

Special Focus: Eliminating Health Disparities

Interventions to Eliminate Health Disparities Are Innovative

To help the people hurt the most by disparities, public health workers are trying creative approaches that engage community members and new partners. Across the country, churches, schools, public housing authorities, hospitals, and health departments are teaming up to fight health disparities.

Helping Black Teens Eat Healthier Foods and Be More Active

Children's eating habits and physical activity decline during the early teen years, and the decline is especially acute for black teens. To counter this trend, CDC's Division of Nutrition and Physical Activity has partnered with 100 Black Men of America (100 BMOA), the U.S. Department of Agriculture's (USDA) Food and Nutrition Service, and the California Adolescent Nutrition and Fitness Program (CANFit) to work with 11-18-year-old African American boys. They developed a curriculum-based program that teaches young people the benefits of good nutrition and physical activity, with the goal of preventing cardiovascular disease, diabetes, and hypertension.

CDC developed the curriculum to complement 100 BMOA's existing guide, "Mentoring the 100 Way." The curriculum was revised after being tested in 100 BMOA's chapters in Dallas, Los Angeles, and Atlanta. The extensive testing process included gathering feedback from the young people. It has since been expanded to include girls and is again being revised for use nationwide. A few professional men who are members of 100 BMOA were trained to use the curriculum. The training was conducted in Los Angeles by CANFit, which specifically addresses the needs of youth of color and also combines physical activity with nutrition.

"One lesson learned is that it takes time, patience, and endurance to work with volunteer organizations," said Annie Carr, MS, RD, CDC Public Health Nutritionist. "We had to defer to their schedules and priorities."

The interventions are culturally sensitive. For example, the chapter in DeKalb County, Georgia, integrated this curriculum into their program, which is based on Kwanzaa

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This issue of CDNR is the second part of a 2-part series on eliminating health disparities.

Commentary

What We Do About Health Disparities Matters

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In our last issue, we began to explore the problem of health disparities among different racial and ethnic groups. Inequalities in health are a threat to our principles and a reflection of disparities in other areas such as living conditions, income, education, and access to health care. They also undermine our entire public health system. For example, the recent surge in new cases of diabetes, particularly among African Americans, Hispanics, and Native Americans, demonstrates the economic and health impact of just one disease (page 24).

This issue of CDNR outlines interventions that can eliminate health disparities, reminding us that the problems are not insurmountable. Our efforts do make a difference. The innovative programs featured in our cover story—including the Boston University Partners in Health and Housing project that works with public housing residents—show that new partnerships and approaches are possible. Other creative projects discussed in this issue are supported by CDC’s Racial and Ethnic Approaches to Community Health (REACH 2010) program, which emphasizes the creation of new coalitions. This program has enabled communities to improve the health of underserved groups and form relationships that can be strengthened in future collaborations.

REACH 2010 meets another public health need as well. Because project activities are well documented and evaluated, they will help us understand what works in eliminating disparities. Good data are essential to identifying health disparities. In addition, communities sometimes need help translating data into useful public health action. Our article on new CDC guidelines for applying data to health disparities (page 17) discusses how the gap between data and action is being bridged.

Bridging this gap is especially important when communities suddenly find that unfamiliar ethnic groups are their new neighbors. An influx of immigrants or migrant workers can disrupt a previously stable social support system. Many communities have found the demand for new or different services overwhelming. In such situations, learning from the experiences of others can be invaluable. In many cases, we find that the most important changes occur when community members simply get to know one another.

The programs featured in this issue show that cultural and linguistic barriers can be overcome. The diversity of groups such as Asian Americans and Pacific Islanders (page 5) also teaches us that what we think is one community may be several, with varying customs and needs. Ensuring that health care practitioners can communicate with patients and their families is an essential first step that may require more time and effort than expected. And language is not the only barrier to communication, as illustrated by an insightful article on challenges faced by lesbians seeking health care (page 22).

