REACH

Racial and Ethnic Approaches to Community Health

For more information about CDC's REACH program,
visit http://www.cdc.gov/reach2010/index.htm

Removing Barriers to Increase Cervical Cancer Screening Among Vietnamese American Women

Public Health Problem

Vietnamese American women have the highest incidence rate of cervical cancer of any ethnic group in the United States—43 cases per 100,000, which is 5 times as high as rates among non-Latina whites. In addition, cervical cancer is the second most common cancer among Vietnamese American women. More than 25% of Vietnamese American women living in Santa Clara County reported in 2000 that they had never had a Pap test, compared with less than 5% of all women in the United States.

Program Example

The Vietnamese Community Health Promotion Project organized the Vietnamese REACH for Health Initiative Coalition to prevent cervical cancer among Vietnamese American women in Santa Clara County. The coalition has held community forums, meetings, and retreats to develop an action plan. Community members identified multiple barriers to Pap testing: lack of information, concerns resulting from traditional beliefs, and absence of culturally and linguistically appropriate screening services that are affordable. To address these barriers, the coalition developed and launched a community action plan to promote Pap screening by creating change among community leaders, the health care system, Vietnamese American medical providers, and Vietnamese American families. The coalition's integrated strategy uses six approaches: 1) a media education campaign; 2) outreach efforts using lay health workers; 3) patient navigation and a low-cost Vietnamese-language Pap clinic staffed by a female Vietnamese American physician; 4) continuing medical education; 5) mailed reminders; and 6) advocacy to reestablish a Breast and Cervical Cancer Control Program in the county.

Implications and Impact

Preliminary results from the outreach efforts show that 46.8% of Vietnamese American women who had never had a Pap test obtained a Pap test after meeting with lay health workers. The patient navigator has received calls from more than 1,214 Vietnamese American women seeking information and assistance. As a result, 724 women have registered to receive a Pap test. In addition, 50 Vietnamese American physicians have been educated about cervical cancer screening, diagnosis, and treatment, and 29 physicians have registered 4,187 women in a reminder system. A cancer information Web site established for this program has received more than 1,200 visitors and 10,600 hits per month. Moreover, the Breast and Cervical Cancer Control Program has been reestablished in Santa Clara County, with two clinics and three providers.

Contact Information

University of California in San Francisco • Vietnamese Community Health Promotion Project
44 Page Street • Suite 500 • San Francisco, California 94102
Phone: (415) 476-0557 • Web site: http://www.healthisgold.org

New Mexico

Building Tribal Communities' Capacity to Raise Awareness About Cancer, Improve Screening Behaviors, and Establish Lasting Partnerships

Public Health Problem

All types of cancer are on the rise among Native Americans, recent studies show, and Native Americans have the poorest cancer survival rates of any group in the United States. One critical public health problem facing tribes is Native American women's lack of sufficient knowledge about breast and cervical cancer screening practices, including the age when a woman should begin having mammograms and Pap tests and how often these screening tests should be performed.

Program Example

The Albuquerque Area Indian Health Board has launched a culturally appropriate pilot plan to build capacity in a tribal community. By building public health capacity within the community, the board aims to reduce health disparities by improving health outcomes for Native American women with breast or cervical cancer. Additional goals are to enhance the capacity of tribes to conduct cancer surveillance activities, collect and analyze cancer data, identify health concerns and disease trends, evaluate cancer programs, and work effectively with researchers and outside organizations. The project will achieve these goals by building relationships, building skills, promoting interdependence, and promoting sustainability. For example, a culturally appropriate curriculum for training to improve public health skills has been developed and delivered to members of seven Southwestern Tribes. Additionally, a comprehensive public health needs assessment has been completed in the pilot tribal community. The results of this assessment have been used as part of a strategic planning process to bolster the local public health infrastructure to respond to pressing health issues. Interdependent partnerships between tribes and relevant public health entities have also been established. In addition, a health promotion video specific to the pilot community is being developed to raise people's awareness about breast and cervical cancer.

Implications and Impact

This project is developing and conducting tribal-specific preventive interventions that aim to raise Native Americans' awareness about cancer and improve screening behaviors. The project aims to boost the tribe's capacity to gather and apply cancer data and create a model for developing public health capacity within tribes. The project is also working to establish sustainable networks and partnerships within tribal communities as well as between tribes and relevant outside programs.

Contact Information

Albuquerque Area Indian Health Board, Inc.
5015 Prospect Avenue, NE • Albuquerque, New Mexico 87110
Phone: (505) 764-0036 Web site: http://www.aaihb.org

Changing Community Norms to Address Cardiovascular Disease

Public Health Problem

For African Americans living in Oregon, rates of cardiovascular disease deaths are alarmingly high, considering the small size of the population. Cardiovascular disease trends in Oregon parallel national trends, except that the black-white gap between rates of cardiovascular disease deaths is greater in Oregon than in the nation. In fact, Oregon's African Americans are 51% more likely to die of stroke than whites.

