (84%) rather than immigration. African American women have a fertility rate of 63.2 compared to 60 for Whites, 95.1 for Latinas, and 54.6 for Asians and Pacific Islanders per 1,000. In 2000, the African American population’s median age was 30.2 years, 7 years younger than that of the White population and 4.7 years older than the Latino. The median age of African American women was 31.7, for men, 28.5. Because of the youth of the African American population, some demographers feel that African Americans may grow to be near 23% of the U.S. population by the year 2015.

In recent years, immigrant additions to the African American population came primarily from Caribbean or African nations. For example, there are an estimated 506,000 Jamaicans in the United States (1996). Haitians make up the second largest Caribbean group at about 400,000. Most of the immigration of Caribbean Blacks has occurred since 1980, and a vast majority of these immigrants have settled in Florida (356,000), New York (459,000) and New Jersey (66,000).

There has also been a small increase in immigration from Africa in the last 20 years as a result of several factors: refugee resettlement from civil unrest in Ethiopia, Eritrea and Somalia and the impact of the Immigration and Naturalization Diversity Program. From 1994-1996, legal immigration from Africa totaled 122,057.

African Americans are primarily an urban population and are more widely distributed than most other population segments. Many of the heaviest concentrations of African Americans live in the southern and eastern United States; the cities of Baltimore, Atlanta, New Orleans, Memphis, and Norfolk all have African American populations in excess of 60% of the total population. African Americans comprise more than one-half of the population in the following cities: Washington, D.C., New York, Chicago and Los Angeles. The four most populous states in the union, California, New York, Texas and Florida contain the largest concentrations of African Americans.

## African American Families

African American families are generally larger and younger than White families. Only one in five White family householders is under the age of 35, while in African American families the

proportion is one in four. The average family size for African Americans is 3.33 and 3.02 for Whites.

One of the most critical issues for America is that a number of social and historical events have resulted in a high proportion of female-headed households in the African American community. In 2000, nearly half (44%) of African American families were headed by a woman and 68% of these households included children under age 18. Because of this, African American families were less likely to have two or more wage earners than Whites (43% vs. 59%) and more likely to have no earners (20% vs. 15%). These factors in family composition contribute to the greater proportion of African American families living at or below poverty levels than Whites.

Another unique characteristic is that children living in grandparent maintained families are more likely to be Black, younger and living in the South compared to grandchildren in parent-maintained families. Black grandmothers are more likely to care for grandchildren on their own (53%) than White grandmothers caring for grandchildren on their own (28%). More than 60% of African American children live with their grandmother and do not have either parent present in the household, so the grandmother is the major caretaker. Grandchildren living with only their grandmother have the highest poverty rate (63%) compared to living with their grandmother and one or both parents (30%). While some of the children in these families receive health care through Medicaid, many are among those who have “fallen through the holes in the safety net” and have received inadequate health care. Providers may expect to care for some of these children as programs funded by recent federal and state legislation to address their health care needs get underway.

## **Education, Income and Occupation Patterns**

The percentage of African Americans achieving a high school diploma has increased significantly. In 2000, 88% of African Americans 25-34 years old had completed high school; up from 51% in 1980. By 1999, the annual high school drop-out rate of African Americans (6.5%) was not significantly different from that of Whites. Recent California data indicate that the proportion of Whites and African Americans over age 25 that do not have a high school diploma is the same: 14%. Thirteen percent of African Americans were college graduates. According the U.S. Department of Education, 17.9% of 25-29-year-old African Americans completed a bachelor's degree or higher in 2001, up from 6.7% in 1971 for both sexes.

The economic situation for African Americans is complex and dynamic and demonstrates important gains in many areas. As with other Americans, the gap between affluent and poor African Americans has widened in recent years.

- In 2000, the poverty rate for African Americans remained disproportionately high at 22%, still far in excess of White Americans at 8%.
- On the other hand, two thirds of African Americans can be considered middle-class as defined by their incomes relative to the U.S. median family income.
- In 2000, 14% of the group had family incomes of \$50,000 or more and 41% had incomes of \$25,000 to \$49,900.
- For African Americans, as with others, increases in earnings are strongly linked to education. The median earnings of African Americans with a B.A. (\$32,360) were 75% higher than that of high school graduates.

In metropolitan areas, the economic situation of African Americans varies greatly, reflecting differences in opportunity structures. According to a study conducted by the Population Studies Center at the University of Michigan, nearly one in four African American residents of Washington, D.C. is affluent (5 times above the poverty level), one in ten in San Francisco, but just one in twenty five in Miami. The median income of an African American family living in the northern or western U.S. in 1993 (\$29,910) was 47% higher than in the southern U.S. (\$20,370). The increasing number of middle class and affluent African Americans in many cities has fueled a sizable growth in suburban African American populations.

In 2000, a higher proportion of African American women than men, were employed in professional or managerial jobs (25% and 18%). Thirty-eight percent of Black women worked in technical, sales and administrative support jobs. Of African American men, 15% were in skilled production jobs and 29% worked as operators and laborers.

In 2000, African American men age 16 and older were less likely to be in the labor force than White men (68% as compared to 74%), but African American women age 16 and older were more likely to be in the labor force than White women (64% as compared to 61%.) African Americans experience an unemployment rate nearly three times that of Whites (8% compared to 3%.)

According to the 1997 Economic Census, 4% of all U.S. businesses were owned by African Americans compared to 5.8% by Hispanics, 4.3% by Asians and 83.2% by non-Hispanic Whites.

## **Health Care Coverage**

According to the 2000 U.S. Census Bureau Current Population Survey, the proportion of African Americans who did not have health care insurance dropped from 21% in 1995 to 19% in 2000. Whites, starting at much lower levels, experienced a similar proportional drop, from 14% to 13%, while Latinos dropped from 33% to 32%. In 2000, about 59% of African Americans, 48% of Latinos and 79% of Whites were privately insured, either through self or employer paid plans.

In 2000, 88% of the nation's 72 million children were covered by either private or government health insurance; 36% of African American children, compared to 17% of Whites, were covered by government health care insurance.

## **Racism**

In several U.S. geographic regions, African Americans represent the largest ethnic population of color. Published in 2002, the Institute of Medicine's Report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" reported the many ways in which populations of color and, particularly, African Americans bear a disproportionate burden of illness, disability and mortality, when compared to American Whites.

The data showing the relatively poor overall health status of African Americans raises tremendous concerns and, taken as a whole, can be discouraging. However, it is important to consider that the painful reality of the data reflect centuries of racial oppression, political and social discrimination, and reduced health care access.

## Implications for Kaiser Permanente Care Providers

- The African American population, while not increasing proportionally as rapidly as others, will increase steadily as a source of healthcare consumers. The growing African American middle class, unionized workers in manufacturing areas, and rapidly expanding mandates by state and federal governments for Medicaid and Medicare risk groups to receive health services from managed care plans will continue to make this an important healthcare market segment. Many African Americans will be unfamiliar with managed care systems, and many will be receiving such coverage for the first time.
- African and Caribbean immigrants are expected to have a lack of information regarding how American health systems work. They are also likely to be distinctly different from African Americans in terms of culture, language, health beliefs and disease prevalence.
- Poverty, discrimination and lack of access to quality health care have created circumstances where many African Americans suffer more from chronic life style diseases and environmental hazards than other Americans. Culturally appropriate health education, outreach and prevention strategies will be especially critical in achieving good health outcomes in this population.
- Prejudices are an integral part of the human experience. As healthcare professionals, we should assess our individual stereotypes, biases, and perceptions about African Americans and determine if or how they might influence our clinical practice.
- Awareness of the heterogeneity of African American experiences and health care beliefs and behaviors is critical to the successful delivery of culturally competent health care to this population. We do not, by any means, imply that we stereotype patients or that we view African Americans or any other ethnic group as a monolithic group. Throughout this handbook we stress that the high variability within the African American population is a result of factors which include: geographic region, urban or rural, socioeconomic status, recent immigrant status, and country of origin.

## HEALTH BELIEFS AND BEHAVIORS

Because of the heterogeneous origins and subsequent dispersal found among African Americans, each cultural group has a variety of beliefs and perceptions that shape health behavior, including care, compliance and treatment outcomes. We describe various cultural values and beliefs and their relationship to health behavior and perceptions of illness, diseases, and symptoms related to disease among African Americans. Also discussed are a number of social and structural factors that influence health.

Similar to documented universal patterns of health beliefs and behaviors, African American health beliefs and behaviors may be shaped by factors such as the following:

- Whether the individual is an immigrant or U.S. born;
- Whether the individual is of middle or lower socioeconomic status (SES);
- Whether the individual grew up in an urban or rural environment;

- Gender and age; and
- Religious beliefs and practices.

## **Effects of Cultural Orientation**

It is well documented that aspects of cultural orientation, including cultural values, world view, beliefs about health, illness, and pain, and expectations regarding health care professionals, all affect health behaviors. We address some dimensions of cultural orientation that have been documented among African Americans.

Religious doctrine has a lengthy tradition in the African American community. As such, spiritual or religious experiences of African Americans may shape beliefs about the causes of illness, as well as treatment decisions. There is also a tendency for religious faith and prayer to be seen as having substantial potential for healing and may serve as an alternative to medical care for serious illnesses. Strong religious faith among many African Americans has been associated with a preference for life-sustaining procedures.

Cross-cultural interactions between providers and patients may be marked by differences in the understanding and definition of health terms. As cultural distance between individuals increases, so does the likelihood of a communication problem. Sociocultural issues in African American health care include eye contact, touch, facial expressions, language, and symbolism. Black patients may be particularly sensitive to impersonal or hasty treatment by non-Black providers and may interpret their experiences as racism. African American patients prefer personalized interactions that include a greeting, an introduction of the provider to the patient, as well as a handshake. African American patients may also prefer to be greeted and/or addressed by Mr. and Mrs. rather than by their first names. In the southeastern United States, African Americans may prefer to be addressed by “Sir” or “Ma’am.”

Family and friends play an important role in successful treatment and healing. Several social scientists have documented extended family networks among African Americans. Many African American families are organized around blood lineage with the oldest members as heads of the extended family unit, that may also include non-blood related individuals. Often people who are not related by blood lineage are accepted as family members and given titles such as “Aunt” or “Uncle,” or “Brother” or “Sister.” Among African Americans, it is generally expected that family members, including extended family members, will play an important role in treatment decisions. Where possible, it is critical to increase family education about disease states and the benefits of compliance in achieving successful outcomes.

A strong “sense of the present” has been documented in research on cultural and economic challenges in diabetes and hypertension management among African Americans. Preventive health behaviors are more consistent with an orientation toward the future. A more “present-based” cultural orientation has been associated with a tendency for fatalism among African Americans. This “present-based” orientation is reinforced by the reality that, in the lives of African Americans, events may often be associated with the unpredictability of discrimination and legal and social conflicts.

Fatalism, which may or may not be linked to the “will of God,” is also a critical factor in explaining racial differences in health beliefs. Notions of fate or an attitude of resigned forbearance are typical of poor and/or traditional people worldwide, probably as a result of their inability to control many factors impacting their lives. Fatalism is a known factor in influencing an individual’s decision to (a) seek health care and (b) adhere to preventive health care recommendations.

Fatalism may also stem from perceptions that developing diseases such as cancer are inevitable regardless of an individual's actions. A study of African American women residing in urban Chicago found that personal stress arising from caring for families on very limited resources took precedence over being tested for diseases for which they perceived themselves as unable to control. Recent literature has recast fatalism as experientialism, and argued that individuals are more likely to perceive acquisition of a disease as inevitable, and/or particularly lethal if watching scores of individuals in their communities develop and die from a disease has been an integral part of their experience.

## **Traditional Beliefs and Practices**

Several social scientists have described the retention of African and Caribbean beliefs and practices among those individuals transported to the Americas in the 17th through 19th centuries. In Africa, healers relied heavily on medicinal roots, herbs, and leaves for the treatment of illness. Variations have occurred as a result of the intermixing of African and Caribbean belief systems. Recent African and Caribbean immigrants may revitalize folk traditions, especially in urban areas. Health professionals are more likely to see these beliefs and practices among older, rural, or lower income African Americans. Not all beliefs held by African Americans are grounded in traditional African Americans beliefs and practices for the majority of African Americans in urban areas will follow popular American health care beliefs.

Many African groups perceive the individual as existing as part of a community. Although illness is seen as having natural causes, Africans may also believe that illness results from discordant relations between a person and their natural or social worlds. Similar beliefs of illness as a consequence of evil influences or spirits have been observed among contemporary African Americans, particularly those who are older, from the south and/or rural communities, or low income.

African Americans of lower socioeconomic status have been described as seeing illness as "natural" or "unnatural." "Natural" illnesses result from failure to take care of the body and soul, or by sinful behavior. "Unnatural" illnesses do not follow natural laws and may be seen as work of the Devil. Some African Americans believe that the body will stay healthy indefinitely with moderate diet, rest, and exercise. It is believed that the body must be protected from extremes of heat and cold and must be kept clean inside and out. In addition, individuals must keep their relationship with God in order. A study of Haitian immigrants found similar beliefs in the power of God's will and health. Health and welfare are seen as God's gifts to give or take. God, prayer, and the Bible are seen by many African Americans as protecting the individual from illness and misfortune and enhancing the effects of Western biomedicine.

Accounts of slavery describe how Blacks maintained their own medical system, utilizing root and herbal remedies and avoiding treatment by enslaved doctors. Contemporary studies of African American health beliefs and behaviors indicate that many individuals will seek medical attention only after exhausting traditional remedies that include the use of aloe vera, garlic, beets, poke greens, lemon, and other plant based home remedies in preparations such as teas, tonics, and poultices.

A common cultural phenomena is the concept of "draft," air current that one should avoid while sweating, as a cause for colds or arthritis. The belief is that the body is more susceptible to a cold when the skin "pores are open." Cold is seen especially dangerous to the very young, women of childbearing years, and the very old, as their bodies are viewed as "open" and more susceptible to illness.

## **Blood Beliefs**

Foods, diets, and concepts about blood play an important role in traditional models of health and illness among African Americans. For example, blood may be spoken of as too much, too little, too sweet, too bitter, too thin, bad, high, or low. Similar beliefs about blood have been found among Southern Whites, and immigrants to the United States from Haiti, Jamaica, the Bahamas, and the Cape Verde Islands.

“Low blood” refers to anemia, resulting from not eating the right foods, but may be confused with low blood pressure. The perceived symptoms of “low blood” are weakness and “falling out” (fainting). Self medication includes the consumption of the “blood builder” foods such as beets, carrots, grape juice, red wine, and red meat, especially pork.

Some Blacks may be suspicious of many blood tests or feel that they are more harmful than helpful. This belief may be based upon mistrust of the medical system, as well as upon traditional beliefs about the importance of retaining the proper balance of blood in the body.

## **Peoples of Caribbean Descent and African Immigrants**

Recent political and economic changes have resulted in increased numbers of African immigrants to the United States. Also, many people from places such as Puerto Rico, Cuba, Panama, and the Dominican Republic are of African descent and Latin descent which may result in cross-cultural issues in health perceptions. Below are a few perceptions from Caribbean and African cultures:

- If a patient is terminally ill, Somalis, Ethiopians, and Eritreans may consider it uncaring for a physician to tell the patient. It is preferable for the physician to tell the patient’s family about the terminal illness.
- Haitians may refer to illness as “battement de coeur.” Religious beliefs, such as voodoo, divide illness into natural and supernatural. Supernatural illness appears suddenly and is caused by evil spirits. The intervention of a voodoo priest may be sought. Dreams are also important events that allow an individual to communicate with deceased relatives. Patients may rely on these dreams to interpret their illness.
- Emotions, harmony, and balance in life may play an important role in treating Jamaicans. Hence, warm foods and medications may be preferred to cold.
- Among Haitians there may be a preference for medication in the form of injections rather than pills.
- Beliefs about the central role of blood in illness are found among Haitians. Like some American born African Americans, some Haitians are suspicious of many blood tests. Patients may feel that losing blood will make them weak, that the blood could be used for voodoo purposes, or that the doctors could be selling the blood for profit. Illness may be seen as related to a spell of grief, anger, or fear which may reduce the quality of the patient’s blood.
- Personal fortitude is valued by Haitians, and illness is shared only with family and friends. Public displays of weakness are discouraged.

- In many Haitian families parental authority is respected without question, even into adulthood. Parents may control decisions, including the selection of a spouse or occupation, and healthcare decision-making.

## **Implications for Kaiser Permanente Care Providers**

- Consider that each patient represents a mixture of culture and experience. Each patient is an individual and the degree to which an individual is representative of their culture is varied and up to the health care professional to explore, interpret, and not stereotype.
- Make your patients feel comfortable. Address your patient by his or her surname unless given permission to use another form of address particularly if you introduce yourself by surname and title. Be sensitive to the implicit distrust that may exist between the patient and yourself.
- It is important that patients feel comfortable with and trust their health care professional for diagnosis, patient compliance, treatment decisions, and follow-up treatment. Demonstrating understanding of how the patient's day-to-day life factors might interfere with positive health promoting behaviors is important in delivering high quality health care as is working empathetically with patients to overcome these barriers. For example, a provider may mention, "The subtle forms of discrimination and racism may be contributing to your condition."
- Failure to elicit a patient's understanding of an illness, as well as its cause and how he or she believes it should be treated often results in fear, anger, frustration, and noncompliance.
- Doctor-patient interactions may be characterized by the use of extremely technical language often inaccessible to patients without medical training. When possible, use visual aids such as models, drawings, or educational pamphlets to aid patient understanding. Health care professionals can check patient understanding by having them describe treatment regimens back to them. This process lends itself to fostering better communication with members and patients, as well as increased likelihood of patient compliance.
- Because socialization shapes health care beliefs and behaviors, knowledge of the origin of a patient's parents may be helpful in illuminating patients' perspective relative to health, disease states, etiology, compliance, and treatment. Determine whether the patient is from the southern or northern United States, Africa or the Caribbean.
- Health care professionals need to be aware of folk medicinal practices. Many folk practices are kept secret and patients might feel too embarrassed to volunteer information. Give credibility to patients' folk beliefs in a non-judgmental way. It is important to realize that folk beliefs and practices are important strategies for coping, survival and medical empowerment.
- Where possible, combine folk and biomedical therapies. It is believed that combining folk and biomedical therapy may increase compliance since it places the biomedical plan within the context of the patient's cultural system. Many folk medicinal beliefs and practices are benign and do not interfere with biomedical therapy. However, there are some that can be potentially hazardous. Asking what other treatments or therapies the patient has tried may prove beneficial.

- As with all patients, take extra efforts to be certain that the patient understands his or her illness and its implications. Use models and drawings to assist in educating patients. Make certain patients understand the implications of non-compliance. Write down complete drug regimens for patients.

## **RISK FACTORS**

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The disparities in health status between Black and White Americans, discussed previously, have been documented extensively. It is widely accepted that health status is determined by a number of risk factors. Here we discuss how five key risk factors shape health status and influence disease patterns among African Americans: (i) socioeconomic status, (ii) environment, (iii) medical bias, (iv) lifestyle choices and behaviors, such as obesity, physical inactivity, and inadequate diet and nutrition, substance abuse and chemical dependency, and (v) aspects of our society that affect health behaviors. Age, race, heredity, and gender differences are also risk factors that individuals have the least control over. However, the preponderance of evidence points to the influence of their lifestyle choices as a major precursor of disease.

### **Socioeconomic Risk Factors**

Socioeconomic status (SES) is a reliable predictor of health status throughout the world. Generally, high SES is associated with better health status and low SES with poorer health status. In the United States, people of lower socioeconomic status have decreased chances of adopting healthy eating and exercise patterns, and less access to adequate, regular health care.

Levels of income and education, and occupation are widely used indices of socioeconomic class. However, numerous social scientists have argued that these indices are inappropriate for studying all groups, including African Americans. Despite the significant economic, social, political gains experienced by African Americans over the last fifty years, Whites still have more resources than Blacks at every income level. Also, compared to Whites, African Americans are less likely to have a formal education. These disparities in education and economic resources may negatively influence health beliefs and behaviors among African Americans.

People of lower SES are more likely than their wealthier peers to concentrate on day-to-day survival and experience feelings of hopelessness, powerlessness, and social isolation. These psychological factors limit health self-efficacy.

Lower SES is more likely to increase risk in the following areas:

- Lack of knowledge of preventive health care or screening tests for diseases such as cancer;
- Higher rates of premature death due to stroke, heart disease, homicide, suicide, and acquired immunodeficiency syndrome (AIDS);
- Higher levels of hypertension, stroke and end-stage renal disease; and
- Higher rates of injuries, homicides, and accidents.

## **Environmental Risk Factors**

Various environmental hazards in the home, workplace, and neighborhood (*i.e.*, lead exposure, proximity to toxic waste, abandoned landfills) have been associated with increased risk for certain health problems and diseases.

### **Occupational Hazards**

- The American Lung Association indicates that occupational lung disease is the number one work related illness in the United States.
- People of color have been traditionally overexposed to occupational respiratory hazards and are more likely to hold the “dirty” jobs, involving occupational exposures to asbestos, textile, silica and coal dust, poisons, radiation and certain biologic agents.
- Higher smoking rates among individuals exposed to workplace environmental hazards create what the American Lung Association describes as an “insidious synergy,” the exacerbation of the effects of toxic dust due to smoking.
- People who hold blue collar jobs, in rural and urban areas, face increased risk for disability and death due to accidents and injuries in the workplace.

### **Residential Hazards**

- Approximately 86% of Blacks, as compared to 70% of Whites, live in urban settings. Residents in urban settings are placed at increased risk for exposure to hazards that include: toxic waste; air pollution; higher concentration of crime, and older, poorly maintained buildings with inadequate heating, lead paint, and cockroach allergen.
- Three out of every five African Americans (more than 15 million) and Latinos (more than 8 million) live in communities with uncontrolled toxic waste.
- Crime tends to be concentrated in urban areas which is associated with the excessive deaths due to intentional injury among African Americans, especially in males. Lower income Blacks and Latinos are more likely to experience exposure to urban violence. Researchers believe that exposure to violence may increase feelings of alienation, powerlessness, and hopelessness and may foster negative perceptions of health, well-being, and health promotion behaviors. Ethnic minorities who live under these conditions may perceive limited benefit in adopting lifelong health promoting behavioral changes.

Social and economic variability exists in the African American population, as in all populations. Although some of these SES and environmental factors are less likely to be operative in a middle-class African American privately insured population than in the general African American population, the early effects of poverty may even have early influences on some upwardly mobile African Americans.

## **Medical Bias: Truth or Fiction**

In 2002, the Institute of Medicine reviewed evidence suggesting that persistent and substantial racial disparities in health care delivery do exist. These disparities may help explain some part of the disproportionate number of “excess deaths” and morbidity experienced by African Americans. “Excess deaths” refers to the difference between the number of deaths

experienced by African Americans and the number that would have occurred if African Americans had experienced the same death rates as Whites.

The following list provides a general overview of the areas in which medical bias has been identified as a factor that significantly shapes patient outcomes. The reader is referred to the bibliography at the end of this handbook for references to studies that demonstrate racial disparities in treatment.

A substantial number of studies indicate that African Americans in the general population, even when insured, are less likely than Whites to receive:

- High tech hospital procedures including: Carotid endarterectomy, coronary artery bypass grafting, coronary angiography, angioplasty, automatic implantable cardioverter-defibrillator, and organ transplantation;
- Thrombolytic therapy;
- Prescription drugs, such as more effective antibiotics and analgesics;
- Intervention therapy for coronary artery disease and stroke;
- Medical services, such as intensive care, for critical illnesses;
- Full options for treatment of prostate, breast, and colorectal cancer;
- Cutting edge drugs for HIV infection; and
- Adequate prenatal care and advice from health care professionals.

It is clear that such biased treatment does not exist in all medical settings, yet socioeconomic status and health care access may play a role.

Given African Americans' experiences with discrimination and abuse and medical biases, it is natural that many African Americans would develop a sense of mistrust towards the health care system. Numerous other practices and events such as medical experimentation on Blacks in the "Tuskegee Study of Syphilis in the Negro Male" have added to that mistrust.

- Studies report that many African Americans may delay reporting disease symptoms and health problems to physicians due to their general mistrust of the medical establishment.
- Negative feelings about the medical establishment have been associated with lower African American participation in clinical trial studies and with some members of the Black communities' belief that AIDS is a form of global genocide.

## **Behavioral/Lifestyle Risk Factors**

While genetic and social factors are important in defining African American disease patterns, so, too are lifestyle choices and behaviors. In general, these particular risk factors are more responsive to alteration by individual choice.

## **Substance Abuse/Chemical Dependency**

Tobacco, alcohol and drug use are major risk factors for coronary heart disease, stroke, cancer, chronic obstructive pulmonary disease, liver disease, fetal abnormalities, premature and low birthweight infants, accidental injury, suicide and violence. African Americans experience a significant burden of a majority of these diseases.

### **Smoking**

Estimates of mortality associated with smoking-related diseases demonstrate the toll tobacco use is taking on this population:

- Approximately forty-five thousand African Americans die from smoking-related diseases each year. While African Americans smoke fewer cigarettes per day than Whites on average, they tend to smoke brands with higher nicotine levels.
- African Americans have the highest lung cancer mortality rate in the general population. In 1998, the age-adjusted death rate for lung cancer among African Americans was 46 per 100,000 compared to 38 per 100,000 among Whites and 17 per 100,000 among Asian and Pacific Islanders.

Educational efforts and media publicity have been effective in reducing smoking among U.S. adults from 42% in 1965 to 24% in 1999. Although the overall percentage of American adults who smoke has decreased, African American males still smoke more than African American females and their White counterparts.

Interestingly, studies indicate that fewer African American teens smoke. Black American teens initiate smoking later in life, 14 years of age, as opposed to 12 years of age for Whites.

Studies demonstrate a very different age-related smoking pattern for African Americans than for Whites:

- Among White women, there is very little increase in percentage of smokers across 10 year cohorts from age 18 to 64, hovering consistently around 26%. Among White males, a similar consistency prevails through 18-64 at about 29%.
- Among African American females however, from a low of 8% in the 18-24 age cohort, the percentage of smokers triples to 25% in the 25-34 age group, and increases further to 32% in ages 35-44 and finally drops after age 44 to 21%.
- Among African American males, the percentage is relatively low in the 18-24 age group, 20%, but increases to 31% in the 25-34 group, goes up further to 37% in the 35-44 age group and goes even higher, to 42%, among those in the 45-64 group.

Therefore, African Americans, beginning in their young adulthood, have rates of smoking that increase through middle age. This persistent pattern may account for their higher mortality rate from smoking related disease. Studies appearing in the Journal of the American Medical Association suggest the possibility of a greater susceptibility to nicotine addiction among African Americans as a result of a variation in nicotine metabolism. JAMA editors summarize:

“Emerging from these studies is an appreciation for the complex interaction of distinct pharmacogenetic mutations associated with racial ancestry, bestowing some individuals unfavorable combinations of drug-metabolizing genes or gene products

that alter nicotine metabolism or the body burden of toxic substances increasing genetic damage or risk for cancer.”

If further research validates racial differences in the metabolism of nicotine and differences in the extent to which carcinogenic compounds are deactivated in the body, these differences may contribute to a greater understanding of the long-term persistence of smoking among African Americans and the greater risk for lung cancer.

## **Alcohol**

Use of alcohol is normative among the American population: more adults drink than do not. However, there is wide variation in the frequency and quantity of alcohol consumption. The terms “alcohol abuse” or “problem drinking” are used to indicate drinking practices which are associated with personal and social problems experienced by the drinker. The terms “alcohol dependence” and “alcoholism” are used to designate drinkers who demonstrate both social problems and signs of physiological dependence on alcohol. These distinctions are more fully described in the Diagnostic and Statistical Manual, IV-R, of the American Psychological Association.

Studies in 1984 and 1992 recorded an interesting pattern of alcohol use that distinguished African Americans from the larger population:

- There was no difference in lifetime rates of abstinence among African Americans and Whites and no differences in overall lifetime prevalence of abuse and dependence;
- Young Blacks had lower rates of alcohol use, abuse and dependence than Whites;
- African American men in the youngest age group (18-25) were more likely to be abstainers than men in other groups.
- Older cohorts of African American males had higher rates of alcohol use and heavier drinking than Whites and higher prevalence of abuse and dependence; African American women who consumed alcohol in middle-age were heavier consumers than White women of a similar age.
- As they aged, African American and Latino men were more likely to increase or remain stable in heavy drinking categories through middle life, thus increasing their risk for cirrhosis and other alcohol-related problems; White men usually reduced heavy drinking as they entered their thirties.
- By middle age, African Americans who drank were experiencing comparatively greater numbers of alcohol-related problems.
- Abstinence increases with age among African American women. Light drinkers maintain this pattern with age. The very small number of heavy drinking women tend not to break this practice with age.

Drinking practices among African American men and women are affected differently by their income levels. Increased income leads to lower rates of abstinence among women but no increase in the prevalence of heavy drinking. Abstinence remained similar across income levels among men, though men in the lowest and highest income levels were the heaviest drinkers.

Studies of adolescent drinking confirm lower rates of drinking among African American youth as compared to other youth:

- According to the 2000 National Household Survey on Drug Abuse, African American youth reported a past month alcohol use rate of 19% compared to 31% among Whites and 14% among Asians.
- The 2000 Youth Risk Behavior Survey conducted by the CDC showed that White and Hispanic students (36% and 32%, respectively) were significantly more likely than Black students (16%) to report episodic heavy drinking.

The epidemiological patterns of alcohol use follow the same general trajectory as those of smoking: limited use among youth, but increasing use through young adulthood and middle age.

These patterns, research indicates, result in higher rates of Fetal Alcohol Syndrome, cirrhotic liver disease, esophageal cancer and social and employment problems for the African American population, that add to and interact with preexisting problems related to disadvantage and discrimination. Studies of African American treatment populations indicate that this group suffers from:

- Greater feelings of social isolation;
- Limited financial support, including insurance for chemical dependency treatment;
- Combined alcohol and polydrug use; and
- Employment difficulties.

No specific treatment modality is more effective than others, although the need for culturally sensitive awareness, whatever the modality, has been stressed.

## **Drugs**

A major paradox is found in African American drug use. National household surveys generally show small differences in rates of drug-taking among Blacks, Whites and Latinos. A National Institute on Drug Abuse survey showed that cumulative illicit drug taking is lower among Blacks than their White counterparts in all age cohorts below 35. The 2000 National Household Survey showed:

- Lifetime prevalence of illicit drug use for 12-17 year olds was 28% among Whites, 27% among Latinos and 25% for African Americans.
- For 26-34 year olds, the rates were, respectively 41%, 28% and 36%.

As with smoking and alcohol use, drug use prevalence starts out lower among African American youth, but is higher among the middle-aged than in other groups.

On the other hand, case indicators and mortality and morbidity data all show substantial over-representation of African Americans. This may be partially attributable to public perceptions and media coverage which focus on associations between drugs and violence among people of color in central cities.

A National Research Council review of illicit drug use in the United States (1993) characterizes this contrast as one of “two worlds.” While African Americans are less likely to be involved with drugs than most other population groups, those who do get involved are far more likely to be dysfunctional and have difficulty getting off illicit substances. A combination of unfavorable factors such as inadequate housing, economic instability and high crime rates predispose Black youth who do use drugs to abuse.

- Clearly, illicit drug use is highly variable across segments of the African American population.
- Heavy cocaine derivative use by inner city African American young women is associated with the birth of “crack babies.”
- Injected drug use by inner city African Americans is associated with high rates of HIV and AIDS.

Findings from the 1999 Youth Risk Behavior Survey conducted by the Centers for Disease Control among high school students in grades 9-12 report that:

- Use of illicit substances is not pervasive among African American youth.
- There were no significant differences across racial/ethnic groups of lifetime marijuana use (47%).
- Latino (15%) and White (10%) students were significantly more likely than Black (2%) students to have used cocaine during their lifetime.
- About 2% of all students had used injected drugs.
- Black students (2%) were significantly less likely to have used methamphetamines than Latinos (11%) and Whites (10%).

## **Obesity**

Overweight is defined as a Body Mass Index (BMI) equal to or greater than the 85th percentile of the total U.S. population, and severe overweight or obesity are defined as a BMI equal to or greater than the 95th percentile of the total U.S. population. Data from the Fourth National Health and Nutrition Examination Survey 1999 showed the percent of overweight and obese male and female Americans increased from 56% to 61% between 1994 and 1999. Data collected by the CDC in 1997 showed that among Americans age 18 and older, the median percentages of obesity were 16% among Whites, 18% among Hispanics and 26% among Blacks. Overweight and obesity are established risk factors in association with cardiovascular diseases, diabetes mellitus, hypertension, high blood cholesterol, arthritis, respiratory problems and some forms of cancer. Obesity, therefore, is a definite risk factor among African Americans, contributing significantly to higher incidence of cardiovascular disease and type II diabetes.

Investigations of metabolic responses during rest, exercise, and recovery suggest that African American females may be genetically predisposed to the eventual onset of obesity. Compared to White women with similar family histories of obesity, African American women were found to have patterns in metabolic response associated with slower impact on energy balance which predispose them for eventual onset of obesity.

These differences in metabolic patterns include:

- lower rates of oxygen consumption;
- higher metabolic reliance on carbohydrates;
- higher insulin levels.

Black women are less likely than White women to perceive themselves as overweight, regardless of their actual relative weight. Based on U.S. Department of Agriculture statistics, 22.6% of African American men and 56.9% of African American women exhibited centralized fat distribution or elevated waist-to-hip ratio. Centralized body fat distribution, the concentration of fat on the trunk or abdomen relative to the limbs or lower body, has been associated with a number of serious metabolic disturbances and chronic diseases.

### **Diet and Nutrition**

Of the four major lifestyle risk factors associated with increased risk for disease among African Americans, diet and nutrition are the factors most intimately tied to cultural practices, such as family eating practices, ethnic food habits, dietary preferences, and cultural beliefs and values. Hence, because dietary habits may be associated with personal and group identity, they may pose the biggest challenge to modification for patients and health care professionals.

Although there have been few empirical studies to support it, there is a general assumption that major differences exist between the eating patterns of American Blacks and Whites. Increased wealth among African Americans is unlikely to change dietary preferences for culturally preferred foods. Undernourishment and poor quality food sources exist in poorer African American and White communities, leading to growth retardation and increased risk of inadequate dietary intake of vitamins and minerals. Rural/urban residence may also account for diversity of dietary patterns and level of consumption within the African American population.

Strengths of African American diets include frequent consumption of leafy green vegetables, cruciferous vegetables and citrus fruits and consumption of rich sources of Vitamin A and thiamin and relatively high rates of fish and poultry. On the other hand there are several weaknesses in African American dietary practices that contribute to inadequate nutrition:

- Food preparation methods that tend to include overcooking of vegetables and extensive use of frying.
- A preference for high fat and sodium seasoning methods, including high fat meats such as pork, lunch meats, and organ meats. These animal protein sources represent a significant number of calories consumed, and are high in saturated fats. The fat drippings that remain after meat preparation are often recycled as gravy.
- Over 60% of adult African Americans are lactose intolerant resulting in habitual avoidance of milk and milk products. Those who do consume milk are more likely to use whole milk as opposed to non-fat milk which can lead to decreased calcium intake.
- Analysis of the National Health and Nutrition Examination Study II data found that African Americans consumed more eggs, sweets and salty snacks than White Americans.
- Patterns of low consumption of fresh total fruits and vegetables resulting in decreased consumption of dietary fiber and potassium and with its associated risk for colorectal cancer and hypertension.

**Offer culturally appropriate recommendations for African Americans as follows:**

| <b>INSTEAD OF:</b>   | <b>TRY:</b>   |
|--|---|
| <b>Fried foods such as fried chicken, fried fish, or fried beef liver</b>  | <b>Broiling, boiling, grilling, stewing, poaching, or baking meats instead of frying; roasting or broiling meat on a rack; trimming extra fat from meat; removing skin from poultry; limiting intake of organ meats</b> |
| <b>High-fat cuts of meat, such as pig feet, spare ribs, neck bone, sausage, pork bacon, ham; high salt lunch meat (cold cuts), hot dogs</b>    | <b>Lower-fat meats, such as skinless chicken or turkey (choose white meat); chicken or turkey based meat products, such as turkey bacon or chicken or turkey sausage or fish</b>  |
| <b>Pork sausage and ground beef or pork</b>  | <b>Ground skinless turkey breast; Ground turkey or sirloin</b>  |
| <b>Basting meat with fat and using extra fat for gravy</b>   | <b>A gravy substitute such as non-fatty marinades</b>   |
| <b>Lard, butter, or other fats that are hard at room temperature</b>   | <b>A small amount of vegetable oil; nonstick pans or spray or virgin olive oil</b>  |
| <b>Cooking vegetables and beans with high fat and high salt meats cuts such as fat back, salt pork, or ham hocks; seasoning food with salt</b> | <b>Cooking vegetables with fresh turkey parts without skin, fresh seasonings such as garlic, onions, celery, bell peppers, lemon juice, or saltless dried seasonings and spices</b>                                     |
| <b>Baked macaroni and cheese, fried potatoes, or grits served with extra butter</b>  | <b>Baked macaroni with low-fat cheese, baked or broiled potatoes, or grits with a little margarine</b>  |
| <b>Whole milk</b>  | <b>Low-fat (1-2%) or non-fat (skim) milk</b>  |
| <b>Instead of whole-milk cheeses</b>   | <b>Low-fat or part-skim-milk cheeses</b>  |
| <b>Cream</b>   | <b>Evaporated skim milk</b>   |
| <b>Ice cream, frosted cake, and cobbler made with lard or shortening</b>   | <b>Low-fat frozen yogurt, ice milk, sorbet, sherbert, fruit ice, angel food cake or fruit cobbler made with a small amount of margarine</b>   |
| <b>High fat and/or high salt foods such as potato chips, corn chips, salted nuts, pickles, many canned foods and donuts or cakes</b>           | <b>Foods high in dietary fiber, plain popcorn, especially fresh whole fruits and vegetables and high fiber grains</b>   |

## **Physical Activity**

Health practitioners generally agree that a significant correlation exists between physical inactivity and overweight or obesity. Inactivity is an established risk factor for many of the chronic diseases prevalent among all Americans. The majority of the U.S. population is relatively physically inactive. As reported by the American Heart Association, the rates of physical inactivity among Black women and men are 68% and 63%, respectively, compared to 56% for White women and men.

Black men and women have been found to have lower energy expenditure for leisure-time activity than their gender-specific White counterparts, and Blacks are more sedentary than Whites independent of income and education.

The perceptions and beliefs about exercise, rest and health among African Americans have been studied. It is generally believed by African Americans, albeit erroneously, that:

- Since African Americans have more blue-collar jobs, they experience physical activity through increased job-related physical labor.
- A “rest ethic” exists, which posits that rest is needed to compensate for job- and family-related physical labor. Lack of exercise is a physical stressor that may cause or aggravate certain health conditions, such as high blood pressure.

## **Aspects of American Society that Affect Health Behavior**

Because historical circumstances of persistent discrimination and racism have resulted in blocked access to health care for African Americans, understanding the role of structural and economic barriers to health care utilization is critical. The marked disparities between Black and White morbidity and mortality have resulted in numerous studies that have documented the role of beliefs, values, and perceptions in influencing health behavior among African Americans.

- Many African Americans were blocked from health care access until Title VI of the Civil Rights Act of 1964, which decreed that Blacks could not be legally barred from health services delivery.
- Low socioeconomic status with its major impact on health is approximately fourfold greater among Blacks than Whites. Consequentially, many Blacks reside in neighborhoods with increased violence and exposure to environmental toxins and decreased opportunities for quality nutrition, or safer environmental opportunities for physical activity and exercise facilities.
- More than 30% of Blacks, the highest concentration of all ethnic groups, reside in central cities. Residence in urban areas increases exposure to the hazards of urban decay, including congested neighborhoods, unsanitary and dilapidated housing, high crime and drug trafficking, inadequate and/or unwilling police protection, high unemployment, and deteriorating schools. Residence in urban areas has been associated with a disproportionate incidence of asthma and lead poisoning among African American children.
- Blacks are more likely than Whites to live in racially segregated neighborhoods. For Blacks, residence in racially segregated neighborhoods has been associated with higher rates of homicide, accidents, suicides, infant mortality, cancer, HIV, and cardiovascular disease.

- Lack of information about available services, lack of culturally competent health care professionals, dialect differences, cost, need for child care, lack of transportation, loss of pay from being away from work are documented barriers to adequate health care and are validated socioeconomic predictors of health disparities.

## **Implications for Kaiser Permanente Care Providers**

- Inquiring about patient workplaces and homes can assist in determining the potential risk factors and associated health problems faced by patients. Educating patients about strategies for reducing their risk is critical to efforts to combat major health problems and foster favorable quality of life experiences for our patients.
- Prejudices and biases are part of reality and have a deleterious impact of quality of life, health status and life expectancy. Health care professionals should examine their personal practices for unintentional bias along the health care continuum. Sometimes inappropriate assumptions can impact the selection of treatment options. Only through increased awareness of prejudices and meaningful efforts to remove them when treating patients can existing and potential disparities in diagnosis and treatment be addressed.
- Knowing the level and scope of lifestyle-related risk factors among African Americans, providers can help to plan improved treatment strategies for their patients.
- Recognize that the increase in use and persistence of use of tobacco, alcohol and illicit drugs through middle age among African Americans is a critical, group-specific epidemiological pattern that:
  - May cause earlier onset and greater acuity of diabetes and hypertension.
  - Makes treatment of diabetes, hypertension and other disorders more difficult and compliance more problematic.
  - Creates social and economic problems that compound medical problems.

The persistence and stability of substance use among some African American patients is a particular challenge for chemical dependency providers. The literature indicates that while there is no specific chemical dependency treatment modality that works best for African Americans, clients will stay in treatment and respond better when providers and treatment are sensitive to African American culture. Programs must address the issues of mistrust and provide a level of respect for the patient that is often missing from other areas of their lives.

Early and consistent screening for overweight, especially among African American women is critical in the prevention and management of several major health problems. Dietary differences may contribute to the higher propensity for overweight among African American patients. Assist patients in developing weight control goals and culturally specific strategies to reach these goals. Encourage the participation of family and friends in the adoption of healthy strategies for weight control.

Patients are more likely to comply with dietary changes if they are consistent with current eating patterns. Because some African American diets are distinct from other Americans, it would be important to be clear on each patient's dietary practices and use those practices as a point of departure.

- Educate patients about the need to read food information labels in order to make healthy choices in purchasing low-fat and low-sodium foods.
- Encourage patients whose dietary habits may be deficient in vital nutrients to supplement their diet with a multiple vitamin.
- Encourage family participation in dietary modification.
- Educate children about the importance of healthy eating and exercise and its relationship to a lifelong program of health promoting fitness and health.
- Studies on dietary modification report reasons given by African Americans for not making dietary changes for health reasons include: enjoyment of food, belief that existing diets were healthy, too many recommendations about what to eat or not eat became a barrier in making change, recommended changes too costly. These barriers in making dietary changes and the documented correlation between dietary choices and health status signal the need for the development of classes that address cultural dietary issues and socioeconomic realities.
- Encourage the creation of culturally appropriate health promotion and education classes and brochures.
- Educate patients about the association between physical inactivity and increased risk for cardiovascular diseases, some cancers, type II diabetes, osteoarthritis, osteoporosis, obesity, falling, depression, and anxiety and the benefits of exercise in reducing stress. Assist patients in establishing goals related to physical activity (both anaerobic and aerobic exercise) and a strategy to meet their goals. Encourage the adoption of exercise as a daily health promotion activity.
- Because some African Americans may reside in areas where it is unsafe to exercise, encourage group exercise with friends, relatives, and neighbors (*i.e.*, walking, at home aerobic dance videotape sessions) may help such patients develop a consistent exercise routine.

## **MAJOR DISEASES**

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### **Introduction**

**A**lthough genetic factors determine specific diseases (*i.e.*, sickle cell disease), hereditary propensity also plays a major role in diseases like hypertension, diabetes, and perhaps even in prostate cancer. There is substantial evidence that the increased prevalence of hypertension and its cardiovascular consequences in the African American population can be ascribed to both hereditary and lifestyle factors. For example, salt sensitivity in animal studies suggest the propagation of generations of salt sensitive subjects, whose lifestyle habits include use of salt and fats, low potassium and low calcium intake, and low physical activity, may have severe implications. Similar genetic influences are hypothesized to affect human beings.

## Hypertension

The American Heart Association reports that high blood pressure is the leading preventable cause of excess deaths annually among African Americans. Prevalence of hypertension among African Americans in the United States is among the highest in the world. Compared to Whites, African Americans tend to develop hypertension earlier in life and their average blood pressures are much higher. African Americans have higher rates of hypertension and hypertensive related morbidity and mortality rates compared to Whites. The precise cause of the higher incidence of hypertension among African Americans remains unknown.

In 1999, the overall age-adjusted death rate from high blood pressure was:

- 46.8 per 100,000 for African American males (366% higher than for White males)
- 40.3 per 100,000 for African American females (315% higher than for White females)

Risk factors associated with hypertension among African Americans include:

- Sodium intake resulting in genetic susceptibility;
- Higher rates of overweight and obesity often resulting from poor diet and lack of physical activity;
- Higher incidence of cigarette smoking over 35 years of age when Blacks have been shown to increase smoking, and its relationship among women when combined with oral contraceptives; and
- High salt consumption.

Factors increasing complications among African Americans with hypertension include:

- Younger age of onset, but later diagnosis;
- Higher prevalence of severe hypertension at any decade of life; and
- Concomitance with type II Diabetes.

Numerous studies have documented reasons in patient compliance to pharmacologic control of hypertension. These reasons for patient non-compliance include: cost-prohibitiveness of drugs and unpleasant side effects such as impotence, drowsiness, and lethargy.

Late diagnosis leads to higher rates of hypertension-related complications, and poor compliance control in diagnosed cases results in:

- Increased risk for the development of hypertensive End Stage Renal Disease (ESRD). Statistics show that nationwide, Blacks have a 10- to 17-fold increased risk over Whites for the development of hypertensive ESRD.
- Increased risk for heart disease and stroke, which is a leading cause of mortality among African Americans.
- Increased risk for development of left ventricular hypertrophy and therefore cardiovascular disease.

## Diabetes Mellitus

The American Diabetes Association (ADA) estimates that approximately 2.3 million, or 10.8%, of African Americans in the United States have type II diabetes. However, it is estimated that approximately half of the African Americans who meet diagnostic criteria for diabetes remain undiagnosed.

Latinos have the highest prevalence of diabetes mellitus, but African Americans experience the next highest rate, with increased morbidity and mortality than their Latino counterparts. This increased prevalence is almost exclusively limited to type II or non-insulin dependent diabetes mellitus. Type II diabetes is most prevalent among individuals in the 45-64 year age group with the rate for Blacks being 51% higher than Whites. African American women are more likely to develop diabetes than are African American men, and women with diabetes are generally overweight or obese. National Health and Nutrition Examination Survey data indicate that the prevalence of reported diabetes is 2.9 times higher in persons who are overweight than non-overweight, although non-obese African Americans are still at higher risk than non-Hispanic Whites. Compared to White men and women, the 1999 age-adjusted death rate due to diabetes was 188% higher for Black men, and 246% higher for Black women.

Risk factors associated with increased risk for type II diabetes among African Americans include:

- Family history.
- Impaired glucose tolerance rates.
- Higher prevalence of microalbuminuria, a marker for renal involvement.
- Overweight and obesity with earlier onset of both.
- Higher rates of centralized obesity.
- Concomitant hypertension.
- Lower levels of physical activity, especially among African American women.
- Southern born African Americans who have migrated to other regions of the United States have a higher incidence of diabetes related morbidity and mortality.

Late diagnosis is a major issue defining diabetes among African Americans. Estimates for the duration of diabetes before diagnosis range from 4-7 years. Late diagnosis and higher rates of type II diabetes, as well as poor control in diagnosed cases result in much higher prevalence of severe complications:

- Higher rates of diabetic retinopathy: African Americans are twice as likely as Whites to suffer from diabetes related blindness. Documented barriers to retinal screening include lack of knowledge or understanding that screening and treatment can prevent visual loss.
- Higher rates of lower extremity amputations: African Americans are 1.5 to 2.5 times more likely than Whites to suffer from lower limb amputation.
- Increased chance of developing end-stage renal disease (ESRD): The increased frequency of ESRD in Black diabetics compared with White diabetics ranges from 2.5 to 5.6 times

excess, with higher rates for Black women. The probability of developing ESRD is greater for African Americans who have type I diabetes than for those with type II diabetes. However, statistics show that survival after development of diabetic ESRD may be better for Blacks than Whites.