Program Example

To target the root causes of this black-white gap in cardiovascular disease and stroke, the African American Health Coalition developed a program that promotes physical activity and other heart-healthy behaviors among African Americans. The program "Lookin' Tight, Livin' Right" uses existing relationships between beauty shop and barbershop operators and their clients to assess readiness to change and promote healthy behaviors. In addition, "HOLLA!" is a project that trains high school students to educate their peers about cardiovascular disease and related risk factors. Another program uses educational mailings to low-income African Americans enrolled in Oregon's Medicaid program to raise their awareness and promote use of cardiovascular disease preventive services. Finally, the "Wellness Within REACH" program offers free physical activity classes to African Americans, helping reduce some of the barriers to healthy, active lifestyles.

Implications and Impact

For example, almost a third of people attending the "Wellness Within Reach" classes reported being told by a physician that they have high blood pressure, 21.8% reported being obese, and 14% reported having diabetes. Preliminary data show that 76% of participants in these exercise classes are now exercising more. These programs have become movements in the local community, changing the community's norm about physical activity and nutrition to the extent that community members have come together to raise funds to support and sustain these classes.

Contact Information

African American Health Coalition, Inc.
2800 North Vancouver • Suite 100 • Portland, Oregon 97227
Phone: (503) 413-1850 • Web site: http://www.aahc-portland.org

South Carolina

Bringing Together Community Partners to Improve Diabetes Care and Control for African Americans

Public Health Problem

African Americans in South Carolina have a greater risk for developing diabetes than whites. They also have a greater risk for diabetes complications, such as heart disease, stroke, blindness, renal failure, and amputations. Diabetes is the sixth leading cause of death in this state, claiming more than 1,600 lives each year. One of every seven patients in a South Carolina hospital has diabetes. The American Diabetes Association reports that the average costs of expenditures for diabetes in 2002 totaled $13,243 per person with diabetes, compared with $2,560 per person without diabetes.

Program Example

The REACH 2010: Charleston and Georgetown Diabetes Coalition's goal is to improve diabetes care and control for more than 12,000 African Americans with diabetes. The Diabetes Initiative of South Carolina and more than 40 partner organizations are supporting the Coalition as it develops and carries out a comprehensive community action plan to reach out to African Americans where they live, worship, work, play, and seek health care. The plan aims to decrease the tremendous burden of diabetes and link people with needed services. Strategies include establishing walk-and-talk groups, providing diabetes medicines and supplies, and creating learning environments where health professionals and people with diabetes learn together. In addition, the plan calls for establishing library learning and resources, offering advice on how to buy and prepare healthier foods, and improving the quality of diabetes care.

Implications and Impact

Just 2 years after the program began, African Americans in South Carolina are more physically active, are being offered healthier foods at group activities, and are getting better diabetes care and control. In addition, some disparities have been greatly reduced for African Americans with diagnosed diabetes. For example, more African Americans are undergoing the recommended annual A1c testing, annual lipid profile, annual kidney testing, referral for dilated eye examinations, and blood pressure control. By 2007, the coalition's goal is to eliminate all disparities in diabetes care and control.

Contact Information

Medical University of South Carolina • College of Nursing
99 Jonathan Lucas Street • Fourth Floor • Room 425 • Charleston, South Carolina 29425
Phone: (843) 792-4625 • Web site: http://www.musc.edu/diabetes/reach

Tennessee

Working Together to Reduce the Burden of Cardiovascular Disease and Diabetes

Public Health Problem

Nearly 42,000 African Americans living in North Nashville were at greater risk for early death and disability from cardiovascular disease and diabetes than white residents, according to data from the Nashville Metropolitan Public Health Department. African Americans also had much higher death rates than white residents: more than 215 African Americans per 100,000 in North Nashville died of heart disease vs. 141 whites per 100,000 (rates are age-adjusted). There was also a significant disparity for stroke, with 54.8 deaths per 100,000 for North Nashville residents vs. 29.9 deaths for their white neighbors. Rates were no better for complications of type 2 diabetes: 54.3 African Americans per 100,000 died of diabetes vs. only 14.1 of the county's white residents.

Program Example

The Nashville project has mobilized four action teams focusing on specific risk factors, and a Community Action Plan that stresses that teams—in conjunction with community leaders, residents, health professionals and others—promote community readiness to address environmental supports and barriers in North Nashville. All activities are designed to promote healthy behavior changes including healthy eating, regular exercise, no smoking, accessing quality care, and getting screened for cardiovascular disease and diabetes. Team members are trained and motivated to instigate changes in procedures, practices, and systems so healthy behavior changes are achieved and maintained over time. Community-based interventions include nutrition and exercise classes, walking clubs, Tai Chi demonstrations, cook-offs, and smoking cessation classes. In addition, local health clinics have expanded their hours, local agencies have offered residents new opportunities for disease screenings, and team members have helped neighborhoods improve the physical environment. Also under way are several faith-based interventions, including the Faith and Health course offered through the American Baptist College and work with individual congregations in North Nashville.

Implications and Impact

The Nashville project is designed to increase people's readiness to change important lifestyle behaviors including nutrition, regular exercise, no smoking, and screening. In addition, environmental barriers to change are being addressed. The program also is working with groups to develop support systems that will help to maintain these healthy changes over time. The project has developed and launched a Web-based data collection system that will help health officials to evaluate and analyze the process, community actions, and capacity-building activities.

Contact Information

Matthew Walker Comprehensive Health Center
1501 Herman Street • Nashville, Tennessee 32208
Phone: (615) 327-9400 • Web site: http://www.mwchc.org