- Increased risk of microvascular disease, including cardiovascular disease and cerebrovascular disease. However, prevalence of cardiovascular disease in diabetic Blacks appears lower than in diabetic Whites.
- Increased risk for mortality among babies of African American women with diabetes.

## **End Stage Renal Disease (ESRD)**

African Americans, Latinos, and Native Americans experience a disproportionate incidence of ESRD. This is related to the greater prevalence of hypertension and diabetes in these populations. While rates of hypertension have decreased over the past two decades, for unknown reasons renal failure has continued to increase during the same time period.

Increased rates and complications among African Americans are thought to be related to but not entirely explained by:

- Higher rates of hypertension, including younger age at onset for hypertension.
- Higher rates of diabetes.
- Higher rates of hypertensive nephrosclerosis and nephropathy secondary to type I and II diabetes.
- Higher incidence of ESRD among lower socioeconomic status individuals, possibly related to lack of access to preventive health measures.
- In 1992, the median age of onset of hypertensive ESRD was age 59 years for Blacks and 70 years for Whites. Although the risk for ESRD increases with age, African Americans show disproportionate higher incidence rate of hypertensive ESRD in all age groups beginning at age 15.

## **Cardiovascular Disease**

The American Heart Association estimates that over 61 million Americans have one or more types of cardiovascular disease. Cardiovascular disease includes high blood pressure, coronary artery disease, stroke and congestive heart failure. African Americans experience higher rates of death resulting from all causes of cardiovascular disease.

The 1999 overall mortality rate due to cardiovascular disease was 28% higher for Black males and 36% higher for Black females compared to Whites. From ages 35-74, the age-adjusted mortality rate from coronary artery disease for Black women is more than 71% higher than for White women. Blacks are more likely to have higher out-of-hospital mortality from acute myocardial infarction. This trend may be related to disparities in the recognition and interpretation of symptoms. Medical literature has documented racial bias in the treatment of coronary artery disease. For example, Whites undergo one-third more coronary angiographies and more than twice as many coronary bypass graft procedures as Blacks. Sociocultural factors may adversely affect the quality of care of Black patients, (*e.g.*, medical decisions are sometimes influenced by race.)

Increased risk for cardiovascular disease, among African Americans is associated with the following:

- Increased prevalence of hypertension, increased severity of hypertension, earlier onset and often inadequate therapy;
- Higher rates of high blood cholesterol, diabetes and the effect of vascular disease;
- Cigarette smoking, especially in the more vulnerable years over 35;
- For nonsmokers, exposure to second hand smoke;
- Overweight or obesity, especially centralized obesity;
- Increased rates of physical inactivity;
- Previous heart attack or stroke; and
- Longer delay times for seeking treatment.

## **Cerebrovascular Disease**

African American stroke mortality rates are among the highest in the world. Stroke incidence is one of the major contributors to the differential mortality rates between Black and White Americans. The late 1960s to early 1970s increased public health and private organization emphasis on the detection and treatment of hypertension. These decades have resulted in a marked onset of a decrease of stroke mortality for Black and White Americans and the overall rates of decline have been greater for Blacks than for Whites. However, the frequency of stroke mortality for Blacks remains markedly higher, particularly in the “stroke belt,” (the southeastern United States.) Although the specific causes of the “stroke belt” remain unknown, researchers estimate a greater than 40% excess risk of stroke mortality, and more than 1200 excess stroke deaths occur in this region annually. Recent data from the Centers for Disease Prevention and Control estimate that the cluster is beginning to break up and extend into Texas and Arkansas. U.S. Census data estimates that nearly 60% of African Americans reside in the south, in states considered part of the “stroke belt.”

- According to the National Heart, Lung and Blood Institute, age-adjusted stroke incidence rates per 1,000 people were 4.44 for Black males (249% higher than for White males) and 3.1 for Black females (250% higher than for White females.)
- African American men and women are more likely to die from stroke than their White counterparts. Compared to Whites, exceedingly higher stroke mortality occurs for Blacks in every age group over 25. Stroke mortality in Blacks occurs at younger ages.
- Research has documented that African American patients have a significantly lower likelihood than White patients of undergoing carotid artery angiography and subsequent endarterectomy. Explanations for these lower rates include racial bias, racial differences in pathophysiology of the carotid disease, affordability, and racial variation in patient decisions regarding care.

Increased risk for stroke among African Americans is associated with the following:

- Increased prevalence and severity of hypertension with earlier onset, inadequate therapy and/or poor compliance resulting in higher rates of untreated or uncontrolled hypertension;

- Diabetes and hypercholesterolemia, both of which are more prevalent among Blacks;
- Higher rates of smoking, particularly in the more vulnerable years over 35 when Blacks have been shown to increase their use of smoking; and
- Higher rates of physical inactivity.

## Cancer

The aggregation of cancer within families is well documented. Risk factors such as smoking and drinking do not account for the excess cancer deaths experienced by Blacks and have hypothesized that certain cancers, such as cancers of the prostate, lung, skin, bladder, and breast are more aggressive in African Americans. The American Cancer Society reports that prostate, lung and colorectal cancer in Black males, and breast, colorectal and lung among Black females are the leading causes of cancer in the African American population. African American men have a higher overall cancer incidence rate than any other racial or ethnic group in the United States. Between 1979 and 1990, for all cancer sites combined, Blacks experienced 10% higher cancer incidence and 30% higher mortality than Whites.

Although advances have been made in establishing risk factors, screening and treatment and the overall mortality rates have decreased, substantial racial disparities still exist in survival rates:

- In a description of 5-year survival rates for American Blacks and Whites between 1989 and 1993, for all sites survival rates were 44% for Blacks and 60% for Whites. Black females experienced higher survival rates than Black men. Overall, cancers in Blacks are diagnosed at a later stage.
- The National Cancer Institute’s Surveillance, Epidemiology and End Results Program reports cancer mortality rates for deaths occurring between 1989 and 1993, as 0.9 times higher for prostate, colon and rectum, lung and bronchus, and breast; the leading causes of cancer mortality among African Americans.
- Southern-born African Americans almost always had higher cancer-related death rates than their counterparts born in the northeast, midwest, and west. Southern-born migrants almost always experienced higher cancer mortality rates than persons who were born and remained in the South.
- Lower rates of cancer have been documented among foreign-born Blacks.

Risk factors specific to African Americans for leading cancer are summarized in the following chart:

| <b>Cancer Site</b> | <b>Specific Factors Associated with Higher Mortality Among African Americans</b>  |
|--------------------|---|
| <b>Breast</b>      | <p><b>Breast cancer strikes African American women at an earlier age, under 40. The causes may be:</b></p> <ul style="list-style-type: none"> <li>• <b>Earlier onset of menstruation</b></li> <li>• <b>Higher mortality due to diagnosis at later stage of disease</b></li> </ul> |

| <b>Cancer Site</b>        | <b>Specific Factors Associated with Higher Mortality Among African Americans</b>  |
|---------------------------|---|
| <b>Breast (cont.)</b>     | <ul style="list-style-type: none"> <li>• <b>Possibly a difference in tumor biology</b></li> <li>• <b>Possibly a high fat diet, inadequate fruit and vegetable consumption, alcohol consumption, physical inactivity</b></li> </ul>  |
| <b>Colon &amp; Rectum</b> | <ul style="list-style-type: none"> <li>• <b>Studies show Blacks treated less aggressively than Whites. Blacks less likely than Whites to undergo surgery or adjuvant therapy. When Blacks undergo surgical resection, they experience lower post-operative survival.</b></li> <li>• <b>Higher rates of physical inactivity</b></li> <li>• <b>Consumption of a high-fat or low-fiber diet</b></li> <li>• <b>Higher mortality due to diagnosis at later stage of disease</b></li> </ul>   |
| <b>Lung</b>               | <ul style="list-style-type: none"> <li>• <b>Cigarette smoking and exposure to environmental tobacco smoke</b></li> <li>• <b>Increased likelihood of workplace exposure to certain substances, including asbestos and some chemicals</b></li> <li>• <b>Higher mortality due to diagnosis at later stage of disease</b></li> <li>• <b>Possibly larger mediastinal tumor burden than Whites</b></li> </ul>   |
| <b>Prostate</b>           | <ul style="list-style-type: none"> <li>• <b>Possibly a higher burden of high histologic grade prostate cancer in Blacks, indicating a more aggressive form of the disease</b></li> <li>• <b>Higher mortality due to diagnosis at later stage of disease</b></li> <li>• <b>Possibly related to the prevalence of higher testosterone levels in young Black men as compared with age-matched White men</b></li> <li>• <b>Increased risk for developing prostate cancer at younger ages</b></li> <li>• <b>Blacks less likely to undergo biopsy or radical prostatectomy for treatment</b></li> </ul> |

Beliefs, perceptions, and attitudes are known predictors of health behaviors. Research that has investigated the disproportionate burden of cancer of Blacks has shown that Blacks are:

- Less likely than Whites to:
  - Be knowledgeable of or perceive the importance of early detection through screening.
  - Be knowledgeable about the signs and symptoms of cancer.
  - See their doctor when they experience symptoms of cancer.
  - Engage in cancer risk-reduction behaviors, such as dietary modification.

- More likely than Whites to:
  - Fear a diagnosis of cancer and potential treatment, pain and embarrassment.
  - Be fatalistic, or pessimistic about their survival, and to perceive a diagnosis of cancer as a “death sentence,” thus undervaluing early detection and therapy.
  - Express disbelief in the value of early detection and therapy.
  - Underestimate the prevalence of cancer and their own susceptibility.
  - Believe cancer myths and misconceptions, including those surrounding the causes of cancer or the side effects of screening tests.
  - Believe that “surgery can expose cancer to the air” and cause it to spread.
- Poverty, decreased access and less knowledge about diseases, such as cancer are typical risk factors used to explain racial differences in disease morbidity and mortality. However, in studies where these factors are statistically controlled, African Americans are less likely to participate in screening. Similarly, even with intervention, such as providing knowledge about colorectal cancer, African Americans remain less likely to participate in cancer screening. These findings suggest that other factors affect important health care decisions. It is also important to note that socioeconomic variability exists within the African American population and that some of these factors may be less likely to be operative in a middle-class African American privately insured population.
- African American men are receptive to screening, despite anecdotes about their reluctance to undergo prostate cancer screening.
- In 1993, the CDC reported no difference in the proportion of Black and White women, age 40 and older who reported use of mammography within the previous two years. However, use of mammography rates decline for women in all ethnic groups at 65-years-old and older. Similar rates have been reported for Pap smear use. Not surprising, the highest rates of mammography and Pap smear screening are reported by women who belong to an HMO.

## **Autoimmune Diseases**

### **Systemic Lupus Erythematosus**

Systemic lupus erythematosus (SLE) is a chronic autoimmune disease that occurs more frequently in females throughout the United States. African American females are three to four times more likely to manifest this disease than their Latino or White counterparts. The incidence and prevalence of the disease appears almost equally among Black and White males.

African-Americans demonstrate SLE at an earlier age, with musculoskeletal, arthritic and cutaneous manifestations occurring more frequently in the initial presentation. More severe disease activity and organ involvement occurs as age progresses, contributing to a higher incidence of morbidity and mortality. Although overall survival rates have improved, renal involvement is still more frequent and more aggressive in Blacks and contributes to a higher incidence of death. Such differences in renal outcomes remain unknown but are independent of age, duration of illness, history of hypertension, hypertension control during therapy and activity or chronicity indices on renal biopsy and suggest some familial clustering.

In comparison to other ethnorracial groups, there is evidence that a genetic difference exists in the African American population with the gene yet to be identified. Various serologic markers have been identified in Blacks that are different than their White counterparts.

Numerous studies have linked socioeconomic status and psychosocial well-being with the incidence and outcome of the disease, although there is no difference between African Americans and Whites in this same socioeconomic group. This status seems more to correlate with the availability and quality of medical treatment, education, and counseling.

## **Pulmonary Disease**

Populations of color in the United States are disproportionately affected by respiratory diseases. Chronic Obstructive Pulmonary Disease, sarcoidosis, pneumonia and influenza have a higher incidence among African Americans, than among Whites or Latinos. Chronic bronchitis and emphysema are the only major lung diseases for which Whites carry a disproportionate burden of morbidity and mortality.

In addition to cigarette smoking, pulmonary diseases are generally attributed to the following risk factors:

- Low socioeconomic status, less education and residence in urban areas.
- Occupational hazards. Men in occupations who are exposed to cotton, hemp or grain dust or fire fighting work involving exposure to asbestos experience higher mortality rates.

## **Asthma**

The American Lung Association reports:

- In 2002, the asthma prevalence rate among Blacks was almost twice as high than that of Whites. In 1998, there were an estimated 1.7 million cases of asthma among Blacks.
- Although Blacks represent only 12% of the population, Blacks account for 24% of all asthma deaths. In 1998, the age-adjusted death rate for asthma among Blacks was 3.7 per 100,000, almost three times the death rate of 1.1 for Whites.
- Asthma prevalence has increased steadily among all sex, race, and age groups since the 1970s and is the most chronic disease in childhood. Studies show that compared to Whites, Black children experience increased asthma prevalence, with symptoms presenting between the ages of 1 and 3 years old. It is believed that Blacks have a more severe form of asthma beginning in childhood.
- An analysis of National Center for Health Statistics data found that between 1979 and 1998, the rate of increase for asthma deaths was nearly two times higher for Blacks than Whites. Researchers hypothesize that the racial disparity in asthma morbidity and mortality may be attributed to the level of health care services available and to environmental factors posed by the increased likelihood that Blacks reside in urban areas with higher levels of air pollution.

## **Infectious Diseases**

Compared to White Americans, tuberculosis, Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STD) are infectious diseases that disproportionately affect African Americans.

## **Tuberculosis**

Following a decrease in the occurrence of tuberculosis in the early 1980s, the last two decades have been characterized by increased occurrence, especially among Blacks and Latinos.

The American Lung Association reports:

- Blacks are nearly eight times more likely to contract active tuberculosis than are Whites.
- In 1999, the total number of new tuberculosis cases among Blacks was 5,552. While Blacks represent 12% of the U.S. population, they accounted for 32% of the tuberculosis cases.
- American Lung Association statistics for 2000 indicate that 77% of the 16,377 cases of tuberculosis in the United States were people of color. Of these, approximately 32% were Black, 23% Latino, 21% Asian and Pacific Islander, and 1% American Indian and Alaska Native. Among children from birth to 15 years of age, 89% of tuberculosis cases were among children of color.

## **HIV/AIDS**

HIV/AIDS is a major health problem of national and international proportions. Globally, there are an estimated 35 million adults and 1.5 million children (15 years and below), living with HIV/AIDS. In the United States, CDC data show 800 - 900,000 residents living with HIV infection.

Since 1997, U.S. data indicate an average of 40,000 new HIV infections per year, with half of the cases occurring in individuals under the age of twenty-five. Alarming, more than half of these new HIV infections occur among African-Americans (54%), who represent only 12% of the U.S. population. (Hispanics are also disproportionately affected (19%), although they constitute 13% of the population.)

Black men most often contract the disease through homosexual activity. Black women are most often infected through heterosexual contact, with intravenous drug use being the second most common cause of infection in both groups. Ninety-five percent of pediatric AIDS cases are in utero from HIV infected mothers. An encouraging finding has been a decrease in the progression of perinatal HIV since the prompt implementation of zidovudine at the onset of pregnancy.

By the end of year 2000, overall deaths from AIDS were 448,660 in the U.S., making AIDS the fifth leading cause of death among residents 25-44 years of age. In the African American population, AIDS has become the leading cause of death in males of this age group and the third leading cause among African American women.

Although the introduction of new medication in the mid-1990's has caused a dramatic decline in AIDS deaths by slowing the progression of HIV to AIDS, this decline is slowing with the emergence of new multi drug resistant strains of HIV and by the growing incidence of cardiovascular disease presumed related to interactions of these protease inhibitors with the cardiovascular system.

## Other Sexually Transmitted Diseases (STD)

According to the CDC, about 12 million cases of STD are reported annually in the United States. The CDC reports that risk factors associated with STD include low socioeconomic status, poor access to good quality health care, poor health care seeking behavior, illicit drug use, and living in communities with high prevalence of STD.

As reported in the CDC's Sexually Transmitted Surveillance 2000, when STD statistics were examined by race or ethnicity, very wide discrepancies existed between racial and ethnic groups. For example, the congenital syphilis rate has decreased nationally in recent years, yet 2000 surveillance data indicate that among African American women, rates of congenital syphilis were 33 times greater than among Whites. The CDC attributes discrepancies such as this to reporting biases resulting from more complete reporting from public sources (*e.g.*, STD clinics) than from private sources. Since populations of color may utilize public clinics more than Whites, differences in rates between people of color and Whites may be inflated. The reader is advised to keep this information in mind when reviewing the epidemiological data that follows:

The CDC's Sexually Transmitted Disease Surveillance 2001 Report indicates that:

- Of the 361,000 total reported cases of gonorrhea, African Americans accounted for about 76% of these cases, with high rates reported among African American adolescents and young adults. The rates for Black adolescent (15- to 19-year-old) females and males were the highest among all racial/ethnic groups. The rate for African Americans in the 20- to 24-year-old age group was 26 times that of Whites.
- Of the 6,100 total reported cases of primary and secondary syphilis, African Americans accounted for about 62% of all cases, a rate about 15 times greater than for Whites.

## Implications For Kaiser Permanente Care Providers

- A thorough family history is critical in determining the association of a patient's hereditary propensity for diseases, such as breast, bladder, prostate or lung cancer, and diabetes, hypertension, heart or autoimmune disease. Encouraging patients to informally interview their family members about health problems and diseases can assist in developing an inventory of patients' family medical histories. These health inventories can assist in taking more aggressive preventive measures for those patients with family histories of major health problems. Educating patients about increased risk resulting from genetic propensity and strategies that can be undertaken to counter associated risks may result in lack of or delayed onset and/or decreased severity of disease states.
- Educate patients about the importance of controlling the risk factors that they have the most control over:
  - Decreasing consumption of salt and alcohol;
  - Decreasing fat and cholesterol intake by decreasing meat consumption and increasing intake of whole grains and fresh fruits and vegetables;
  - Smoking cessation and the avoidance of second-hand smoke;
  - Adopting daily exercise as a regularly occurring health promotion activity;
  - Controlling weight;
  - Taking prescribed medication as directed; and
  - Establishing safe sexual practices.

- Culturally appropriate dietary recommendations should take into consideration African American dietary patterns and family cooperation. Exercise recommendations should be consistent with the patient's lifestyle and patterns of behavior.
- Early and consistent screening for overweight, elevated blood glucose, blood pressure, and cholesterol levels in African American patients is necessary in slowing the complications of hypertension, diabetes, and ESRD. Screening as early as adolescence, particularly of individuals from high risk families, is critical to early detection. Health care professionals who serve populations with high African American representation may want to develop culturally sensitive outreach programs (*e.g.*, utilize religious institutions or programs featuring high profile African American celebrities.)
- Educate diabetic patients about proper foot care. This strategy can help prevent serious diabetic related foot complications, assist in early detection of problems, and possibly reduce the incidence of amputations. Also encourage diabetic patients to have regular eye examinations.
- It is critical that we increase patient knowledge about heart attack symptoms and stress the importance of seeking immediate attention when symptoms present. Give patients culturally specific brochures that describe heart attack, stroke prevention, and warning signs.
- Present menopausal women with the option of estrogen replacement therapy to protect against heart attack.
- Given the increased risk for complications in pregnancy due to hypertension and diabetes, early diagnosis and control are critical to reducing infant and maternal mortality.
- Review the pharmacology of anti-hypertensives among African Americans.
- The prevention of the onset of smoking and the timely cessation of smoking are critical in preventing the development of pulmonary diseases. Encourage family participation in the education of the health dangers posed by smoking and the value of behavior modification resulting in smoking cessation.
- Educate patients and especially parents of children with asthma about the symptoms of asthma including shortness of breath, wheezing, tightness of the chest, and coughing that last more than six weeks. Encourage parents/caregivers to take classes related to controlling asthma attacks.
- Educate parents about the potential detrimental outcomes of noncompliance in asthma management including hospitalization, loss of days of school and work, pneumonia, and death.
- Because the effective control of pulmonary diseases requires the elimination of irritants and potential sources of infection, encourage family support in the avoidance of factors realistically within their control (*e.g.*, cigarette smoke and dusty work or residential environments). Encourage covering mattresses and pillows. Encourage dust and animal dander control to decrease symptom severity. Since some patients reside in rental properties and have less control over manipulating their environments, health care professionals should be aware that environmental changes typically suggested for asthma maintenance, such as carpet and drapery removal may be unrealistic for some patients. Work with patients to help them determine what they can change to make the task of eliminating home respiratory risks more realistic for them.

- Encourage patients to investigate whether Occupational Safety and Hazards Administration (OSHA) requirements and rules are being complied with in their workplace.
- Encourage patient compliance in the use of medications by enlisting family support.
- The prophylaxis regimen is a documented challenge for patients diagnosed with tuberculosis. Patient education and support throughout the regimen is critical to successful medical management and eradication of tuberculosis.
- Patient screening and education play important roles in the prevention, detection, and treatment of HIV and STDs (*e.g.*, gonorrhea and syphilis.)
- Educate patients about high risk behaviors and the potential outcomes relative to the transmission of infectious diseases.
- Assessing patients' exposure to infectious diseases is critical in prevention and diagnosis. Help patients assess their risk based on behavioral (*e.g.*, multiple sex partners, unprotected sex) or occupational (*e.g.*, needle sticks) risk factors.
- Encourage “safe sex” practices, including abstinence and the correct and consistent use of latex condoms, beginning in early adolescence.

## **SPECIAL AREAS OF CLINICAL FOCUS**

### **Obstetrics/Gynecology**

In addition to facing substantially higher rates of uterine leiomyomas, review of United States Vital Statistics Data, beginning in 1940, indicates that African American rates of infant deaths, fetal deaths, neonatal deaths, and maternal deaths have been consistently and significantly higher than among Whites.

#### **Relevant Traditional Beliefs and Practices**

Women in most cultures hold non-biomedical beliefs relating to birth and reproductive health. Among African American women, one may observe:

- Geophagia, the ingestion of earth or clay, is a folk practice that has been observed among pregnant women and children in Africa and some parts of the United States. As African American women migrated from the south to the north and west, the ingestion of laundry starch replaced the red clay indigenous to the southern United States. Pagophagia, the ingestion of large quantities of ice and freezer frost, has been observed among African American women and children. Studies have also documented pica, the ingestion of nonfood substances, such as the consumption of cornstarch, baking soda, baking powder, undissolved Alka Seltzer tablets, milk of magnesia in cake form, soap, ashes, chalk, paint, and burnt-matches. Pregnant women may perceive the consumption of starch as a practice that will aid in blood building. This practice could potentially lead to gastrointestinal impaction, decreased iron absorption, lead toxicity, and anemia.

- Some African American women may be reluctant to use contraceptive devices or medication that affect menstrual blood flow, such as “the Pill,” IUD, or Depo-Provera. Because of traditional beliefs about the importance of maintaining a “normal” amount of blood in the body, any alteration in menstrual flow whether in the form of lighter menstrual flow, occasional spotting of blood, or actual cessation of the menses may be seen as dangerous to health and well-being. Among some African American women, there may be resistance to using the intrauterine device (IUD) because of a fear that the device might get lost inside the body.
- Perdition refers to a Haitian belief that a woman may have a fetus trapped in her womb for several years before eventually delivering the child. Perdition is believed to result from walking barefoot, carrying too heavy of a load, or the result of a spell cast on the unborn child’s family.
- There are strong cultural injunctions against causing a lactating woman to lose her temper. Some believe that should a lactating woman lose her temper, her milk will physically rise to her head and enter her brain causing violent behavior and perhaps insanity.
- Some women after childbirth, experience weakness, dizziness, confusion, and disorientation. Haitian cultural beliefs interpret these symptoms as the wandering womb, the effect of the displaced womb moving around the body in search for the child.
- Among some Haitians, gas (gaz) is seen as a cause of illness, particularly pain and anemia. Gas can enter the body through the ears and mouth and lead to pain in the head, stomach, legs, back, and shoulder. A woman who has just given birth may wear a tight belt around her waist to keep gas from entering her body.
- Some Eritrean women believe that in the West, too much blood is drawn for testing. Pregnant Eritrean women believe that pregnant women need all of their blood and may not understand that blood needs to be drawn. Many Eritrean women may feel that western doctors practice too many Cesarean sections and would prefer for the baby to come naturally. Eritrean women generally prefer to be cared for by women.

### **Female Circumcision**

There are still many cultural groups throughout the world who believe in the custom of clitoridectomy or female circumcision which involves various degrees of excision of the clitoris, labia menora and labia majora. Circumcised women may have the labia sewn nearly closed. It is estimated that 2.5 million women have undergone some form of circumcision. With increased immigration to the U.S., more cases of female circumcision are presenting in OB/GYN practices.

- Women who have experienced female circumcision typically suffer severe medical complications including increased risk of: cysts, bleeding, infection, difficulties with menstruation and urination, painful intercourse, perinatal difficulties, obstetric complications, including prolonged labor and a higher incidence of maternal mortality.

### **Maternal Health**

In 1999, the Centers for Disease Control and Prevention reported a maternal mortality rate for Black women of 25.1 per 100,000, a rate more than 4 times the rate for White women (6.0 per 100,000.)

- During pregnancy, African American women face increased risk for:
  - developing maternal hypertension (includes pregnancy induced hypertension, hypertension and chronic hypertension preceding pregnancy). Analysis of National Hospital Discharge Survey data indicate that hypertensive African American women had a threefold greater risk of antepartum hemorrhage as a complication during pregnancy.
  - developing amniotic infection, including amniotic infection syndrome, histologic chorioamnionitis, clinical chorioamnionitis, premature rupture of the membranes, and early neonatal mortality from sepsis contribute to poorer perinatal outcome.
  - retaining more weight after pregnancy. This finding generates hypotheses about the higher rates of obesity found in Black mothers. It is important to monitor weight gain during and after pregnancy.
- The Office of Minority Health reports that the mortality rate for babies of Black women with diabetes is three times the mortality rate for babies of White women with diabetes.

### **Infant Mortality and Low Birth Weight**

The U.S. infant mortality rate has dropped dramatically over the past four decades. Despite the overall decrease in infant mortality rates, the U.S. Department of Health and Human Services reports that infant mortality among African Americans remains a national health crisis.

- Data from the Centers for Disease Control and Prevention/Center for Health Statistics, show that in 1999 the infant mortality rate for Black infants was 2.4 times the rate for White infants. In 1999, the three leading causes of infant death for Black and White infants were congenital anomalies, disorders relating to short gestation and low birthweight, and sudden infant death syndrome (SIDS). The rate for disorders related to short gestation and low birthweight was 4.0 times higher among Blacks than Whites. Rates for Black infant deaths due to SIDS were 2.3 times higher. In fact, mortality rates for Black infants were an average of 2.5 times higher than Whites in all ten leading causes of infant death.
- The precise cause for racial disparities in infant mortality remain unknown. Biologic, behavioral, socioeconomic studies remain inconclusive. However, two of the primary antecedents of infant mortality are low birthweight and small-for-gestational-age preterm delivery. Blacks are two times as likely as Whites to have low birthweight babies and preterm birth. Also, Black women experience higher rates of intra-uterine growth retardation, a disorder related to higher risks for infant mortality.
- Low birthweight babies face increased risk of death and disability and are at greater risk of dying during their first year of life. Low birthweight has been associated with increased risk of mental retardation, learning disability, birth defects, blindness, autism, cerebral palsy, epilepsy, visual and hearing disabilities, delayed speech, and asthma.
- Analysis of 1999 vital statistics indicate that infant mortality and low birth weight rates are highest among both Black and White poor and less educated women. However, it is surprising to learn that the Black/White ratio is lowest among women who have not completed high school and highest among women with a college education. It has been reported that college-educated Black women are twice as likely to give birth to low birth weight infants and three times as likely to give birth to very low birth weight infants than White counterparts. Research has not yet demonstrated reasons for these discrepancies.

As previously stated, the precise cause for racial disparities in infant mortality remain unknown. However, risk factors associated with increased rates of low birthweight among African American women include:

- Increased rates of hypertension, diabetes, elevated cholesterol, anemia/abnormal hemoglobin, preeclampsia/toxemia and urinary tract infections;
- High rates of low and high pre-pregnancy weight;
- High rates of maternal cigarette smoking;
- High rates of alcohol and drug intake during pregnancy;
- Lower rates of prenatal care, especially in the first trimester;
- Poorer pre-pregnancy health and nutritional practices;
- High rates of unplanned, unintended, unwanted, or mistimed pregnancies;
- High rates of low maternal weight gain;
- Unmarried status;
- Increased likelihood of previous preterm birth;
- Increased exposure to physical, environmental, and psychosocial stressors;
- Residence in the most racially segregated areas;
- Shorter intervals between pregnancies; and
- Increased exposure to factors associated with prolonged social and economic hardship including very young maternal age, high birth order, and lower education.

### **Implications for Kaiser Permanente Care Providers**

- Given the incidence of sickle cell anemia among African Americans, screen African Americans for hemoglobinopathy and review the results and genetic implications for childbearing.
- Encourage patient adherence to prenatal care guidelines.
- Given the increased risk the development of maternal hypertension among African American women, screen African American women for hypertension and review the results and implications for associated pregnancy complications.
- Given the incidence of diabetes among African American women, and the increased risk for mortality of babies born to diabetic African American women, early and consistent screening, as well as assisting patients with control of diabetes can reduce the number of African American patients at risk.

- Given the incidence of overweight and obesity among African American women and the evidence that African American women tend to retain more weight following pregnancy, screen for weight gain and review the results and implications for overall health.
- Inquire about patient's cultural beliefs relevant to reproductive health, including contraception, pregnancy, breastfeeding and childbirth. When possible, incorporate beliefs and practices into treatment.
- Be aware of the practice of female circumcision among African and Middle Eastern immigrants and its implications. The practice of female circumcision is illegal in the United States. This may become an issue for obstetricians who need to surgically undo the closures prior to delivery then are requested to re-suture the closure following delivery.

## **SPECIAL AREAS OF CLINICAL FOCUS**

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### **Childhood and Adolescent Health**

Despite the improvements in children's health since the 1950s, morbidity and mortality rates for African American children compared to Whites, continue to be higher. African American children face a higher risk of asthma, lead poisoning, malnutrition, sickle cell disease, iron deficiency anemia, disabling accidents or injuries, and poor dental care. U.S. Census data indicate a higher incidence of extended family parenting, particularly among grandparents. In this section, we use parent to imply caregiver.

#### **Immunizations**

Immunizations are the most cost-effective medical interventions available. However, data show that:

- African American infants are less likely than White infants to have completed their immunization series.
- Higher rates of infants and toddlers who have not received age-appropriate immunizations are found among residents in inner cities and rural areas. Documented barriers include lack of knowledge, cost, and inadequate health care access.

#### **Asthma**

African American children and adolescents, when compared to Whites, experience disproportionately higher rates of prevalence, hospitalization, and mortality. The CDC reports that in 1993:

- Among children 0-4 years of age, African Americans were six times as likely to die from asthma than Whites.
- Among children aged 5-17, African Americans were four times more likely than Whites to die from asthma, and boys were 1.3 times more likely than girls.
- Among persons 15-24, African Americans were six times more likely than Whites to die from asthma, and males were 1.5 times more likely than females.

## Lead Poisoning

The U.S. Department of Health and Human Services reports that average blood lead levels for American children and adults have dropped more than 80 percent since the late 1970's. However, childhood lead poisoning is one of the most common pediatric health problems in the United States.

- According to the Centers for Disease Control and Prevention:
  - About one million American children younger than 6 years of age have blood levels of at least 10 micrograms per decimeter (ug/dL), a level high enough to adversely affect their intelligence, behavior, and development.
  - Children of color and poor children are disproportionately affected by lead poisoning. More than one-fifth of Black children living in older homes have elevated blood lead levels.
  - Residence in large inner cities and rural areas is associated with increased risk for blood lead poisoning.
- The most serious sources for lead exposure are:
  - Deteriorated paint in older housing, especially housing built before 1960.
  - Dust and soil contaminated by paint and other substances containing lead.
  - Residues from past emissions of leaded gasoline.
  - Improperly fired ceramic ware and imported pottery.
  - Water contaminated from lead pipes.

## Sickle Cell Disease

Sickle cell diseases comprise a group of three common genetic blood disorders: sickle cell anemia, hemoglobin SC disease, and sickle beta-thalassemia. Although sickle cell disease is found in a few other ethnicities, it is found most commonly in the United States among African Americans.

Initial signs of sickle cell disease may be presented in infants with fever, or swollen hands or feet.

Consider early problems in childhood as early signs of sickle cell anemia:

- Temperature elevation above 101° F;
- Changes in behavior, such as increased irritability, tiredness, weakness;
- Feeding disturbances such as not eating, vomiting, or diarrhea;
- Rapid breathing; or
- Pale blue or gray skin or lips.

Annually, the disease affects about 1 in 500 African American newborns and 1 in 1,000 Latino newborns. Approximately 8% of African Americans carry the gene for sickle cell trait. Babies with sickle cell anemia face increased risk for a number of potentially life-threatening complications that continue into adulthood (*i.e.*, pain crises, anemia, aplastic and splenic sequestrant (crises, hand-and-foot syndrome, potentially life-threatening infections, stroke, lung infarction or sickle cell syndrome) and chronic organ dysfunction.

The emerging understanding of sickle cell disease has led to new experimental therapies with variable results, which nonetheless has greatly improved care and survival well into the third and fourth decade and occasionally beyond.

### **Overweight**

Recent studies show that while the general American population is becoming increasingly overweight, African American children show early onset of obesity. Overweight is related to risk factors for cardiovascular disease and diabetes, two leading causes of excess mortality among American Blacks.

- In an investigation of relation of percentage body fat and maximal aerobic capacity to risk factors for atherosclerosis and diabetes in Black and White 7- to 11-year-old children, researchers found that Black children had higher insulin levels, a risk factor for cardiovascular disease and diabetes.
- Findings from the Bogalusa Heart Study and Coronary Risk Development in Young Adults (CARDIA) indicate that early onset of overweight and obesity is more prevalent in African Americans girls in the 6- to 17-year-old range.
- Data from the National Heart, Lung, and Blood Institute Growth and Health Study suggests that at an early age, Black girls engage in eating practices and physical inactivity that have been associated with weight gain. Early eating practices and sedentary activity may have significant implications for obesity development.

### **Adolescent Pregnancy**

According to the CDC, the birth rates for teenagers (aged 15-19) declined each year between 1991 and 2000, with an overall decline of 22% since 1991. Among African American adolescents between the ages of 15 and 17, the birthrate declined 3% between 1999 and 2000, and has declined 23% since 1991, reaching a record low of 52 per 1000, compared to 15.8 for Whites, and 60 for Latinas.

- Adolescent mothers are more likely to have low-birth weight babies, to lack timely prenatal care, and to smoke during pregnancy. However, smoking rates differ significantly among racial and ethnic groups. For example, in year 2000, 30.85% of White mothers smoked during pregnancy compared to 8.2% of Black mothers and 3.2% of Mexican American mothers.
- Analysis of a 19-year (1975-1993) computerized perinatal data base on 69,096 births indicate that White, Black and Latina adolescent mothers between the ages of 12-15 years face a higher risk of having a low birthweight baby. However, in all racial groups, females 16-19 years had better outcomes than adults.

### **Accidents, Injuries and Homicide**

The CDC and the National Center for Education in Maternal and Child Health report that unintentional accidents (including traffic accidents, falls, misuse of toys, poor toy design, unintentional shootings resulting from unsecured firearms, drowning) are the leading cause of death in children and adolescents.

CDC data indicate that homicide is the second leading cause of death of all persons 15 to 24 years of age. Homicide is the leading cause of death for African Americans and Latinos aged 15 to 24, and the second leading cause of death among Black children 1 to 14 years of age.

The homicide rate for Black older adolescents is eight times higher than for Whites of the same age. Homicide and other forms of intentional injury are the major causes of death and disability among Black adolescents and young adults.

## **Implications for Kaiser Permanente Care Providers**

### ***Asthma***

- Educate parents/caregivers in the need for control of environmental factors that trigger asthma attacks while being sensitive to the difficulties of doing so in inner city environments. Emphasize control of those factors that parents can manage.

### ***Sickle Cell Anemia***

- Sickle cell anemia has been widely studied and scientific evidence clearly indicates that its passage through generations can be averted through early detection of the hemoglobin type and adequate genetic counseling. Screen African Americans for hemoglobinopathy and review the results and genetic implications for childbearing.
- Infants and children who have received a genetic diagnosis of sickle cell disease should seek medical attention any time the child is ill, particularly when presenting with fever. Abdominal, chest and bone pain are also indicators of underlying sickle cell crisis.
- Educate parents/caregivers about sickle cell disease and the risk of non-compliance to medical management of their child's health. Encourage participation in sickle cell anemia support groups.
- Educate staff and emergency physicians on effective management of pain crises and the implication of fever or pulmonary symptoms. Adolescents and adults who present to emergency rooms requesting painkilling drugs are frequently mistaken for street drug addicts.

### ***Immunizations***

- Parental awareness of the importance of adhering to and completing immunization schedules as part of childhood preventive health is critical in reducing many preventable infectious diseases. Counsel parents about the common diseases that can be prevented through immunization. Direct parents/caregivers to culturally relevant literature on immunizations.

### ***Lead Poisoning***

- Educate parents/caregivers about the key causes and hazards of childhood lead poisoning. Provide them with written materials on how to protect children from lead exposure.
- Children ages 6 to 72 months comprise the highest priority group for screening. Screening is critical in the diagnosis and treatment of childhood lead poisoning. Perform routine blood lead test screening for children at risk for lead exposure.
- Diets high in calcium, iron, and low-fat foods can help protect children from blood lead poisoning.

- The CDC recommends that due to the need to work with public health agencies for appropriate environmental investigation and remediation, lead-poisoned children and their families may benefit from social services follow-up.

### **Obesity**

- Early and consistent screening for overweight, especially among African American girls is critical in preventing a number of potentially debilitating health problems and diseases.
- Encourage balanced exercise and dietary habits for children starting at an early age. Encourage parents/caregivers to adopt family-oriented health promotional activities (*i.e.*, family walks, incorporate children in healthy meal planning and preparation).

### **Adolescent Pregnancy**

- Promote “safer sex” strategies, including abstinence and condom use.
- To prevent adolescent pregnancy, educate patients about birth control methods.
- To prevent pre-term labor, educate patients about the signs of pregnancy, the benefits of pre-pregnancy nutritional counseling and early prenatal care.

### **Accidents, Injuries and Homicide**

- Among all teens, gang membership is the leading cause of homicide. Encourage parents/caregivers to stay involved in their children’s lives, and to involve their children with positive and productive influences, such as academic, social, church, or community activities.
- Support participation in schools educating children and adolescents about the importance of healthy nutrition, regular exercise habits, remaining substance free, and non-violent methods of conflict resolution.

## **SPECIAL AREAS OF CLINICAL FOCUS**

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### **Mental Health**

A number of researchers have argued that the experiences of racism and discrimination place African Americans at increased risk for mental health disorders. However, epidemiological data are inconsistent and suggest that a range of biases shape past and current research on African American mental health. Analysis of national hospitalization data portray poorer mental health status for African Americans. However, analysis of structured interviews and large-scale studies such as the Epidemiological Catchment Area (ECA) Project identify few consistent patterns of racial or ethnic differences in mental health disorders.

Racial and ethnic differences have been documented in a number of areas including: diagnosis categories, hospitalization rates, treatment regimen of medical care, medical care utilization and treatment preferences. Possible reporting biases can be attributed to a focus on lower-income African Americans, or due to more Blacks being treated in public facilities that have more consistent reporting methods than private institutions where more Whites are treated. Further research is needed to clarify the effects of race on the decision-making process in the diagnosis and disposition from psychiatric service providers.

Compared to Whites with similar symptoms, Blacks are more likely to:

- Receive a diagnosis of a severe mental disorder such as schizophrenia.
- Be diagnosed with substance abuse, when in truth, the rates for substance abuse for Blacks are no greater than for Whites.
- Be diagnosed with anxiety disorder.
- Be misdiagnosed, hospitalized, hospitalized involuntarily, to receive seclusion and restraints, to receive inadequate treatment for the severity of their diagnosis, and to be discharged earlier.

Data also suggest racial and ethnic differences in prescribing patterns. Some studies show that when treating African American and Latino patients, providers underuse psychotropic drugs. Conversely, other studies show that when treating African Americans and Latinos, providers are more likely to overuse anti-psychotics, dispense higher doses, and give involuntary treatment which may place patients at increased risk for side effects or poorer outcomes than when treating Whites. Despite the tendency to overmedicate African American patients, some studies indicate that African Americans may respond more quickly than Whites to anti-psychotic agents and require lower dosages.

Although depression has been identified as a major public health problem among all Americans, studies of depression have been inconclusive in documenting the incidence and prevalence of depression among African Americans. In a national probability study, Blacks who were 30-39 years of age, belonged to non-Western religious groups, and lived in the West were at greater risk compared to Whites. Yet, other studies have identified differing ranges in age, and income levels and marital status as associated with depression among African Americans. One explanation for the inconsistency in existing studies is that depression may present differently in different ethnic groups.

Family breakdown, illicit drug use, increased indifference to organized religion resulting in increased acceptability of suicide, and easier access to alcohol and lethal suicide methods are believed to have contributed to a recent increase in suicide rates among all youth. African American suicide rates had been traditionally lower than for Whites. But now, the CDC reports a disturbing trend in the increase of suicide rates among all youth, especially Black youths. Possible reasons for the increased suicide rates amongst Black youths include a differential recording of suicide as a cause of death, and with the growth of the middle class, the increased possibility that Black teens may mimic the “coping behaviors” of the mainstream society.

- From 1980-1995, the rate of suicide among Black youths, 10 to 19 years of age increased 114%.
- The National Center for Injury Prevention and Control (NCIPC) reports that from 1980-1992, the rate for suicide among African American males, aged 15-19 years old increased by 165.3%.

Compared to Whites, Blacks and Latinos show underutilization of specialized mental health services. Once in the mental health system, African American patients tend to terminate earlier than White patients. African American and Latino families are less likely than Whites to seek help from agencies and mental health professionals for their children, and are more likely to seek help from family and community sources. Possible explanations for underutilization include:

- A difference in physician referral services among ethnic groups;
- A tendency for African Americans to delay seeking help;
- Use of more informal support than formal services, with a preference for prayer, faith, or religion as coping mechanisms;
- Seeking treatment and support from friends, family, clergy, non-mental health professionals; and
- Stigma or social embarrassment about seeking psychological help.

Given the differences in diagnosis and treatment reported in scientific studies, it not surprising that other documented reasons for Blacks’ differential use of mental health services include fear and suspicion of the mental health system, as well as fear of hospitalization.

Risk factors associated with increased risk for mental disorders among African Americans may include the following stressors:

- Racism, discrimination, and prejudice place Blacks at greater risk for reduced mental health status. Blacks at all levels of socioeconomic status are more likely to have access to fewer economic, social, and political resources and to be affected by institutional racism which may place them at increased risk for the development of some mental disorders.
- The confounding influence of racism and sexism may place some African American women at increased risk for mental disorders. Studies of overweight Black women have shown an association between experiences of racism and sexism and challenges with

weight control. In addition to changes in eating patterns as a coping mechanism, higher rates of heavy drinking found among some Black women may be attributed to the confounding of psychosocial and environmental stressors.

- Lower socioeconomic status among African Americans has been associated with higher risk for mental disorders, especially major depression. Yet, less than half of African Americans with major depression receive clinical treatment. Compared to Whites, lower income African Americans are more likely to reside in unsafe neighborhoods with environmental stressors such as chronic exposure to violence, and increased likelihood of having witnessed or been a victim of violence.
- Compared to Whites, Blacks experience significantly higher rates of morbidity and mortality due to chronic health problems. Blacks also tend to face increased severity of disease and more complications. African Americans, especially the elderly, are more likely than Whites, to have multiple chronic illnesses, such as hypertension, diabetes, heart disease, end-stage renal disease, stroke, or cancer. Multiple stressors may also take the form of feelings of isolation, loneliness, and alienation for elderly African Americans who live alone. On the other hand, elderly African Americans who have taken on full-time child care responsibilities for their grandchildren may face multiple stressors incurred in their caregiver role and in caring for their own health.
- Bias, stereotypes, and misperceptions held by some health care professionals and African American patients may place African Americans at increased risk for challenges in mental health, from diagnosis through treatment. Stereotypes that African Americans are not easily susceptible to depression and related mental disorders may negatively influence diagnosis or discourage some patients from seeking treatment. Blacks are more likely than Whites to be misdiagnosed. It is believed that, in mental health especially, misdiagnosis often occurs as a result of social distance between treating psychiatrists and the patient. Among the elderly, misdiagnosis might also be attributed to inaccessibility of mental health screening instruments due to cognition and literacy challenges.

## **Implications for Kaiser Permanente Care Providers**

- Acknowledge the impact that racism and discrimination have on the daily lives of African American members and patients.
- Assist patients in identifying mental health risks and make appropriate referrals for professional therapy.
- Because African Americans tend to terminate mental health services early, follow-up of patients who miss appointments is critical.
- Work with patients to gain insight into their values and perceptions of mental health care, risk factors, coping, and treatment expectations and preferences. Where possible for those patients who prefer the support of spiritual venues or family, incorporate patient preference into treatment.
- Work with patients to understand their perceptions of how feelings are expressed, what emotions are viewed as appropriate to express, as well as how, when, and to whom.
- Early diagnosis and treatment of depression is critical for those patients who experience depression comorbid with a chronic medical problem. Treatment can improve patient

distress and treatment compliance, and reduce morbidity and mortality associated with chronic medical problems.

- Educate patients, particularly parents in reference to their children, those with chronic illnesses, and the elderly and their caregivers about the symptoms of depression.
- Consider how family members might be incorporated into the treatment process.
- Facilitate the development of culturally sensitive mental health programs to aid in higher return patient rates and improved outcomes.
- Prejudices are an integral part of the human experience. As health care professionals, we should assess our individual stereotypes, biases, and perceptions about African Americans and determine how they might influence our clinical practice.
- Review pharmacologic implications of African American ancestry when prescribing medications.

## **SPECIAL AREAS OF CLINICAL FOCUS**

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### **Gerontology**

The Census 2000 reports that older adults comprise 12.4% of the U.S. population within all major racial and ethnic groups. The older adult population is likely to grow substantially in the years to come as health care preventive and treatment practices advance.

- Many elderly African Americans experienced poor quality health care from conception through adulthood. That, combined with environmental risk factors, has resulted in a population that bears a disproportionate prevalence of acute and chronic disease, illness, and disability, compared to Whites. Improvements in the social and economic status of elderly African Americans since the 1950s, combined with the advent of Medicaid and Medicare in the 1960s has resulted in improved health status for all older Americans. Despite the improved health status of African Americans, mistrust of the medical establishment and fatalism among groups of color is associated with decreased utilization of screening procedures. This is true even among affluent, elderly African Americans.
- Blacks and Whites experience an interesting “crossover” in mortality statistics past the age of 80 years, with Blacks surviving longer than Whites.
- Studies show that African American elderly patients may have the tendency to:
  - Not report or under report illness and physiological changes;
  - Delay reporting symptoms;
  - Ignore certain physiological changes, such as edema of the legs, morning stiffness, dizziness on rising, constipation, and urinary changes;
  - Accept bladder fullness or a sense of urgency as part of the normal process of aging;
  - Perceive illness as a sign of weakness;
  - Engage less frequently than Whites in health promoting practices; and
  - Treat illness at home whenever possible.

- A study of cancer fatalism among elderly Whites and African Americans found that as participants' level of education increased, cancer fatalism decreased. African Americans and women were found to be most fatalistic. Despite the tendency for African Americans to engage in fatalistic beliefs, studies show that of all ethnic elders of color, African Americans would like to and expect to live the longest.
- Elderly Blacks experience more ophthalmological problems. Compared to Whites, African Americans experience an estimated 4 to 8 times greater risk of developing glaucoma, one of the most common causes of preventable blindness in the United States. A recent study by the National Institutes of Health found that Black patients with open-angle glaucoma, the most common form of the eye disorder, respond differently than White to treatment options. Black patients did better when their treatment process began with laser therapies. Whites did better beginning with a course of treatment of trabeculectomy.

### **Advanced Directives**

Studies have shown that compared to Whites, African Americans want more life-sustaining treatments, yet they are less likely to have discussed life-sustaining treatments with their physicians and families, and have or want fewer living wills. There is still speculation as to the causes of these contradictions. Some researchers suggest that compared to Whites, Black patients may be less likely to have discussed life-sustaining treatments with their physicians and have a living will. This may be because they trust the health care system less, fear inadequate health care more, and feel less confident that a living will would give them control over their terminal health care. It follows that elderly African Americans may be resistant to completing written advanced directives because of mistrust or misunderstanding of the medical system, or because they lack of knowledge of living wills, durable power of attorney, and advanced directives.

### **Implications for Kaiser Permanente Care Providers**

- Be sensitive to their potential mistrust of the medical system and fatalism (See Risk Factors Section: Medical Bias.)
- Refer members and patients to social workers regarding living wills, durable power of attorney, and advanced directives. These documents can empower the patient to have their wishes honored.
- Involve family members in assessing patient health problems and behaviors. Enlist family involvement in patient care and compliance.
- For those who live alone, address loss of self-esteem and depression. Encourage social support through participation in family, community, or church activities

## CONCLUSION

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In this handbook we have addressed some of the major health problems that affect the African American population. It is unfortunate that many of the factors negatively affecting the health of this group are related to socioeconomic factors brought about by the lack of opportunity due to racial discrimination. African Americans experience a disproportionate amount of health care disparities compared to Whites. Many studies show that these disparities remain even when socioeconomic factors are controlled.

In many sections of this handbook we report significant racial differences of chronic diseases and mortality rates. Many of these deaths were most likely preventable through modification of risk factors, early diagnosis, and access to good health care. Bear in mind that the African American population is heterogeneous as a result of factors that include urban or rural resident, socioeconomic status, recent immigrant status, and country of origin. It is unknown whether or not the data reported in this handbook reflect the Kaiser Permanente membership as there is minimal information available.

The National Center for Chronic Disease Prevention and Health Promotion identifies the primary risk factors for chronic diseases that comprise the leading causes of death among Americans as smoking, poor nutrition, sedentary lifestyle, alcohol misuse, inadequate health services, and unprotected sexual intercourse. As a health maintenance organization, we are in a unique position to address each one of these risk factors through the provision of regular preventive health care.

Patient education, patient compliance, and medical management are critical to the prevention, management, and cure of many chronic diseases that disproportionately affect African Americans. In a nation as diverse as the United States, cultural experiences shape these aspects of care from the perspectives of both patient and health care professional. Healthcare providers can make a difference in the overall health status of Americans, and particularly African Americans who experience such a disproportionate burden of morbidity and mortality. The path to continued success as a national health care leader is paved with the practice of medicine as a healing art that combines advances in the science and technology of medicine with personalized health care delivery that recognizes and respects individual and cultural differences among patients. We hope that this handbook will serve as a tool that assists you in delivering high quality culturally competent health care.

A Provider's Handbook on Culturally Competent Care: African American Population, 2nd Edition.

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## RESOURCES

The following are national resources that may assist the health care provider and/or your patient. Check with your local Kaiser Permanente Health Education Department for additional materials, videos and local resources. Appearance of a web site link or resource does not necessarily imply endorsement by the National Diversity Department or by Kaiser Permanente.

|   | Phone   | Web Site  |
|---|---|---|
| <b>Breast Cancer</b>  |   |   |
| <b>Sisters Network</b> is a national breast cancer network that provides online health information, support and referrals to African American survivors of breast cancer.                                 | 713-781-0255  | <a href="http://www.sistersnetworkinc.org">http://www.sistersnetworkinc.org</a>   |
| <b>Diabetes</b>   |   |   |
| <b>National Diabetes Information Clearinghouse</b> provides health information, references and resources for African Americans with diabetes.   | 1-800-860-8747  | <a href="http://www.niddk.nih.gov/health/diabetes/pubs/afam/afam.htm">http://www.niddk.nih.gov/health/diabetes/pubs/afam/afam.htm</a>   |
| <b>The American Diabetes Association</b> provides health information and community support for African Americans with diabetes.   | 1-800-DIABETES<br>or 1-800-342-2383                           | <a href="http://www.diabetes.org/main/community/outreach/african_americans/diabetesin.jsp">http://www.diabetes.org/main/community/outreach/african_americans/diabetesin.jsp</a> |
| <b>The National Women's Health Information Center</b> provides health information and resources for African American women with diabetes.   | 1-800-994-WOMAN or<br>1-800-994-9662<br>or 1-888-220-5446 TTY | <a href="http://www.4woman.gov/faq/diabetesafrc.htm">http://www.4woman.gov/faq/diabetesafrc.htm</a>   |
| <b>General Health Issues</b>  |   |   |
| <b>African American Health</b> , a service of the U.S. National Library of Medicine, provides online health information on African American health issues ranging from depression to glaucoma.            |   | <a href="http://www.nlm.nih.gov/medlineplus/africanamericanhealth.html">http://www.nlm.nih.gov/medlineplus/africanamericanhealth.html</a>                                       |
| <b>Black Health Care</b> is a private, for profit online resource that provides health information on a variety of health issues including sickle cell, prostate cancer and diabetes.                     |   | <a href="http://blackhealthcare.com">http://blackhealthcare.com</a>   |
| <b>Closing the Health Gap</b> , a U.S. Department of Health and Human Services agency, provides health information ranging from cardiovascular health to diabetes affecting African American communities. | 1-800-444-6472  | <a href="http://www.healthgap.omhrc.gov">http://www.healthgap.omhrc.gov</a>   |
| <b>The Magic of Good Health</b> is an online resource that provides information on health issues affecting the African American community.  |   | <a href="http://www.magicjohnson.org/GoodHealth/About/index.html">http://www.magicjohnson.org/GoodHealth/About/index.html</a>   |

|   |  |   |
|---|--|---|
| <b>HIV/AIDS</b>   |  |   |
| <b>The Minority HIV/AIDS Initiative</b> , of the U.S. Department of Health and Human Services, provides links to fact sheets, statistical reports and videos on HIV/AIDS among African Americans. | 1-800-444-6472<br>301-230-7874<br>301-230-7199 (TDD) | <a href="http://www.omhrc.gov/omh/aids/prevention/6C2_toc_pub.htm">http://www.omhrc.gov/omh/aids/prevention/6C2_toc_pub.htm</a> |
| <b>HIV InSite</b> is an online source for HIV/AIDS health information and resources for African Americans.  |  | <a href="http://hivinsite.ucsf.edu/InSite.jsp?page=li-06-02">http://hivinsite.ucsf.edu/InSite.jsp?page=li-06-02</a>             |
| <b>Legal Issues</b>   |  |   |
| <b>NAACP Legal Defense and Educational Fund</b> is the primary civil rights firm representing the African American community.   | 212-965-2202   | <a href="http://www.naacpldf.org">http://www.naacpldf.org</a>   |
| <b>Women's Health</b>   |  |   |
| <b>National Black Women's Health Project</b> provides online health information ranging from nutrition to domestic violence for African American women.   | 202-548-4000   | <a href="http://www.blackwomenshealth.org">http://www.blackwomenshealth.org</a>   |

# **BIBLIOGRAPHY**

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## **Demographics**

- American Demographics Black Americans Reprint Package. Ithaca, NY: Dow Jones & Company, Inc. 1995.
- Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. Monthly Vital Statistics Report 1997 Jun; 45(11 Suppl 2).
- Bachu A. Fertility of American Women: June 1995 (Update). Department of Commerce, Bureau of the Census, Current Population Reports (US) 1995. Washington: U.S. Government Printing Office.
- Bennett C. The Black Population in the United States: March 1994 and 1993. Department of Commerce, Bureau of the Census, Current Population Reports (US)1995; P20-480. Washington: U.S Government Printing Office.
- Federal Glass Ceiling Commission (US). Good for Business: Making Full Use of the Nation's Human Capital. Washington;1995.
- Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy Press; Washington, D.C.
- Norton A, Miller L. Marriage, Divorce and Remarriage in the 1990's. Bureau of the Census, Current Population Reports 1992; Series P23, No. 180. Washington: U.S. Government Printing Office.
- U.S. Census Bureau. Average Family Size (White Alone). Census 2000 Summary File 1.
- U.S. Census Bureau. Average Family Size (Black or African American Alone). Census 2000 Summary File 1.
- U.S. Census Bureau. Coresident Grandparents and Grandchildren. Current Population Reports: Pamphlet 23-198;1999.
- U.S. Census Bureau. Current Population Survey, March 2000. Washington: U.S. Government Printing Office; 2001.
- U.S. Census Bureau. Detailed Occupation of the Employed Civilian Population 16 Years and Over by Sex, Race and Hispanic Origin. March 2000. Washington: U.S. Government Printing Office; 2001.
- U.S. Census Bureau. Employment Status of the Population 16 Years and Over in the Civilian Labor Force by Sex, Race and Hispanic Origin. March 2000. Washington: U.S. Government Printing Office; 2001.
- U.S. Census Bureau. Fertility of American Women: June 2000. October, 2001.
- U.S. Census Bureau. Labor Force Status of the Civilian Population 16 Years and Over by Sex, Race and Hispanic Origin. March 2000. Washington: U.S. Government Printing Office; 2002.
- U.S. Census Bureau. Major Occupation Group of the Employed Civilian Population 16 Years and Over by Sex, Race and Hispanic Origin. March 2000. Washington: U.S. Government Printing Office; 2001.
- U.S. Census Bureau. Median Age by Sex (Black or African American Alone). Census 2000 Summary File 1.
- U.S. Census Bureau. Tenure by Age of Householder (White Alone). Census 2000 Summary File 1.
- U.S. Census Bureau. Tenure by Age of Householder (Black or African American Alone). Census 2000 Summary File 1.
- U.S. Census Bureau. The Black Population: 2000. Washington: U.S. Government Printing Office; 2001.
- U.S. Census Bureau. We, the American Blacks. Washington: U.S. Government Printing Office;1993.

U.S. Department of Education, National Center for Education Statistics, Dropout Rates in the United States: 1999. <http://nces.ed.gov/pubs2001/dropout>.

U.S. Department of Education, National Center for Education Statistics, The Condition of Education, 2002, NCES 2002-025, Washington, DC; U.S. Government Printing Office, 2002.

U.S. Department of Health and Human Services. Excess Deaths and Other Mortality Measures for the Black Population: 1980 and 1991-92. Pamphlet 5-1571;1995.

U.S. Department of Health and Human Services. Health, United States: 1995. DHHS 1996; Pub. No. (PHS)96-1232. Washington: U.S. Government Printing Office.

U.S. Department of Health and Human Services. Report of the Secretary's Task Force on Black and Minority Health. Washington: US Government Printing Office;1986.

Ventura S, Peters K, Martin J, Maurer J. Births and deaths: United States, 1996. Monthly Vital Statistics Report 1997; 46(1 Suppl 2).

## **Health Beliefs and Behaviors**

Airhihenbuwa C, Lowe A. Improving the health status of African Americans: Empowerment as health education intervention. In: Livingston IL (editor), Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects. Westport, CT: Greenwood Press 1994. p. 387-398.

Belgrave FZ, Lewis D. The role of social support in compliance and other health behaviors for African Americans with chronic illnesses. J of Health and Social Policy 1994; 5(3-4):55-68.

Bowser B. African-American culture and AIDS prevention: From barrier to ally. Cross-cultural Medicine—A Decade Later [Special Issue]. West J of Medicine 1992 Sept; 157:286-289.

Brown C, Segal R. Ethnic differences in temporal orientation and its implications for hypertension management. J of Health and Social Behavior 1996; 37(4):350-361.

Bullard R. Urban infrastructure: Social, environmental, and health risks to African Americans. In: Tidwell BJ (editor), The State of Black America 1992; New York: The Urban League, Inc.

Byrd W, Clayton L. An American health dilemma: A history of blacks in the health system. J of the National Medical Assoc 1992; 84(2):189-200.

Carter J. Psychosocial/cultural issues in medicine and psychiatry: Treating African Americans. J of the National Medical Assoc 1995; 87(12):857-860.

DeSantis L, Tappen R. Preventive health practices of Haitian immigrants. In: Wang SF, Simoni PS, Nath CL (editors), Vision of Excellence: The Decade of the Nineties. Charleston, WV: West Virginia Nurses' Association Research Conference Group;1990.

EthnoMed, Ethnic Medicine Guide, Harborview Medical Center, University of Washington. Eritrean Cultural Profile. [Online] 1995-96 [cited 1997 July 22]. Available from: URL: <http://www.hslib.washington.edu/clinical/ethnomed/eritcp.html>.

Fishman B, Bobo L, Kosub K, Womeodu R. Cultural issues in serving minority populations: Emphasis on Mexican Americans and African Americans. Am J of Medical Science 1993 Sept; 306(3):160-166.

Giger J, Davidhizar R, Turner G. Black American folk medicine health care beliefs: Implications for nursing plans of care. The ABNF J 1992 Spring; 3(2):42-46.

Hacker A. Two Nations: Black and White—Separate, Hostile, Unequal. New York: Ballantine Books; 1992.

Jones J. Bad Blood: The Tuskegee Syphilis Experiment. New York: The Free Press;1993/1981.

- Jones W, Rene A. Barriers to health services utilization and African Americans. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood; 1994. p. 378-386.
- Kiple K, King V. *Another Dimension to the Black Diaspora: Diet, Disease, and Racism*. Cambridge: Cambridge University Press; 1981.
- Kleinman A. *Patients and Healers in the Context of Culture*. Berkeley University Press; 1980.
- Klessig, J. The effect of values and culture on life-support decisions. *Cross-cultural Medicine—A Decade Later [Special Issue]*. *West J of Med* 1992 Sept; 157:316-322.
- Knapp R, Keil J, Sutherland S, Rust P, Hames C, Tyroler H. Skin color and cancer mortality among black men in the Charleston Heart Study. *Clinical Genetics* 1995; 47(4):200-206.
- Lacey L. Cancer prevention and early detection strategies for reaching underserved urban, low-income black women. *Cancer* 1993; 72(3 Suppl):1078-1083.
- Lewis T. Somali Cultural Profile. EthnoMed, Ethnic Medicine Guide, Harborview Medical Center, University of Washington. [online] 1995-6 [cited 1997 July 22]. Available from:URL: <http://www.hslib.washington.edu/clinical/ethnomed/somalicip.html>.
- Molakign A. Ethiopian Community Profile. EthnoMed, Ethnic Medicine Guide, Harborview Medical Center, University of Washington. [online] 1995-6 [cited July 22 1997]. Available from: URL: <http://www.hslib.washington.edu/clinical/ethnomed/ethiopcp.html#birth>
- McKinley E, Garrett J, Evans A, Davis M. Differences in end-of-life decision making among black and white ambulatory care patients. *J of General Internal Med* 1996; 11:651-656.
- Oliver M, Shapiro T. *Black Wealth/White Wealth: A New Perspective on Racial Inequality*. New York: Routledge; 1995.
- Pachter L. Culture and clinical care: Folk illness beliefs and behaviors and their implications for health care delivery. *JAMA* 1994; 272(9):690-694.
- Price J, Everett S. Developing cancer pamphlets for economically disadvantaged African Americans. *Patient Education and Counseling* 1996; 28(2):159-167.
- Raboateau A. The Afro-American Traditions. In: Numbers RL, Amundsen DW (editors), *Caring and Curing: Health and Medicine in the Western Religious Traditions*. New York: Macmillan Publishing Company; 1989.
- Rice M, Jones W. Public policy compliance/enforcement and Black American health: Title VI of the Civil Rights Act of 1964. In: Jones W, Rick M (editors), *Health Care Issues in Black America: Policies, Problems, and Prospects*. New York: Greenwood Press; 1987.
- Robinson S, Ashley M, Haynes M. Attitude of African-Americans regarding prostate cancer clinical trials. *J of Community Health* 1996; 21(2):77-87.
- Snow L. Folk medical beliefs and their implications for the care of patients: A review based on studies among black Americans. *Ann of Internal Med* 1974; 81(1):82-96.
- Snow L. Ethnicity and clinical care: American Blacks. *Physician Assistant & Health Practitioner* 1980 Jul; 50-58.
- Snow L. Traditional health beliefs and practices among lower class black Americans. *Cross-cultural Medicine [Special Issue]*. *The West J of Med* 1983 Dec; 139:820-828.
- Snow L. *Walkin' Over Medicine*. San Francisco: Westview Press; 1993.
- Stryker J. Tuskegee's long arm still touches a nerve. *The New York Times* 1997 April 13, Sect. 4E.

Thomas S, Quinn S. The Tuskegee Syphilis Study, 1932 to 1972: Implications for HIV education and AIDS risk education programs in the black community. *Am J of Public Health* 1991 Nov; 81(11):1498-1505.

Tull E, Roseman J. Diabetes in African Americans. In: National Diabetes Data Group, Diabetes in America. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases;1995.

U.S. Department of Health and Human Services. Common Health Care Beliefs and Practices of Puerto Ricans, Haitians and Low Income Blacks Living in the New York/New Jersey Area. Washington;1983.

Van Son A. Crossing cultural and economic barriers. Diabetes and patient education: A daily nursing challenge. New York: Appleton-Century Crofts;1981. p. 160-177.

Williams D. Black-white differences in blood pressure: The role of social factors. *Ethnicity and Dis* 1992; 2:126-141.

Womeodu R, Bailey J. Barriers to cancer screening. *Medical Clinics of North America* 1996; 80(1):115-133.

## **Risk Factors Introduction**

African American Task Force for the Unity in Health, Diversity in Culture Conference. African American Task Force Report on the Year 2000 Health Promotion Objectives and Recommendations for California;1992.

Anderson N, Bastida E, Kramer B, Williams D, Wong M. Panel II: Macrosocial and environmental influences on minority health. *Health Psychology* 1995; 14(7):601-612.

Centers for Disease Control and Prevention. Chronic Disease in Minority Populations. Atlanta: Centers for Disease Control and Prevention;1992.

Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. National Academy Press; Washington, D.C.

Myers H, Kagawa-Singer M, Kumanyika S, Lex B, Markides K. Panel III: Behavioral risk factors related to chronic diseases in ethnic minorities. *Health Psychology* 1995; 14(7):613-621.

Neel J. Diabetes mellitus—a thrifty genotype rendered detrimental by progress. *Am J of Human Genetics* 1962; 14: 353-362.

Otten M, Teutsch S, Williamson D, Marks J. The effect of known risk factors on the excess mortality of black adults in the United States. *JAMA* 1990; 263:848-850.

Thomas V. Explaining health disparities between African-American and white populations: Where do we go from here? *J of the National Medical Assoc* 1992; 84(10):837-840.

U.S. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives; Washington: 1990.

## **Risk Factors Hereditary Factors**

Corder E, Friedman G, Vogelmann J, Orentreich N. Seasonal variation in vitamin D, vitamin D-binding protein, and dehydroepiandrosterone: Risk for prostate cancer in black and white men. *Cancer Epidemiol, Biomarkers, and Prevention* 1995; 4:655-659.

Freeman V, Leszczak J, Cooper R. Race and histologic grade of prostate cancer. *The Prostate* 1997; 30:79-84.

Henderson R, Eastman J, Culkin D, Kattan M.W., Whatley T, Mata J, et al. Prostate-specific antigen (PSA) and PSA density: Racial differences in men without prostate cancer. *J of the National Cancer Institute* 1997; 89(2):134-8.

Kimura M, Cho J, Lasker N, Aviv A. Differences in platelet calcium regulation between African Americans and Caucasians: Implications for the predisposition of African Americans to essential hypertension. *J of Hypertension* 1994; 12(2):199-207.

Lockette W. Controversy in the pharmacologic treatment of hypertension in African Americans. *J of the Assoc for Academic Minority Physicians* 1995; 6(4):125-129.

Materson B, Reda D, Cushman W, Massie B, Fries E, Kochar M et al. Single drug therapy for hypertension in men. *New England J of Med* 1993; 328(13):914-921.

Matthews H. Racial, ethnic, and gender difference in response to medicines. *Drug Metabolism and Drug Interactions* 1995; 12(2):77-91.

Moul J, Douglas T, McCarthy W, McLeod D. Black race is an adverse prognostic factor for prostate cancer recurrence following radical prostatectomy in an equal access health care setting. *J of Urology* 1996; 155(5):1667-73.

Neel J. Diabetes mellitus—a thrifty genotype rendered detrimental by progress. *Am J of Human Genetics* 1962; 14: 353-362.

Saunders E, Weir M, Kong W, Hollifield J, Gray J, Vertes V, et al. A comparison of the efficacy and safety of a beta-blocker, a calcium-channel blocker, and a converting enzyme inhibitor in hypertensive blacks. *Archives of Internal Med* 1990; 150:1707-1713.

Skoularigis J, Strugo V, Zambakides C, Eintracht S, Reddy K, Tshele E, et al. Comparison of captopril-thiazide and enalapril-thiazide combinations in the management of mild to moderate black hypertensive patients: How important is diuretic dose and duration of action of the ACE-inhibitor? *International J of Clinical Pharmacology and Therapeutics* 1996; 34(6):263-268.

Weir M, Gray J, Paster R, Saunders E. Differing mechanisms of action of angiotensin-converting enzyme inhibition in black and white hypertensive patients. The Trandolapril Multicenter Study Group. *Hypertension* 1995; 26(1):124-130.

Wright J, Douglas J. Drug therapy for Black hypertensives. In: Fray J (editor), *Pathophysiology of Hypertension in Blacks*. New York: Oxford University Press;1993.

## **Risk Factors Socioeconomic**

Casper M, Barnett E, Armstrong D, Giles W, Blanton, C. Social class and race disparities in premature stroke mortality among men in North Carolina. *Ann of Epidemiol* 1997 Feb; 7(2):146-153.

Cooper R. Health and social status of blacks in the United States. *Ann of Epidemiol* 1993; 3:137-144.

Fong R. Violence as a barrier to compliance of the hypertensive urban African American. *J of the National Medical Assoc* 1995; 87(3):203-207.

Huss K, Rand C, Butz A, Eggleston P, Murigande C, Thompson L, et al. Home environmental risk factors in urban minority asthmatic children. *Ann of Allergy* 1994; 72(2):173-177.

Johnson B, Coulberson S. Environmental epidemiologic issues and minority health. *Ann of Epidemiol* 1993; 3:175-180.

Laveist T. Segregation, poverty, and empowerment: Health consequences for African Americans. *Milbank Quarterly* 1993; 71(1):41-64.

Lillie-Blanton M, Martinez R, Taylor A, Robinson B. Latina and African American women: Continuing disparities in health. *International J of Health Service* 1993; 23(3):555-584.

Onwuachi-Saunders C, Hawkins D. Black-white differences in injury. Race or social class? *Ann of Epidemiol* 1993 Mar; 3(2):150-3.

Pappas G, Queen S, Hadden W, Fisher G. The increasing disparity in mortality between socioeconomic groups in the United States, 1960 and 1986 [published erratum appears in *New England J of Medicine* 1993 Oct; 329(15):1139] *New England J of Med* 1993 Jul; 329(2):103-109.

Sanders-Phillips K. The ecology of urban violence: Its relationship to health promotion behaviors in low-income black and Latino communities. *Am J of Health Promotion* 1996; 10(4):308-317.

Shea S, Misra D, Ehrlich M, Field L, Francis C. Correlates of nonadherence to hypertension treatment in an inner-city minority population. *Am J of Public Health* 1992; 82(12):1607-1612.

## **Risk Factors Medical Bias: Truth or Fiction**

Allison J, Kiefe C, Centor R, Box J, Farmer R. Racial differences in the medical treatment of elderly Medicare patients with acute myocardial infarction. *J of General Internal Med* 1996; 11(12):736-743.

Ball J, Elixhauser A. Treatment differences between blacks and whites with colorectal cancer. *Medical Care* 1996 Sept; 34(9):970-984.

Bronstein J, Cliver S, Goldenberg R. Racial differences in use of corticosteroids in preterm labor. *Ahsr Fhsr Annual Meeting Abstract Book* 1995; 12:104.

Carlisle D, Leake B, Shapiro M. Racial and ethnic disparities in the use of invasive cardiac procedures among cardiac patients in Los Angeles County, 1986 through 1988. *Am J of Public Health* 1995 Mar; 85(3):352-356.

Cooper G, Yuan Z, Landefeld C, Rimm A. Surgery for colorectal cancer: Race-related differences in rates and survival among Medicare beneficiaries. *Am J of Public Health* 1996 Apr; 86(4):582-586.

Council on Ethical and Judicial Affairs. Black-white disparities in health care. *JAMA* 1990; 262:2344-2346.

Dula A. African American suspicion of the healthcare system is justified: What do we do about it? *Cambridge Quarterly of Healthcare Ethics* 1994; 3:347-357.

Ebell M, Smith M, Kruse J, Drader-Wilcox J, Novak J. Effect of race on survival following in-hospital cardiopulmonary resuscitation. *The J of Family Medical Practice* 1995; 40(6):571-577.

Ford E, Cooper R. Racial/ethnic differences in health care utilization of cardiovascular procedures: A review of the evidence. *Health Services Research* 1995 Apr; 30(1 pt 2):237-52.

Ford E, Cooper R, Castaner A, Simmons B, Mar M. Coronary arteriography and coronary bypass surgery among whites and other racial groups relative to hospital-based incidence rates for coronary artery disease: Findings from NHDS. *Am J of Public Health* 1989; 79(4):437-440.

Giacomini M. Gender and ethnic biases in the implicit rationing of high technology hospital procedures in California. *Ahsr Fhsr Annual Meeting Abstract Book* 1994; 11:157-158.

Gillum R. Epidemiology of carotid endarterectomy and cerebral arteriography in the United States. *Stroke* 1995 Sept; 26(9):1724-1728.

Gillum R, Gillum B, Francis C. Coronary revascularization and cardiac catheterization in the United States: Trends in racial differences. *J of the Am College of Cardiology* 1997 Jun; 29(7):1557-1562.

Institute of Medicine. *Unequal Treatment: Confronting racial and ethnic disparities in healthcare*. National Academies Press; Washington, DC. 2003.

- Kjellstrand C. Age, sex, and race inequality in renal transplantation. *Archives of Internal Med* 1988; 148(6):1305-1309.
- Kjellstrand C, Logan G. Racial, sexual, and age inequalities in chronic dialysis. *Nephron* 1987; 45:257-263.
- Kogan M, Kotelchuck M, Alexander G, Johnson W. Racial disparities in the reported prenatal care advice from health care providers. *Am J of Public Health* 1994 Jan; 84(1):82-88.
- Maynard C, Fisher L, Passerman E, Pullum T. Blacks in the Coronary Artery Surgery Study (CASS): Race and Clinical Decision Making. *Am J of Public Health* 1986; 76:1446-1448.
- Moore R, Stanton D, Gopalan R, Chaisson R. Racial differences in the use of drug therapy for HIV disease in an urban community. *New England J of Med* 1994 Mar; 330(11):763-768.
- Oberman A, Cutter G. Issues in the natural history and treatment of coronary heart disease in black populations: Surgical treatment. *Am Heart Journal* 1984; 108(3 Part 2):688-694.
- Oddone E, Horner R, Monger M, Matcher D. Racial variations in the rates of carotid angiography and endarterectomy in patients with stroke and transient ischemic attack. *Archives of Internal Med* 1993 Dec; 53(24):2781-2786.
- Peterson E, Shaw L, DeLong E, Pryor D, Califf R, Mark D. Racial variation in the use of coronary revascularization procedures. *New England J of Med* 1997; 336(7):480-486.
- Schapira M, McAuliffe T, Nattinger A. Treatment of localized prostate cancer in African-American compared with Caucasian men: Less use of aggressive therapy for comparable disease. *Medical Care* 1995; 33(11):1079-1088.
- Sherman R, Cody R, Solanchick J. Racial differences in the delivery of hemodialysis. *Am J of Kidney Dis* 1993 Jun; 21(6):632-634.
- Wenneker M, Epstein M. Racial inequalities in the use of procedures for patients with ischemic heart disease in Massachusetts. *JAMA* 1989; 261:253-257.
- Yergan J, Flood A, LoGerfo J, Diehr P. Relationship between patient race and the intensity of hospital services. *Medical Care* 1987; 25:592-603.
- Zito J, Safer D, dosReis S, Magder L, Riddle M. Methylphenidate patterns among Medicaid youths. *Psychopharmacology Bulletin* 1997; 33(1):143-147.

## **Risk Factors Substance Abuse/Chemical Dependency**

- Amaro H, Beckman L, Mays V. A comparison of black and white women entering alcoholism treatment. *J of Studies on Alcohol* 1987; 48(3):220-228.
- American Lung Association. Fact Sheet: African Americans and Lung Disease. [www.lungusa.org/diseases/africanlung\\_factsheet.html](http://www.lungusa.org/diseases/africanlung_factsheet.html).
- Beverly C. Alcoholism and the African American community. In: Braithwaite R, Taylor S (editors), *Health Issues in the Black Community*. San Francisco: Jossey-Bass Publishers;1992.
- Brisbane F, Wells R. Treatment and prevention of alcoholism among Blacks. In: Watts T, Wright R (editors), *Alcoholism in Minority Populations*. Springfield, IL: Charles C. Thomas, Publishers;1989.
- Caetano R, Kaskutas L. Changes in drinking patterns among whites, blacks and Hispanics 1984-1992. *J of Studies on Alcohol* 1995; 56(5).

- Carabello R, Giovino G, Pechacek T, Mowery P, Richter P, Strauss W. Racial and ethnic differences in serum cotinine levels of cigarette smokers: Third National Health and Nutrition Examination Survey, 1988-1991. *JAMA* 1998; 280(2):135-139.
- Centers for Disease Control. Cigarette Smoking Among Adults - United States, 1999. October, 2001; 50(40).
- Chavez G, Cordero J, Becerra F. Leading major congenital malformations among minority groups in the United States, 1981-1986. *Mor Mortal Wkly Rep CDC Surveillance Summ* 1988; 37(3):17-24.
- Edwards R, Thurman P, Beauvais F. Patterns of alcohol use among ethnic minority adolescent women. *Recent Developments in Alcohol* 1995; 12:369-386.
- Gerstein D, Green L (editors), *Preventing Drug Abuse. What Do We Know?* Washington: National Academy Press;1993.
- Gilbert M, Collins R. Ethnic variation in women and men's drinking. In: Wilsnack R, Wilsnack S (editors), *Gender and Alcohol*. Piscataway, NJ: Rutgers University Press;1997.
- Gray M. African Americans. In: Philleo J, Brisbane F (editors), *Cultural Competence for Social Workers. A Guide for Alcohol and Other Drug Abuse Prevention Professionals Working with Ethnic/Racial Communities*. SAMHSA Monograph # 4. DHHS Pub. No. (SMA)95-3075. Washington: U.S. Government Printing Office;1995.
- Herd D. Predicting drinking problems among black and white men: Results from a national survey. *J of Studies on Alcohol* 1994; 55(1):61-71.
- Herd D. Subgroup differences in drinking patterns among black and white men: Results from a National Survey. *J of Studies on Alcohol* 1990; 51(3):221-232.
- Herd D. The epidemiology of drinking patterns and alcohol-related problems among U.S. blacks. In: *Research Monograph # 18, Alcohol Use Among U.S. Minorities* DHHS Pub. No. (ADM)89-1435/ Washington: U.S. Government Printing Office;1989.
- Keppel KG, Percy JN, Wagener DK. Trends in racial and ethnic-specific rates for the health status indicators: United States, 1990-98. *Health people statistical notes*, no 23. Hyattsville, Maryland: National Center for Health Statistics. January 2002.
- Lee J, Mavis B, Stoffelmayr B. A comparison of problems-of-life for blacks and whites entering substance abuse treatment programs. *J of Psychoactive Drugs* 1991; 23(3):233-239.
- Perez-Stable E, Herrera B, Jacob N, Benowitz N. Nicotine metabolism and intake in Black and White smokers. *JAMA* 1998; 280(2):152-156.
- Robins L. Alcohol abuse in blacks and whites as indicated in the Epidemiological Catchment Area Program. In: Spiegler G, Tate D, Aitken S, Christian C (editors), *NIAA Research Monograph #18, DHHS Publication # (ADM) 88-1435*. Washington: U.S. Government Printing Office.
- Sellers E. Pharmacogenetics and ethnoracial differences in smoking. *JAMA* 1998; 280(2):179-180.
- U.S. Department of Health and Human Services. *Health, United States: 1995*. DHHS 1996; Pub. No. (PHS)96-1232. Washington: U.S. Government Printing Office.
- U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services. *Summary of findings from the 2000 National Household Survey on Drug Abuse, 2000*. Washington: U.S. Government Printing Office.

## **Risk Factors Obesity**

- Chitwood L, Brown S, Lundy M, Dupper M. Metabolic propensity toward obesity in black vs. white females: Responses during rest, exercise and recovery. *International J of Obesity and Related Metabolic Disorders* 1996; 20(5):455-462.
- Kumanyika S. Special issues regarding obesity in minority populations. *Ann of International Med* 1993; 650-654.
- Kumanyika S, Wilson J, Guilford-Davenport M. Weight-related attitudes and behaviors of black women. *J of the Am Diet Assoc* 1993; 93(4):416-422.
- Must A, Gortmaker S, Dietz W. Risk factors for obesity in young adults: Hispanics, African Americans and Whites in the transition years, age 16-28 years. *Biomedicine and Pharmacotherapy* 1994; 48(3-4):143-156.
- National Center for Health Statistics (US). Overweight persons 20 years of age and over, according to sex, age, race, and Hispanic origin: United States, 1960-62, 1971-74, 1976-80, and 1988-91. *Health, United States, 1995*. Hyattsville, MD: Public Health Service, 183; 1996.
- National Institutes for Health. Statistics Related to Overweight and Obesity, NIH Publication No. 96-4158 1996-copyright [online] [cited 1997 April 18]. Available from: URL: <http://www.niddk.nih.gov/80/ObStats/Obstats.html>.
- Savage P, Harlan W. Racial and ethnic diversity in obesity and other risk factors for cardiovascular disease: Implications for studies and treatment. *Ethnicity and Disease* 1991; 1:200-211.
- Singh D. Body fat distribution and perception of desirable female body shape by young black men and women. *International J of Eating Disorders* 1994; 16(3):289-294.
- U.S. Department of Health and Human Services. *Health Status of Minorities and Low-Income Groups*: Washington: Third Edition; 1991.

## **Risk Factors Diet and Nutrition**

- Block G, Lanza E. Dietary fiber sources in the United States by demographic group. *J of the National Cancer Institute* 1987; 79(1):83-91.
- Block G, Subar A. Estimates of nutrient intake from a food frequency questionnaire: The 1987 National Health Interview Survey. *J of the Am Diet Assoc* 1992; 92(8):969-977.
- Blocker D. Nutrition concerns of black Americans. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press 1994. p. 269-281.
- Bronner Y. Nutritional status outcomes for children: ethnic, cultural, and environmental contexts. *J of the Am Diet Assoc* 1997; 96(9):891-903.
- Douglas J. Hypertension and diabetes in blacks. *Diabetes Care* 1990; 13(11, Suppl. 4):1191-1195.
- Fitzgerald J, Anderson R, Funell M, Arnold M, Davis W, Aman L et al. Differences in the impact of dietary restrictions on African Americans and Caucasians with NIDDM. *The Diabetes Educator* 1997/Jan/Feb; 23(1):41-47.
- Freimer N, Echenberg D, Kretchmer N. Cultural variation—nutritional and clinical implications. *Cross-cultural Medicine [Special Issue]*. *West J of Med* 1983 Dec; 139:928-933.
- Healthy African American Families Phase II. African American health diet tips. *HAAF Time*, 2(4). Los Angeles, CA: Healthy African American Families, Charles R. Drew University; 1997.

Hoechst-Roussel Pharmaceuticals Inc. The Road to Take—Dietary Directions for a Healthy Heart. Somerville, NJ: Hoechst-Roussel Pharmaceuticals Inc;1987.

Kumanyika S. Diet and nutrition as influence on the morbidity/mortality gap. *Ann of Epidemiol* 1993; 3:154-158.

Kumanyika S, Helitzer D. Nutritional status and dietary pattern of racial minorities in the United States. Report to the Secretary's Task Force on Black and Minority Health. (Volume II), USDHHS, Washington: Government Printing Office;1985.

Myers H, Kagawa-Singer M, Kumanyika S, Lex B, Markides K. Panel III: Behavioral risk factors related to chronic diseases in ethnic minorities. *Health Psychology* 1995; 14(7): 613-621.

National Heart, Lung, and Blood Institute (US). Report on the Working Group on Research in Coronary Heart Disease in Blacks. Bethesda, MD;1994.

National Institutes for Health. National Cancer Institute (US). Down Home Health: Family Recipes of Black American Chefs Leah Chase and Johnny Rivers. NIH Publication No. 94-3408P. Bethesda, MD; 1994.

National Institutes for Health. National Cancer Institute (US). Action Guide for Healthy Eating. NIH Publication No. 95-3877. Bethesda, MD;1995.

National Institutes for Health. National Cancer Institute (US). Tips on how to...Eat Less Fat. NIH Publication No. 96-3910. Bethesda, MD;1996.

National Research Council. Committee on Diet and Health. Food and Nutrition Board. Commission on Life Sciences. Diet and health: Implications for reducing chronic disease risk. Washington: National Academy Press;1989.

Patel C, Nicol A. Adaptation of African-American cultural and food preferences in end-stage renal disease diets. *Advances in Renal Replacement Therapy* 1997 Jan; 4(1):30-39.

Pi-sunyer F. Health implications of obesity. *Am J of Clinical Nutrition* 1991; 53(6 Suppl):159S-1603S.

Swanson C, Gridley G, Greenberg R, Schoenberg J, Swanson G, Brown L, et al. A comparison of diets of blacks and whites in three areas of the United States. *Nutrition and Cancer* 1993; 20(2):153-165.

U.S. Department of Health and Human Services. Health Status of Minorities and Low-Income Groups: Third Edition;1991.

U.S. Department of Health and Human Services. Healthy People 2000. National health promotion and disease prevention objectives. DHHS Publication No. (PHS) 91-50212; 1991.

## **Risk Factors Physical Activity**

Airhihenbuwa C, Kumanyika S, Agurs T, Lowe A. Perceptions and beliefs about exercise, rest, and health among African-Americans. *Am J of Health Promotion* 1995; 9(6):426-9.

Bild D, Jacobs D, Sidney S, Haskell W, Anderssen N, Oberman A. Physical activity in young black and white women. The CARDIA Study. *Ann of Epidemiol* 1993 Nov; 3(6):636-644.

Centers for Disease Control and Prevention (editors). Prevent Chronic Diseases: Modifying Risk Factors, [online] 1996 [cited 1997 May 21]. Available from: URL: <http://www.cdc.gov/nccdphp/riskfact.html>.

Myers H, Kagawa-Singer M, Kumanyika S, Lex B, Markides K. Panel III: Behavioral risk factors related to chronic diseases in ethnic minorities. *Health Psychology* 1995; 14(7): 613-621.

National Heart, Lung, and Blood Institute (US). Report on the Working Group on Research in Coronary Heart Disease in Blacks. Bethesda, MD;1994.

Williams D. Black-white differences in blood pressure: The role of social factors. *Ethnicity and Dis* 1992; 2:126-141.

## Major Diseases Diabetes Mellitus

American Diabetes Association. Diabetes Info: Diabetes Facts and Figures [online] 1997.

[cited 1997 April 18]. Available from: URL: <http://www.diabetes.org/ada/c20f.asp#africanamerican>.

American Diabetes Association. Diabetes Info: Diabetes Facts and Figures (Revised) [online] 1997-copyright [cited 1998 August 25]. Available from: URL: <http://www.diabetes.org/ada/c20f.asp#africanamerican>.

American Diabetes Association. American Diabetes Association: Clinical Practice Recommendations 1998. [online] 1998 [cited 1998 August 25]. Available from: URL: <http://www.diabetes.org/DiabetesCare/Supplement198/S60.html>.

American Diabetes Association. (n.d.) If you have sugar...You have Diabetes.

American Heart Association. Diabetes Mellitus [online] 1996-copyright [cited 1997 May 13]. Available from: URL: [http://www.amhrt.org/hs9\\_diabetes.html](http://www.amhrt.org/hs9_diabetes.html).

Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. Monthly Vital Statistics Report, 1997 Jun; 45(11 Suppl 2).

Beckles G, Blount S, Jiles R. African-Americans. In: Centers for Disease Control and Prevention. Chronic Disease in Minority Populations. Atlanta: Centers for Disease Control and Prevention;1994.

Bell R, Summerson J, Konen J. Dietary intakes by levels of glycemic control for black and white adults with non-insulin dependent diabetes mellitus (NIDDM). J of the Am College of Nutrition 1995; 14(2):144-151.

Bell R, Summerson J, Konen J. Racial differences in psychological variables among adults with non-insulin-dependent diabetes mellitus. Behavioral Med 1995; 21(2):69-73.

Brancati F, Whelton P, Kuller L, Klag M. Diabetes mellitus, race, and socioeconomic status. A population-based study. Ann of Epidemiol 1996; 6(1): 67-73.

Cowie C, Eberhardt M. Sociodemographic characteristics of persons with diabetes. In: National Diabetes Data Group. Diabetes in America. 2nd ed. Bethesda, MD: National Institutes of Health;1995.

Cowie C, Harris M, Silverman R, Johnson E, Rust K. Effect of multiple risk factors on differences between blacks and whites in the prevalence of non-insulin-dependent diabetes mellitus in the United States. Am J of Epidemiol 1993; 137(7):719-732.

El-Kebbi I, Bacha G, Ziemer D, Musey V, Gallina D, Dunbar V, et al. Diabetes in urban African Americans. V. Use of discussion groups to identify barriers to dietary therapy among low-income individuals with non-insulin-dependent diabetes mellitus. Diabetes Educator 1996 Sept-Oct; 22(5):488-492.

Fitzgerald J, Anderson R, Funell M, Arnold M, Davis W, Aman L, et al. Differences in the impact of dietary restrictions on African Americans and Caucasians with NIDDM. The Diabetes Educator 1997 Jan/Feb; 23(1):41-47.

Goldschmid M, Domin W, Ziemer D, Gallina D, Phillips L. Diabetes in Urban African-Americans: II High prevalence of microalbuminuria and nephropathy in African-Americans with diabetes. Diabetes Care 1995; 18(7): 955-961.

Harris M. Summary. In: National Diabetes Data Group. Diabetes in America. 2nd ed. Bethesda, MD: National Institutes of Health;1995.

Helmrich S, Ragland D, Leung R, Paffenbarger R. Physical activity and reduced occurrence of non-insulin-dependent diabetes mellitus. New England J of Med 1991; 325(3):147-152.

Ledda M, Walker E, Basch C. Development and formative evaluation of a foot self-care program for African Americans with diabetes. Diabetes Educator 1997; 23(1):48-51.

Maillet N, D'Eramo-Melkus G, Spollett G. Using focus groups to characterize health beliefs and practices of black women with non-insulin-dependent diabetes. *Diabetes Educator* 1996; 22(1):39-46.

National Heart, Lung, and Blood Institute (US). Report on the Working Group on Research in Coronary Heart Disease in Blacks. Bethesda, MD;1994.

Neel J. Diabetes mellitus—a thrifty genotype rendered detrimental by progress. *Am J of Human Genetics* 1962; 14: 353-362.

Pugh J. Prevention of complications of diabetes mellitus. *Contemporary Management in Internal Med* 1995; 1(5): 147-167.

Pugh J, Medina R, Cornell J, Basu S. NIDDM is the major cause of diabetic end-stage renal disease. More evidence from a tri-ethnic community. *Diabetes* 1995; 44(12): 1375-1380.

Pugh J, Medina R, Ramirez M. Comparison of the course to end-stage renal disease of Type 1 (insulin-dependent) and Type 2 (Non-insulin-dependent) diabetic nephropathy. *Diabetologia* 1993; 36:1094-1098.

Raymond N, D'Eramo-Melkus G. Non-insulin-dependent diabetes and obesity in the black and Hispanic population: Culturally sensitive management. *Diabetes Educator* 1993; 19(4): 313-317.

Schneider D, Greenberg M, Lu L. Early life experiences linked to diabetes mellitus: A study of African-American migration. *J of the National Medical Assoc* 1997 Jan; 89(1):29-34.

Tull E, Makame M, Roseman J. Diabetes mellitus in the African-American population. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press 1994. p. 99-109.

Tull E, Roseman J. Diabetes in African Americans. In National Diabetes Data Group, *Diabetes in America*, 2nd edition. Bethesda, MD: National Institutes of Health;1995.

Will J, Casper M. The contribution of diabetes to early deaths from ischemic heart disease: U.S. gender and racial comparisons. *Am J of Public Health* 1996; 86(4):576-579.

Ziemer D, Goldschmid M, Musey V, Domin W, Thule P, Gallina D, et al. Diabetes in urban African Americans. III. Management of type II diabetes in a municipal hospital setting. *Am J of Med* 1996; 101(1):25-33.

Zimmet P, Collins V, Dowse G, Alberti K, Toumlehto J, Gareeboo H, et al. The relation of physical activity to cardiovascular disease risk factors in Mauritians. *Am J of Epidemiol* 1991; 134(8):862-875.

## **Major Diseases End Stage Renal Disease**

Bergman S, Key B, Kirk K, Warnock D, Rostant S. Kidney disease in the first-degree relatives of African-Americans with hypertensive end-stage renal disease. *Am J of Kidney Dis* 1996; 27(3):341-346.

Brazy P. Kidney disease and hypertension in blacks. *Current Opinion in Nephrology and Hypertension* 1994 Sept; 3(5):554-557.

Byrne C, Nedelman J, Luke R. Race, socioeconomic status, and the development of end-stage renal disease. *Am J of Kidney Dis* 1994; 23(1):16-22.

Cowie C, Port F, Wolfe R, Savage P, Moll P, Hawthorne V. Disparities in incidence of diabetes and end-stage renal disease according to race and type of diabetes. *New England J of Med* 1989; 321(16):1074-1079.

Ferguson R, Morrissey E. Risk factors for end-stage renal disease among minorities. *Transplantation Proceedings* 1993; 25(4):2415-2420.

Flack J, Neaton J, Daniels B, Esunge P. Ethnicity and renal disease: Lessons from the Multiple Risk Factor Intervention Trial and the Treatment of Mild Hypertension Study. *Am J of Kidney Dis* 1993; 21(4 Suppl 1):31-40.

Jones C, Agodoa L. End-stage renal disease. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press 1994 p.59-73.

Klag M, Whelton P, Randall B, Neaton J, Brancati F, Stamler J. End-stage renal disease in African-American and white men. 16-year MRFIT findings. *JAMA* 1997; 277(16):1293-1298.

Lopes A, Hornbuckle K, James S, Port F. The joint effects of race and age on the risk of end-stage renal disease attributed to hypertension. *Am J of Kidney Dis* 1994; 24(4): 554-560.

National Heart, Lung, and Blood Institute (US). Report on the Working Group on Research in Coronary Heart Disease in Blacks. Bethesda, MD;1994.

Pugh J, Medina R, Cornell J, Basu S. NIDDM is the major cause of diabetic end-stage renal disease. More evidence from a tri-ethnic community. *Diabetes* 1995; 44(12):1375-1380.

Pugh J, Tuley M, Basu S. Survival among Mexican-Americans, Non-Hispanic Whites, and African -Americans with end-stage renal disease: The emergence of a minority pattern of increased incidence and prolonged survival. *Am J of Kidney Dis* 1994; 23(6):803-807.

Rostand S. US Minority Groups and end-stage renal disease: A disproportionate share. *American J of Kidney Dis* 1992; XIX(5): 411-413.

Stephens G, Gillaspay J, Clyne D, Mejia A, Pollack V. Racial differences in the incidence of end-stage renal disease in Types I and II diabetes mellitus. *Am J of Kidney Dis* 1990; XV(6): 562-567.

Thornhill-Joynes M, Moore M. Early identification of renal disease among African-Americans: A continuing problem. *Nephrology News and Issues* 1995 Nov:16-18.

## **Major Diseases Cardiovascular Disease**

American Heart Association. 2002 Heart and Stroke Statistical Update. Dallas, Tex.: American Heart Association; 2001.

American Heart Association. African-Americans and Cardiovascular Diseases [online] 1998-copyright. [cited 1998 August 25]. Available from: URL: [http://www.americanheart.org/Heart\\_and\\_Stroke\\_A\\_Z\\_Guide/bioafr.html](http://www.americanheart.org/Heart_and_Stroke_A_Z_Guide/bioafr.html).

American Heart Association. Cardiovascular Diseases [online] 1998-copyright [cited 1998 August 25]. Available from: URL: <http://www.americanheart.org/Scientific/HSstats98/03cardio.html>.

American Heart Association. High Blood Pressure [online] 1998-copyright [cited 1998 August 25]. Available from: URL: <http://www.americanheart.org/Scientific/HSstats98/06hghbld.html>.

American Heart Association. High Blood Pressure in African-Americans. Publication 50-1078, 7-95, 95 05 16 C. Dallas, TX: American Heart Association, National Center;1995.

American Heart Association. Coronary Heart Disease and Angina Pectoris [online] 1998-copyright [cited 1998 August 25]. Available: <http://www.americanheart.org/Scientific/HSstats98/04cornry.html>.

American Heart Association. Other Cardiovascular Diseases [online] 1998-copyright [cited 1998 August 25]. Available from: URL: <http://www.americanheart.org/Scientific/HSstats98/07other.html>.

American Heart Association. Risk Factors [online] 1998-copyright [cited 1998 August 25]. Available from: URL: <http://www.americanheart.org/Scientific/HSstats98/08rskfct.html>.

- American Heart Association. Stroke (Brain Attack) [online] 1998-copyright [cited 1998 August 25]. Available from: URL: <http://www.americanheart.org/Scientific/HSstats98/05stroke.html>.
- American Heart Association. Take Charge! A Woman's Guide to Fighting Heart Disease. Publication 64-1055, 7-97, 97 02 19 A. Dallas, TX: American Heart Association, National Center;1997.
- Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. Monthly Vital Statistics Report, 1997 Jun; 45(11 Suppl 2).
- Arnett D, Tyroler H, Burke G, Hutchinson R, Howard G, Heiss G. Hypertension and subclinical carotid artery atherosclerosis in blacks and whites. The Atherosclerosis Risk in Communities Study, ARIC Investigators. Archives of Internal Med 1996; 156(17):1983-1989.
- Beckles G, Blount S, Jiles R. African-Americans. In: Centers for Disease Control and Prevention, Chronic Disease in Minority Populations. Atlanta: Centers for Disease Control and Prevention;1994.
- Berenson G, Wattigney W, Webber L. Epidemiology of hypertension from childhood to young adulthood in black, white, and Hispanic population samples. Public Health Reports 1996; 111( Suppl 2):3-6.
- Bone L, Hill M, Levine D. Hypertension: A community perspective. In: Livingston IL (editor), Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects. Westport, CT: Greenwood Press; 1994 p. 46-58.
- Braithwaite R, Taylor S (editors), Health Issues in the Black Community. San Francisco: Jossey-Bass Publishers;1992.
- Brownson R, Smith C, Horton J, Bagby J. Racial differences in cardiovascular disease mortality and risk factors. Missouri Med 1992; 89(1): 42-45.
- Calhoun D, Oparil S. Racial differences in the pathogenesis of hypertension. Am J of the Medical Sciences 1995; 310 (Suppl 1):S86-90.
- Carter L, Walton S, Knowles M, Wing S, Tyroler, H. Social inequality of stroke mortality among US Black populations, 1968 to 1987. Ethnicity and Dis 1992; 2:343-351.
- Clark L, Emerole O. Coronary heart disease in African Americans: Primary and secondary prevention. Cleveland Clinic J of Med 1995; 62:285-292.
- Cooper E. Cardiovascular diseases and stroke in African Americans: A call for action. J of the National Medical Assoc 1993; 85(2):97-100.
- Cooper R, Ford E. Comparability of risk factors for coronary heart disease among Blacks and Whites in the NHANES-I epidemiologic follow-up study. AEP 1992; 2(5):637-645.
- Croft J, Strogatz D, Keenan N, James S, Malarcher A, Garrett J. The independent effects of obesity and body fat distribution on blood pressure in black adults: The Pitt County Study. International J of Obesity and Related Metabolic Disorders 1993; 17(7):391-397.
- Curry C. Coronary artery disease in blacks. In: Livingston IL (editor), Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects. Westport, CT: Greenwood Press, 24-32;1994.
- Daniels D, René A, Daniels V. Race: An explanation of patient compliance—fact or fiction? J of the National Medical Assoc 1994; 86(1):20-25.
- Douglas J, Thibonnier M, Wright J. Essential hypertension: Racial/ethnic differences in pathophysiology. J of the Assoc for Academic Minority Physicians 1996; 7(1):16-21.

- Edwards C. Emerging issues in lifestyle, social, and environmental interventions to promote behavioral change related to prevention and control of hypertension in the African-American population. *J of the National Medical Assoc* 1995; 87(Suppl):642-646.
- Ell K, Haywood L, Sobel E, deGuzman M, Blumfield D, Ning J-P. Acute chest pain in African Americans: Factors in the delay in seeking emergency care. *Am J of Public Health* 1994; 84(6):965-970.
- Falkner B. The role of cardiovascular reactivity as a mediator of hypertension in African Americans. *Seminars in Nephrology* 1996; 16(2):117-125.
- Fisher N, Gleason R, Moore T, Williams G, Hollenberg N. Regulation of aldosterone secretion in hypertensive blacks [published erratum appears in *Hypertension* 1994; 23(5): 679]. *Hypertension* 1994; 23(2):179-184.
- Fong R. Violence as a barrier to compliance of the hypertensive urban African American. *J of the National Medical Assoc* 1995; 87(3):203-207.
- Ford E, Cooper R. Racial/ethnic differences in health care utilization of cardiovascular procedures: A review of the evidence. *Health Services Research* 1995 Apr; 30(1 pt 2):237-52.
- Friday G. Cerebrovascular disease in blacks. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press 1994 p. 33-45.
- Gaines K, Burke G. Ethnic differences in stroke: Black-white differences in the United States population. SECORDS Investigators. Southeastern Consortium Racial Differences in Stroke. *Neuroepidemiology* 1995; 14(5):209-239.
- Giles W, Kittner S, Hebel J, Losonczy K, Sherwin R. Determinants of black-white differences in the risk of cerebral infarction. The National Health and Nutrition Examination Survey Epidemiologic Follow-up Study. *Archives of Internal Med* 1995; 155(12):1319-1324.
- Gillum R. Epidemiology of hypertension in African American women. *Am Heart J* 1996; 131(2):385-395.
- Gillum R. Stroke in blacks. *Stroke* 1988; 19(1): 1-9.
- Gillum R. The epidemiology of cardiovascular diseases: An American overview. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press; 1994. p. 3-23.
- Gillum R, Grant C. Coronary heart disease in black populations. II. Risk factors. *Am Heart Journal* 1982; 104(4 Part 1): 852-864.
- Gottdiener J, Reda D, Williams D, Materson B. Left atrial size in hypertensive men: Influence of obesity, race and age. Department of Veterans Affairs Cooperative Study Group on Antihypertensive Agents. *J of the Am College of Cardiology* 1997; 29(3):651-658.
- Grell G. Hypertension in the West Indies. *Postgraduate Medical J* 1983; 59(696):616-621.
- Grim C. On slavery, salt, and the greater prevalence of hypertension in black Americans. *Clinical Research* 1988; 36:426A.
- Hames C, Greenlund K. Ethnicity and cardiovascular disease: The Evans County heart study. *Am J of Medical Sciences* 1996; 311(3):130-134.
- Hebert L, Agarwal G, Ladson-Wofford S, Reif M, Hiremath L, Carlton S, et al. Nocturnal blood pressure in treated hypertensive African Americans compared to treated hypertensive European Americans. *J of the Am Society of Nephrology* 1996; 7(10): 2130-2134.
- Hochberg M, Thomas J, Thomas D, Mead L, Levine D, Klag M. Racial differences in the incidence of gout. The role of hypertension. *Arthritis and Rheumatism* 1995; 38(5):628-632.

- Hoffman-La Roche, Inc. Network, Index of Resources and Information for Those at Risk for Stroke. Nutley, N.J.: Hoffman-LaRoche, Inc; 1995.
- Horner R, Oddone E, Matchar D. Theories explaining racial differences in the utilization of diagnostic and therapeutic procedures for cerebrovascular disease. *Milbank Quarterly* 1995; 73(3):443-62.
- Houghton J, Prisant L, Carr A, Flowers N, Frank M. Racial differences in myocardial ischemia and coronary flow reserve in hypertension. *J of the Am College of Cardiology* 1994; 23(5):1123-1129.
- Howard G, Anderson R, Sorlie P, Andrews V, Backlund E, Burke G. Ethnic differences in stroke mortality between non-Hispanic whites, Hispanic whites, and blacks. The National Longitudinal Mortality Study. *Stroke* 1994; 25(11):2120-2125.
- Howard G, Evans G, Pearce K, Howard V, Bell R, Mayer E, Burke G. Is the stroke belt disappearing? An analysis of racial, temporal, and age effects. *Stroke* 1995; 26(7):1153-8.
- Jamerson K. Prevalence of complications and response to different treatments of hypertension in African Americans and white Americans in the U.S. *Clinical and Experimental Hypertension* 1993; 15(6):979-995.
- Keil J, Sutherland S, Knapp R, Gazes P. Serum cholesterol—risk factors for coronary disease mortality in younger and older blacks and whites the Charleston heart study, 1960-1988. *AEP* 1992; 2(1/2):93-99.
- Kimura M, Cho J, Lasker N, Aviv A. Differences in platelet calcium regulation between African Americans and Caucasians: Implications for the predisposition of African Americans to essential hypertension. *J of Hypertension* 1994; 12(2):199-207.
- Kokkinos P, Narayan P, Collieran J, Pittaras A, Notargiacomoa A, Reda D, et al. Effects of regular exercise on blood pressure and left ventricular hypertrophy in African American men with severe hypertension. *New England J of Med* 1995; 333(22):1462-1467.
- Kuhlemeier K, Steins S. Racial disparities in severity of cerebrovascular events. *Stroke* 1994; 25(11):2126-2131.
- Kumanyika S, Savage D. Ischemic heart disease risk factors in black Americans. Report of the Secretary's Task Force on Black and Minority Health, Cardiovascular and Cerebrovascular Disease, 269-274. Washington: Department of Health and Human Services;1986.
- Lackland D, Keil J. Epidemiology of hypertension in African Americans. *Seminars in Nephrology* 1996; 16(2):63-70.
- Liao Y, Cooper R, McGee D, Mensah G, Ghali J. The relative effects of left ventricular hypertrophy, coronary artery disease, and ventricular dysfunction on survival among black adults. *JAMA* 1995; 273(20):1592-1597.
- Lockette W. Controversy in the pharmacologic treatment of hypertension in African Americans. *J of the Assoc for Academic Minority Physicians* 1995; 6(4):125-129.
- Lopes A, Hornbuckle K, James S, Port F. The joint effects of race and age on the risk of end-stage renal disease attributed to hypertension. *Am J of Kidney Dis* 1994; 24(4): 554-560.
- Lopes A, Port F. The low birth weight hypothesis as a plausible explanation for the black/white differences in hypertension, non-insulin-dependent diabetes, and end-stage renal disease. *Am J of Kidney Dis* 1995; 25(2):350-356.
- Mason J. The health of African Americans: Special emphasis on kidney disease. *Am J of Kidney Dis* 1993; 21(4): 3-5.
- Materson B, Reda D, Cushman W, Massie B, Fries E, Kochar M et al. Single drug therapy for hypertension in men. *New England J of Med* 1993; 328(13):914-921.
- Matthews H. Racial, ethnic, and gender difference in response to medicines. *Drug Metabolism and Drug Interactions* 1995; 12(2):77-91.

- McCarron D. Role of adequate dietary calcium intake in the prevention and management of salt-sensitive hypertension. *Am J of Clinical Nutrition* 1997; 65(2 Suppl): 712S-716S.
- Morgenstern L, Spears W, Goff Jr D, Grotta J, Nichaman M. African Americans and women have the highest stroke mortality in Texas. *Stroke* 1997; 28(1):15-18.
- National Center for Health Statistics (US). Hypertension among persons 20 years of age and over, according to sex, age, race, and Hispanic origin: United States, 1960-62, 1971-74, 1976-80, and 1988-1991. *Health, United States* 1995. Hyattsville, MD: Maryland Public Health Service, 181;1996.
- National Heart, Lung, and Blood Institute (US). Report on the Working Group on Research in Coronary Heart Disease in Blacks. Bethesda, MD: National Heart, Lung, and Blood Institute;1994.
- National Heart, Lung, and Blood Institute Growth and Health Study Research Group (US). Obesity and cardiovascular disease risk factors in Black and White girls: The NHLBI growth and health study. *Am J of Public Health* 1992; 82(12):1613-1620.
- Oddone E, Horner R, Monger M, Matchar D. Racial variations in the rates of carotid angiography and endarterectomy in patients with stroke and transient ischemic attack. *Archives of Internal Med* 1993; 153(24):2781-2786.
- Oh S. Cerebrovascular disease in Negroes. *J of the National Medical Assoc* 1971; 63(2):93-98.
- Peterson E, Shaw L, DeLong E, Pryor D, Califf R, Mark D. Racial variation in the use of coronary revascularization procedures. *New England J of Med* 1997; 336(7):480-486.
- Robinson F, Satterwhite K, Potter C, Craddock K, Beyoglu S. Left ventricular mass index and coronary artery disease in hypertensive black males. *J of the National Medical Assoc* 1993; 85(6):452-456.
- Rotimi C, Cooper R, Cao G, Sundarum C, McGee D. Familial aggregation of cardiovascular diseases in African-American pedigrees. *Genetic Epidemiol* 1994; 11(5):397-407.
- Rutledge D. Race and hypertension. What is clinically relevant? *Drugs* 1994; 47(6):914-932.
- Sacco R, Kargman D, Zamanillo M. Race-ethnic differences in stroke risk factors among hospitalized patients with cerebral infarction: The Northern Manhattan Stroke Study. *Neurology* 1995; 45(4):659-63.
- Samadi A, Mayberry R, Zaidi A, Pleasant J, McGhee N, Rice R. Maternal hypertension and associated pregnancy complications among African-American and other women in the United States. *Obstetrics and Gynecology* 1996; 87(4):557-563.
- Saunders E. Hypertension in minorities: Blacks. *Am J of Hypertension* 1995; 8(12 pt 2):115s-119s.
- Saunders E, Weir M, Kong W, Hollifield J, Gray J, Vertes V, et al. A comparison of the efficacy and safety of a beta-blocker, a calcium-channel blocker, and a converting enzyme inhibitor in hypertensive blacks. *Archives of Internal Med* 1990; 150:1707-1713.
- Shea S, Misra D, Ehrlich M, Field L, Francis C. Correlates of nonadherence to hypertension treatment in an inner-city minority population. *Am J of Public Health* 1992; 82(12):1607-1612.
- Sherwood A., Hinderliter A. Responsiveness to alpha- and beta-adrenergic receptor agonists. Effects of race in borderline hypertensive compared to normotensive men. *Am J of Hypertension* 1993; 6(7 Pt. 1):630-635.
- Skoularigis J, Strugo V, Zambakides C, Eintracht S, Reddy K, Tshela E, et al. Comparison of captopril-thiazide and enalapril-thiazide combinations in the management of mild to moderate black hypertensive patients: How important is diuretic dose and duration of action of the ACE-inhibitor? *International J of Clinical Pharmacology and Therapeutics* 1996; 34(6):263-268.

- Steyn K, Fourie J, Lombard C, Katzenellenbogen J, Bourne L, Jooste P. Hypertension in the black community of the Cape Peninsula, South Africa. *East African Medical J* 1996; 73(11):758-763.
- Strogatz D. Use of medical care for chest pain: Differences between blacks and whites. *Am J of Public Health* 1990; 80(3):290-294.
- Summerson J, Bell R, Konen J. Racial differences in the prevalence of microalbuminuria in hypertension. *Am J of Kidney Dis* 1995; 26(4):577-579.
- Tracy R. Renovasculopathies of hypertension and the rise of blood pressure with age in blacks and whites. *Seminars in Nephrology* 1996; 16(2):126-133.
- Waitzman N, Smith K. The effects of occupational class transitions on hypertension: Racial disparities among working-age men. *Am J Public Health* 1994; 84(6):945-950.
- Weinberger M. Hypertension in African Americans: The role of sodium chloride and extracellular fluid volume. *Seminars in Nephrology* 1996; 16(2):110-116.
- Weinberger M. Salt sensitivity: Does it play an important role in the pathogenesis and treatment of hypertension? *Current Opinion in Nephrology and Hypertension* 1996; 5(3):205-208.
- Weir M. Salt intake and hypertensive renal injury in African-Americans. A therapeutic perspective. *Am J of Hypertension* 1995; 8(6):635-644.
- Weir M, Gray J, Paster R, Saunders E. Differing mechanisms of action of angiotensin-converting enzyme inhibition in black and white hypertensive patients. The Trandolapril Multicenter Study Group. *Hypertension* 1995; 26(1):124-130.
- Wenneker M, Epstein A. Racial inequalities in the use of procedures for patients with ischemic heart disease in Massachusetts. *JAMA* 1989; 261(2):253-257.
- Wild S, Laws A, Fortmann S, Varady A, Byrne C. Mortality from coronary heart disease and stroke for six ethnic groups in California, 1985 to 1990. *Ann of Epidemiol* 1995; 5(6):432-439.
- Williams D. Black-white differences in blood pressure: The role of social factors. *Ethnicity and Dis* 1992; 2:126-141.
- Wright J, Douglas J. Drug therapy for Black hypertensives. In: Fray J (editor), *Pathophysiology of Hypertension in Blacks*. New York: Oxford University Press;1993.
- Zweifler R, Lyden P, Taft B, Kelly N, Rothrock J. Impact of race and ethnicity on ischemic stroke. The University of California at San Diego Stroke Data Bank. *Stroke* 1995; 26(2):245-8.

## **Major Diseases Cancer**

- Akerley W, Moritz T, Ryan L, Henderson W, Zacharski L. Racial comparison of outcomes of male Department of Veterans Affairs patients with lung and colon cancer. *Archives of Internal Med* 1993; 153(14):1681-1688.
- American Cancer Society. Facts and Figures: Cancer in Minorities. [online] 1998 [cited 1998 August 31]. Available from: URL: <http://www.cancer.org/statistics/cff98/minorities.html>.
- Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. *Monthly Vital Statistics Report* 1997 Jun; 45(11), Suppl 2.
- Ball J, Elixhauser A. Treatment differences between blacks and whites with colorectal cancer. *Medical Care* 1996; 34(9):970-84.

- Bang K. Cancer and Black Americans. In: Livingston IL (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press 1994. p.77-93.
- Corder E, Friedman G, Vogelmann J, Orentreich N. Seasonal variation in vitamin D, vitamin D-binding protein, and dehydroepiandrosterone: Risk for prostate cancer in black and white men. *Cancer Epidemiol, Biomarkers, and Prevention* 1995; 4:655-659.
- Danley K, Richardson J, Bernstein L, Langhoiz B, Ross R. Prostate cancer: Trends in mortality and stage-specific incidence rates by racial/ethnic groups in Los Angeles County, California (United States) *Cancer Causes and Control* 1995; 6(6):492-8.
- Demark-Wahnefried W, Strigo T, Catoe K, Conaway M, Brunetti M, Rimer B, Robertson C. Knowledge, beliefs, and prior screening behavior among blacks and whites reporting for prostate cancer screening. *Urology* 1995; 46(3):346-51.
- Demers R, Swanson G, Weiss L, Kau T. Increasing incidence of cancer of the prostate. The experience of black and white men in the Detroit metropolitan area. *Archives of Internal Med* 1994; 154:1211-1216.
- Dosemeci M, Hoover R, Blair A, Figgs L, Devesa S, Grauman D, et al. Farming and prostate cancer among African-American in the Southeastern United States. *J of the National Cancer Institute* 1994; 86(22):1718-1719.
- Eley J, Hill H, Chen V, Austin D, Wesley M, Muss H, et al. Racial differences in survival from breast cancer. Results of the National Cancer Institute Black/White cancer survival study. *JAMA* 1994; 272(12):947-954.
- Freeman V, Leszczak J, Cooper R. Race and histologic grade of prostate cancer. *The Prostate* 1997; 30:79-84.
- Gelfand D, Parzuchowski J, Cort M, Powell I. Digital rectal examinations and prostate cancer screening: Attitudes of African American men. *Oncological Nursing Forum* 1995; 22(8):1253-1255.
- Greenberg M, Schneider D. The cancer burden of Southern-born African Americans: Analysis of a social-geographic legacy. *The Milbank Quarterly* 1995; 73(4):599-620.
- Guillory J. Ethnic perspectives of cancer nursing: The Black American. *Oncology Nursing Forum* 1987; 14(3):66-9.
- Hayes R, Brown L, Schoenberg J, Greenberg R, Silverman D, Schwartz A, et al. Alcohol use and prostate cancer risk in US blacks and whites. *Am J of Epidemiol* 1996; 143(7):692-7.
- Hayes R, Potters L, Swanson G, Liff J, Schoenberg J, Greenberg R, et al. Tobacco use and prostate cancer in blacks and whites in the United States. *Cancer Causes and Control* 1994; 5(3):221-226.
- Henderson R, Eastman J, Culkin D, Kattan M.W., Whatley T, Mata J, et al. Prostate-specific antigen (PSA) and PSA density: Racial differences in men without prostate cancer. *J of the National Cancer Institute* 1997; 89(2):134-8.
- Lyman G, Kuderer N, Lyman S, Cox C, Reintgen D, Baekey P. Importance of race on breast cancer survival. *Ann of Surgical Oncology* 1997; 4(1):80-87.
- Mayberry R, Coates R, Hill H, Click L, Chen V, Austin D, et al. Determinants of black/white differences in colon cancer survival. *J of the National Cancer Institute* 1995; 87(22):1686-1693.
- Miller B, Ries L, Hankey B, Kosary C, Edwards B (editors), *Cancer Statistics Review: 1973-1989*. Bethesda, MD: National Cancer Institute, NIH Publication No. 92-2789;1992.
- Moormeier J. Breast cancer in black women. *Ann of Internal Med* 1996; 124(10):897-905.
- Moul J, Douglas T, McCarthy W, McLeod D. Black race is an adverse prognostic factor for prostate cancer recurrence following radical prostatectomy in an equal access health care setting. *J of Urology* 1996; 155(5):1667-73.
- Moul J, Sesterhenn I, Connelly R, Douglas T, Srivastava S, Mostofu F, et al. Prostate-specific antigen values at the time of prostate cancer diagnosis in African-American men. *JAMA* 1995; 274(16):1277-81.

- Myers R, Wolf T, Balslem A, Ross E, Chodak G. Receptivity of African-American men to prostate cancer screening. *Urology* 1994; 43(4):480-487.
- Myers R, Wolf T, McKee L, McGrory G, Burgh D, Nelson G, et al. Factors associated with intention to undergo annual prostate cancer screening among African American men in Philadelphia. *Cancer* 1996; 78(3):471-479.
- Ndubuisi S, Kofie V, Andoh J, Schwartz E. Black-white differences in the stage of presentation of prostate cancer in the District of Columbia. *Urology* 1995; 46(1):71-77.
- Optenberg S, Thompson I, Friedrichs P, Wojcik B, Stein C, Kramer B. Race, treatment, and long-term survival from prostate cancer in an equal-access medical care delivery system. *JAMA* 1995; 274(20):1599-1605.
- Pienta K, Demers R, Hoff M, Kau T, Montie J, Severson R. Effect of age and race on the survival of men with prostate cancer in the Metropolitan Detroit tricounty area, 1973 to 1987. *Urology* 1995; 45(1):93-101.
- Powe B. Cancer fatalism among African-Americans: A review of the literature. *Nursing Outlook* 1996; 44(1):18-21.
- Powell I, Schwartz K, Hussain M. Removal of the financial barrier to health care: Does it impact on prostate cancer at presentation and survival? A comparative study between black and white men in a Veteran Affairs system. *Urology* 1995; 46(6):825-38.
- Price J, Colvin T, Smith D. Prostate cancer: Perceptions of African-American males. *J of the National Medical Assoc* 1993; 85(12):941-7.
- Price J, Desmond S, Wallace M, Smith D, Stewart P. Black Americans' perceptions of cancer: A study utilizing the health belief model. *J of the National Medical Assoc* 1988; 80(12):1297-1304.
- Robinson S, Ashley M, Haynes M. Attitudes of African Americans regarding screening for prostate cancer. *J of the National Medical Assoc* 1996; 88(4):241-246.
- Schapira M, McAuliffe T, Nattinger A. Treatment of localized prostate cancer in African-American compared with Caucasian men: Less use of aggressive therapy for comparable disease. *Medical Care* 1995; 33(11):1079-1088.
- Smith D, Bullock A, Catalona W, Herschman J. Racial differences in a prostate cancer screening study. *The J of Urology* 1996; 156:1366-1369.
- Spitz M, Hsu T, Wu X, Fueger J, Amos C, Roth J. Mutagen sensitivity as a biological marker of lung cancer risk in African Americans. *Cancer Epidemiol, Biomarkers & Prevention* 1995; 4:99-103.
- Swanson G, Lin C, Burns P. Diversity in the association between occupation and lung cancer among black and white men. *Cancer Epidemiol, Biomarkers, and Prevention* 1993; 2(4):313-320.
- Trock B. Breast cancer in African American women: Epidemiology and tumor biology. *Breast Cancer Research and Treatment* 1996; 40(1):11-24.
- U.S. Department of Health and Human Services. Health, United States 1995. Hyattsville, MD: Public Health Service, Centers for Disease Control and Prevention, National Center for Health Statistics, DHHS Pub. No. (PHS) 96-1232;1996.
- U.S. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington;1990.
- Weiss S, Tartter P, Ahmed S, Brower S, Brusco C, Bossolt K, et al. Ethnic differences in risk and prognostic factors for breast cancer. *Cancer* 1995; 76(2):268-274.
- Whittemore A, Kolonel L, Wu A, John E, Gallagher R, Howe G, et al. Prostate cancer in relation to diet, physical activity, and body size in blacks, whites, and Asians in the United States and Canada. *J of the National Cancer Institute* 1995; 87(9):652-661.
- Womeodu R, Bailey J. Barriers to cancer screening. *Medical Clinics of North America* 1996; 80(1):115-133.

## **Major Diseases Systemic Lupus Erythematosus**

Alarcon, G.S. et al - Systemic Lupus in three ethnic groups, *Lupus* 1999; 8(3):197-209.

McCarty, D.J. et al - Incidence of Systemic Lupus, Race and Gender differences.

*Arthritis & Rheumatism* 1995; 38(9):1260-70.

Symmons, D.P. - Frequency of Lupus in people of African origin *Lupus* 1995; 4(3):176-8.

## **Major Diseases Pulmonary Disease**

American Lung Association. Trends in asthma morbidity and mortality. Epidemiology and Statistics Unit, 2001.

American Lung Association. Trends in tuberculosis morbidity and mortality. Epidemiology and Statistics Unit, 2001.

American Lung Association. Minority lung disease data. [http://www.lungusa.org/pub/minority/asthma\\_00.html](http://www.lungusa.org/pub/minority/asthma_00.html).

Ballas SK. Complications of sickle cell anemia in adults.

Coultas D, Gong Jr. H, Grad R, Handler A, McCurdy S, Plater R, et al. Respiratory diseases in minorities of the United States. *American J of Respiratory Critical Care Med* 1993; 149(Suppl):S93-S131.

Malveaux F, Houlihan D, Diamond E. Characteristics of asthma mortality and morbidity in African-Americans. *J of Asthma* 1993; 30(6):431-437.

NHLBI Working Group. Respiratory disease disproportionately affecting minorities. *Chest* 108:1380-1392. [published erratum appears in *Chest* 1996 Jan; 109(1):295].

Sarpong S, Hamilton R, Eggleston P, Adkinson N. Socioeconomic status and race as risk factors for cockroach allergen exposure and sensitization in children with asthma. *J of Allergy and Clinical Immunology* 1996; 97(6):1393-1401.

Sperber K, Ibrahim H, Hoffman B, Eisenmesser B, Hsu H, Corn B. Effectiveness of a specialized asthma clinic in reducing asthma morbidity in an inner-city minority population. *J of Asthma* 1995; 32(5):335-343.

U.S. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives; Washington;1990.

## **Major Diseases Infectious Disease**

Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. *Monthly Vital Statistics Report* 1997 Jun; 45(11 Suppl 2).

Centers for Disease Control and Prevention. HIV/AIDS Among African Americans. Atlanta, GA; Department of Health and Human Services, September, 2000.

Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance 2001. Atlanta, GA; Department of Health and Human Services, September, 2002.

U.S. Department of Health and Human Services, Public Health Service, Division of STD Prevention. Sexually Transmitted Disease Surveillance, 1996. Atlanta: Centers for Disease Control and Prevention; 1997.

U.S. Department of Health and Human Services, Public Health Service. HIV/AIDS Surveillance Report. Atlanta: Centers for Disease Control and Prevention;1999; II(2).

U.S. Department of Health and Human Services, Public Health Service. Facts about HIV/AIDS among African Americans and Hispanics in the United States. Fact Sheet; 2001.

U.S. Department of Health and Human Services. Healthy People 2000: National Health Promotion and Disease Prevention Objectives. Washington: U.S. Government Printing Office;1990.

The White House. The National AIDS Strategy;1997.

## **Special Areas of Clinical Focus Obstetrics/Gynecology**

Amini S, Catalano P, Dierker L, Mann L. Births to teenagers: Trends and obstetric outcomes. *Obstetrics and Gynecology* 1996; 87(5 Pt 1):668-674.

Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. *Monthly Vital Statistics Report*, 1997 Jun; 45(11), Suppl 2.

Centers for Disease Control. Differences in maternal mortality among black and white women—United States, 1990. *Morbidity and Mortality Weekly Report* 1995 Jun; 44(1):6-7,13-14.

Centers for Disease Control. Fact sheet: Increased risk of dying from pregnancy among Hispanic women in the United States. [www.cdc.gov/nccdphp/drh/surv\\_hispwus.htm](http://www.cdc.gov/nccdphp/drh/surv_hispwus.htm).

Centers for Disease Control. Infant mortality statistics from the 1999 period linked birth/infant death data set. *National Vital Statistics Reports* 2002; 50(4).

Cimons M. Nation healthier than ever, official report. *Los Angeles Times* 1997 Sept; Section A1, A17.

Cooksey N. Pica and olfactory craving of pregnancy: How deep are the secrets? *Birth* 1995 Sept; 22(3):129-137.

Council on Scientific Affairs, American Medical Association. Female genital mutilation. *JAMA* 1995; 274(21):1714-1716.

Edwards C, Johnson A, Knight E, Oyemade U, Cole O, Westney O, et al. Pica in an urban environment. *J of Nutrition* 1994 Jun; 124(6 Suppl):954S-962S.

EthnoMed, Ethnic Medicine Guide, Harborview Medical Center, University of Washington. (1995-96) Eritrean Cultural Profile [online] 1995-96 [cited 1997 July 22]. Available: <http://www.hslib.washington.edu/clinical/ethnomed/eritcp.html>.

Fiscella K. Racial disparities in preterm births: The role of urogenital infections. *Public Health Reports* 1996; 111(2):104-113.

Friedman D, Cohen B, Mahan C, Lederman R, Vezina R, Dunn V. Maternal ethnicity and birthweight among blacks. *Ethnicity and Dis* 1993 Sum; 3(3):255-269.

Geronimus A. Black/white differences in the relationship of maternal age to birthweight: A population-based study of the weathering hypothesis. *Social Science and Med* 1996 Feb; 42(4):589-597.

Grimes D. The morbidity and mortality of pregnancy: Still risky business. *Am J of Obstetrics and Gynecology* 1994 May; 170(5 Pt 2):1489-94.

Hogue C, Yip R. Preterm delivery: Can we lower the black infant's first hurdle? *JAMA* 1989; 262:548-550.

Institute of Medicine, National Academy of Science, Subcommittee on Nutritional Status and Weight Gain During Pregnancy (US). *Nutrition During Pregnancy*. Washington: National Academy Press;1990.

- James S. Racial and ethnic differences in infant mortality and low birth weight: A psychosocial critique. *Ann of Epidemiol* 1993; 3:130-136.
- Kjerulff K, Langenberg P, Seidman J, Stolley P, Guzinski G. Uterine leiomyomas. Racial differences in severity, symptoms and age at diagnosis. *J of Reproductive Med* 1996 Jul; 41(7):483-490.
- Kost K, Forrest J. Intention status of U.S. births in 1988: Differences by mothers' socioeconomic and demographic characteristics. *Family Planning Perspectives* 1995 Jan-Feb; 27(1):11-17.
- Krieger N, Rowley D, Herman A, Avery B, Phillips M. Racism, sexism, and social class: Implications for studies of health, disease, and well-being. *Am J of Preventive Med* 1993 Nov-Dec; 9(6 Suppl):82-122.
- LaLonde A. Clinical management of female genital mutilation must be handled with understanding, compassion. *Canadian Medical Assoc J* 1995; 152(6):949-950.
- Laveist T. Segregation, poverty, and empowerment: Health consequences for African Americans. *Milbank Quarterly* 1993; 71(1):41-64.
- Lepine L, Hillis S, Marchbanks P, Koonin L, Morrow B, Kieke B, Wilcox L. Hysterectomy surveillance—United States, 1980-1993. *MMWR CDC Surveillance Summaries* 1997 Aug; 46(4):1-15.
- Lopes A, Port F. The low birth weight hypothesis as a plausible explanation for the black/white differences in hypertension, non-insulin-dependent diabetes, and end-stage renal disease. *Am J of Kidney Dis* 1995; 25(2): 350-356.
- Oliveti J, Kerckmar C, Redline S. Pre-and perinatal risk factors for asthma in inner city African-American children. *American J of Epidemiol* 1996; 143(6):570-577.
- Orr S, James S, Miller C, Barakat B, Diakoku N, Pupkin M, Engstrom K, Huggins G. Psychosocial stressors and low birthweight in an urban population. *Am J of Preventive Med* 1996 Nov-Dec; 12(6):459-466.
- Polednak A. Trends in U.S. urban black infant mortality, by degree of residential segregation. *Am J of Public Health* 1996; 86:723-726.
- Rawlings J, Rawlings V, Read J. Prevalence of low birth weight and preterm delivery in relation to the interval between pregnancies among white and black women. *The New England J of Med* 1995; 332(2):69-74.
- Rowley D. Framing the debate: Can prenatal care help to reduce the black-white disparity in infant mortality? *JAMA* 1995; 50(5):187-193.
- Samadi A, Mayberry R, Zaidi A, Pleasant J, McGhee N, Rice R. Maternal hypertension and associated pregnancy complications among African-American and other women in the United States. *Obstetrics and Gynecology* 1996; 87(4):557-563.
- Snow L. *Walkin' Over Medicine*. San Francisco: Westview Press;1993.
- Sung J, McGrady G, Rowley D, Hogue C, Alema-Mensah E, Lypson M. Interactive effect of race and marital status in low birthweight. *Ethnicity and Dis* 1993; 3:129-136.
- Toubia N. Female circumcision as a public health issue. *The New England J of Med* 1994; 331(11):712-716.
- U.S. Department of Health and Human Services. Common Health Care Beliefs and Practices of Puerto Ricans, Haitians and Low Income Blacks Living in the New York/New Jersey Area. The Department of Health Human Service;1990.
- Ventura S, Curtin S, Matthews T. Teenage births in the United States: National and state trends, 1990-1996. National Vital Statistics System. Hyattsville, MD: National Center for Health Statistics;1998.

## Special Areas of Clinical Focus Childhood and Adolescent Health

- Air Pollution and Respiratory Health Branch, Division of Environmental Hazards and Health Effects, National Center for Environmental Health, Center for Disease Control (US). Asthma mortality and hospitalization among children and young adults—United States, 1980-1993. *Morbidity and Mortality Weekly Report* 1996 May; 45(17):350-353.
- Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. *Monthly Vital Statistics Report* 1997 Jun; 45(11 Suppl 2).
- Berney B. Round and round it goes: The epidemiology of childhood lead poisoning, 1950-1990. *Milbank Quarterly* 1993; 71(1):3-39.
- Campaigne B, Morrison J, Schumann B, Falkner F, Lakatos E, Sprecher D, et al. Indexes of obesity and comparisons with previous national survey data in 9- and 10-year-old black and white girls: The National Heart, Lung, and Blood Institute Growth and Health Study. *J of Pediatrics* 1994; 124(5 Pt 1):675-680.
- Centers for Disease Control and Prevention. CDC Surveillance Summaries, Youth Risk Behavior Surveillance—United States, 1999. June 9, 2000. *MMWR* 2000;49(No. SS-5).
- Durant R, Baranowski T, Johnson M, Thompson W. The relationship among television watching, physical activity and body composition of young children. *Pediatrics* 1994; 94:449-455.
- Gutin B, Islam S, Manos T, Cucuzzo N, Smith C, Stachura M. Relation of percentage of body fat and maximal aerobic capacity to risk factors for atherosclerosis and diabetes in black and white seven-to eleven-year-old children. *J of Pediatrics* 1994; 125(6 Pt 1):847-852.
- Kimm S, Obarzanek E, Barton B, Aston C, Similo S, Morrison J, et al. Race, socioeconomic status, and obesity in 9- to 10-year-old girls: The NHLBI Growth and Health Study. *Ann of Epidemiol* 1996 Jul; 6(4):266-275.
- Los Angeles County Childhood Lead Poisoning Prevention Program. *Lead Ledger* 2(1);1997.
- Mead Johnson & Company. Birth to Birthday Safety, Infant Safety: First Toy/First Trip. Publication L-B1258-5-87;1987.
- McNutt S, Hu Y, Schreiber S, Crawford P, Obarzanek E, Mellin L. A longitudinal study of the dietary practices of black and white girls 9 and 10 years old at enrollment: The NHLBI Growth and Health Study. *J of Adolescent Health* 1997; 20(1):27-37.
- National Heart, Lung, and Blood Institute Growth and Health Study Research Group. Obesity and cardiovascular disease risk factors in Black and White girls: The NHLBI growth and health study. *Am J of Public Health* 1992; 82(12):1613-1620.
- Norman E, Bordley W, Hertz-Picciotto I, Newton D. Rural-urban blood lead differences in North Carolina children. *Pediatrics* 1994; 94(1):59-64.
- Onwuachi-Saunders C, Hawkins D. Black-white differences in injury: Race or social class? *Ann of Epidemiol* 1993 Mar; 3(2):150-153.
- Simon J, Morrison J, Similo S, McMahon R, Schreiber G. Correlates of high-density lipoprotein cholesterol in Black girls and White girls: The NHLBI Growth and Health Study. *Am J of Public Health* 1995 Dec; 85(12):1698-1702.
- U.S. Department of Health and Human Services. Births: Final Data for 2000. Washington: U.S. Government Printing Office; 2002.
- U.S. Department of Health and Human Services. Health, United States: 2001. Washington: U.S. Government Printing Office; 2001.

U.S. Department of Health and Human Services. Preventing Lead Poisoning in Young Children. Public Health Service. Centers for Disease Control and Prevention;1991.

U.S. Department of Health and Human Services. Sickle Cell Disease: Screening, Diagnosis, Management, and Counseling in Newborns and Infants, Clinical Practice Guideline, Number 6. AHCPR Pub. No. 93-0562. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service;1993.

U.S. Department of Health and Human Services. Update: Blood lead levels—United States, 1991-1994. Morbidity and Mortality Weekly Report 1992 Feb; 46(7):141-6.

## **Special Areas of Clinical Focus Mental Health**

Baker F. Mental health issues in elderly African Americans. Clinics in Geriatric Med 1995 Feb; 11(1):1-13.

Blazer D, Kessler R, McGonagle K, Swartz M. The prevalence and distribution of major depression in a national community sample: The national comorbidity survey. Am J of Psychiatry 1994 Jul; 151(7):979-986.

Brown D, Ahmed F, Gary L, Milburn N. Major depression in a community sample of African Americans. American J of Psychiatry 1995 Mar; 152(3):373-378.

Campbell L, Papillion J, Rochelle-Williams D, Whitmore G. Culturally Competent Mental Health Care for African Americans. (Unpublished Manuscript);1998.

Centers for Disease Control and Prevention. Suicide among black youths—United States, 1980-1995. JAMA 1998 May; 279(18):1431.

Centers for Disease Control and Prevention (US). Suicide Among Black Youths Factsheet;1998.

Chisolm J. Mental health issues in African-American women. Ann of the New York Academy of Sciences 1996; 789:161-179.

Cooper-Patrick L, Crum R, Powe N, Pratt L, Ford D. Factors associated with help-seeking behavior for mental health services among whites and African-Americans. Ahrs Fhsr Annual Meeting Abstract Book 1995; 12:105.

Gallo J, Marino S, Ford D, Anthony J. Filters on the pathway to mental health care, II. Sociodemographic factors. Psychological Med 1995; 25:1149-1160.

Gardano A, Davis R, Jones E. Promoting receptivity to issues of cultural diversity in mental health services at health maintenance organizations. The Family Psychologist 1994 Spr:15-18.

Gazmararian J, James S, Lepkowski J. Depression in black and white women. The role of marriage and socioeconomic status. Ann of Epidemiology 1995 Nov; 5(6):455-463.

Gibbs J. African -American suicide: A cultural paradox. Suicide and Life-Threatening Behavior 1997 Spr; 27(1):68-79.

Jones-Webb R, Snowden L. Symptoms of depression among blacks and whites. American J of Public Health 1993 Feb; 83(2):240-244.

Klinkenberg W, Calsyn R. Race as a moderator of the prediction of receipt of aftercare and psychiatric hospitalization. International J of Social Psychiatry 1997; 43(4):276-284.

Kung K, Liu X, Juon H. Risk factors for suicide in Caucasians and in African-Americans: A matched case-control study. Social Psychiatry Psychiatric Epidemiol 1998 Apr; 33(4):155-161.

Lawson W. The art and science of psychopharmacotherapy of African Americans. The Mount Sinai J of Med 1996 Oct/Nov; 63(5 & 6):301-305.

- Leo R, Narayan D, Sherry C, Michalek C, Pollack D. Geropsychiatric consultation for African-American and Caucasian patients. *General Hospital Psychiatry* 1997; 19(3):216-222.
- Leo R, Sherry C, Jones A. Referral patterns and recognition of depression among African-American and Caucasian patients. *General Hospital Psychiatry* 1998; 20:175-182.
- McMiller W, Weisz J. Help-seeking preceding mental health clinic intake among African-American, Latino, and Caucasian youths. *J of the Am Academy of Child and Adolescent Psychiatry* 1996 Aug; 35(8):1086-1094.
- Millet P, Sullivan B, Schwebel A, Myers L. Black Americans' and White Americans' views of the etiology and treatment of mental health problems. *Community Mental Health Journal* 1996 Jun; 32(3):235-242.
- Mouton C. Special health considerations in African-American elders. *Am Family Physician* 1997 Mar; 55(4):1243-1253.
- Neeleman J, Wessely S, Lewis G. Suicide acceptability in African and white Americans: The role of religion. *J of Nervous and Mental Disorders* 1998 Jan; 186(1):12-16.
- Shaffer D, Gould M, Hicks M. Worsening suicide rate in black teenagers. *Am J of Psychiatry* 1994 Dec; 151(12):1810-1812.
- Strakowski S, Flaum M, Amador X, Bracha H, Pandurangi A, Robinson D, et al. Racial differences in the diagnosis of psychosis. *Schizophrenia Research* 1996 Aug; 21(2):117-124.
- Strakowski S, Lonczak H, Sax K, West S, Crist A, Mehat R, et al. The effects of race on diagnosis and disposition from a psychiatric emergency service. *J of Clinical Psychiatry* 1995 Mar; 56(3):101-107.
- Takeuchi D, Sue S, Yeh M. Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *Am J of Public Health* 1995 May; 85(5):638-643.
- Taylor S. The mental health status of Black Americans: An Overview. In: Braithwaite RL, Taylor SE (editors), *Health Issues in the Black Community*. San Francisco: Jossey-Bass Publishers 1992. p. 20-34.
- Walcott-McQuigg J. Stress, women, and weight control behavior. *J of Cultural Diversity* 1995 Spr; 2(2):64-71.
- Walcott-McQuigg J. The relationship between stress and weight-control behavior in African-American women. *J of the National Medical Assoc* 1995 Jun; 87(6):427-432.
- Walcott-McQuigg J, Sullivan J, Dan A, Logan B. Psychosocial factors influencing weight control behavior in African American women. *West J of Nursing Research* 1995 Oct; 17(5):502-520.
- Weddington W, Gabel L, Peet G, Stewart S. Quality of care and Black American patients. *J of the National Medical Assoc* 1992; 84(7):569-575.
- Wohi M, Lesser I, Smith M. Clinical presentations of depression in African American and white outpatients. *Cultural Diversity in Mental Health* 1997; 3(4):279-284.

## **Special Areas of Clinical Focus Gerontology**

- Anderson R, Kochanek K, Murphy S. Report of Final Mortality Statistics, 1995. *Monthly Vital Statistics Report* 1997 Jun; 45(11 Suppl 2).
- Bernard M. The health status of African-American elderly. *J of the National Medical Assoc* 1993; 85(7):521-528.
- Ferraro K. Are black older adults health-pessimistic? *J of Health and Social Behavior* 1993 Sept; 34:201-214.

Hirsch S, Gutierrez-Pickett A, Margolis B. Medication education for an elderly Black and Hispanic population in the United States. *Hygiene* 1991; X:36-38.

Hobbs F. The Elderly Population. U.S. Census Bureau. [online] 1997 [cited 1997 August 19]. Available from: URL: <http://www.census.gov/population/www/pop-profile/elderpop.html>.

McLeod S, Rabb M. Ophthalmology in blacks: A survey of major entities. In: Livingston, I (editor), *Handbook of Black American Health: The Mosaic of Conditions, Issues, Policies, and Prospects*. Westport, CT: Greenwood Press 1994. p. 140-54.

Mouton C, Johnson M, Cole D. Ethical considerations with African American elders. *Clinics in Geriatric Med* 1995; 11(1):113-129.

National High Blood Pressure Education Program Working Group. National high blood pressure education program working group report on hypertension in the elderly. *Hypertension* 1994 Mar; 23(3):275-285.

Powe B. Cancer fatalism among elderly Caucasians and African Americans. *Oncology Nursing Forum* 1995; 22(9):1355-1359.

Powe B. Fatalism among elderly African Americans: Effects on colorectal cancer screening. *Cancer Nursing* 1995; 18(5):385-392.

Robinson A. Cultural inroads for health service to the African American elderly. *Journal of Cultural Diversity* 1994 Spr; 1(2):50-51.

Tielsch J, Sommer A, Katz J, Royall R, Quigley H, Javitt J. Racial variations in the prevalence of open-angle glaucoma. The Baltimore Eye Survey. *JAMA* 1991; 266(3):369-374.

U.S. Census Bureau. Profile of General Demographic Characteristics: 2000.

Wray L. Health policy and ethnic diversity in older Americans—dissonance or harmony? In *Cross-Cultural Medicine—A Decade Later* [Special later]. *West J of Med* 1992 Sept.; 157:357-361.

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# THE CULTURALLY COMPETENT CARE HANDBOOK EVALUATION

1. In what context did you receive the handbook(s)?

\_\_\_\_ Training/Workshop      \_\_\_\_ Individual Request      \_\_\_\_ Other specify (\_\_\_\_)

2. Please rate the effectiveness of the handbook(s) as learning tools:

|   | Not at All | Somewhat | Extremely |
|---|------------|----------|-----------|
| Latino  | 1          | 2        | 3         |
| African American                                | 1          | 2        | 3         |
| Asian and Pacific Islander (API)                | 1          | 2        | 3         |
| Lesbian, Gay, Bisexual and Transgendered (LGBT) | 1          | 2        | 3         |

3. Please rate the effectiveness of the handbook(s) in improving cross-cultural clinical skills:

|   | Not at All | Somewhat | Extremely |
|---|------------|----------|-----------|
| Latino  | 1          | 2        | 3         |
| African American                                | 1          | 2        | 3         |
| Asian and Pacific Islander (API)                | 1          | 2        | 3         |
| Lesbian, Gay, Bisexual and Transgendered (LGBT) | 1          | 2        | 3         |

4. Describe what you like about the handbook(s):

Latino: \_\_\_\_\_

African American: \_\_\_\_\_

API: \_\_\_\_\_

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5. Describe how we could improve the handbook(s):

Latino: \_\_\_\_\_

African American: \_\_\_\_\_

API: \_\_\_\_\_

LGBT: \_\_\_\_\_

6. Other comments?

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