Another important tool in the process of learning why health disparities exist and how they can be eliminated is prevention research. What we measure and how we measure it can make the difference. For example, risk factors such as tobacco use have a disproportionate effect on the black community (page 12). Research must examine how populations groups are the same and how they are different. Eliminating health disparities means identifying such differences and the disparities they cause and filling the unmet needs. Fortunately, our public health system is capable of achieving these goals. 

Innovative Interventions

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principles. The program empowers young men to conduct community environmental assessments. At one meeting site, for instance, participants created a directory of places where young people could be physically active.

“The basis of the nutrition piece is teaching young people how to assess the fat and sugar content of foods,” said Refilwe Moeti, MA, CDC Public Health Advisor. “For example, they learn to measure the equivalent of the grams of fat and sugar in particular foods.” Because focus group results showed that these young people were frequent customers of fast food restaurants, they also learn how to assess the nutritional values of fast food items and select healthier foods from the menus.

Another nutritional benefit is that the young people, about 12 to 15 per site, are served snacks. Meetings are after school or on Saturdays. At sites where the snacks are funded by USDA, the food and the serving sizes must meet USDA standards. Pure juice, not a juice drink, must be served, for instance. Making sure the snacks were healthy was a challenge when the meetings were held at youth clubs that had soda contracts.

Reaching Boston’s Poorest Residents

The Boston University School of Public Health (BUSPH) Prevention Research Center (PRC) is working with public housing residents, the Boston Housing Authority, and the Boston Public Health Commission to improve the health of the city’s 26,000 public housing

residents. Boston’s public housing residents are some of the city’s poorest, having an average income of \$11,000. They are 35% Hispanic, 30% black, 23% white, and 8% Asian. Robert Meenan, MD, MPH, MBA, BUSPH dean and the PRC’s principal investigator, said that 40% of Boston’s public housing residents are children and 15% are elderly.

In addition, noted Dr. Meenan, their health status is poor. Black infant mortality rates have remained high despite improved access to care. Half the residents are current smokers, three times the rate found in the rest of Boston. Because the city’s 64 developments are in poor, often industrial locations, residents are exposed to environmental hazards as well. They also face high stress related to crime, isolation, and lack of adequate nutrition.

Projects under way in the BUSPH Prevention Research Center are designed to promote physical activity and self-esteem among young girls, prevent domestic violence, increase breast and cervical cancer screening, and establish a new database on the health status of public housing residents.

Boston University School of Public Health has a history of working with housing authorities that precedes the existence of the Prevention Research Center. In one program, returning Peace Corps volunteers received a BUSPH Health and Housing scholarship toward their MPH degree, were provided an apartment by the housing authority, and worked to coordinate public health-related services for

residents. Services included flu shots, tobacco control programs, and computer labs. That program is no longer active, but another program has since been started, with funding from the Department of Housing and Urban Development (HUD), that focuses on improving indoor air quality in Boston public housing and reducing the health impacts of asthma on residents.

Dr. Meenan hopes to expand the PRC program to involve public housing authorities in nearby cities.

Reaching the Border Population

The University of Arizona Prevention Research Center is searching for practical interventions that will improve the health of border populations.

Special Action Groups that include key community members are formed to address problems like finding places for people to walk. Some groups have designed paths for walking and biking and had them approved by the city. Another group convinced the county to award it a Community Development Block Grant for a new park.

In Nogales, one of the Special Action Group's goals was getting rid of school vending machines or radically changing their contents. One school now offers students fresh fruits and carrot sticks as rewards rather than the snack foods given at many other schools.

The Arizona PRC (known as the Southwest Center for Community Health Promotion) also has offered nutrition classes in communities and food demonstrations at supermarkets. One intervention was so successful that some stores had to begin ordering more low-fat dairy products.

In clinics, the PRC aims to change the behavior of providers, partnering with

the clinic to set benchmarks for critical services, tracking the services being provided to diabetic patients and providing feedback on the providers' effectiveness in meeting their own goals. With patients, they try to increase and improve self-management practices. One strategy targets family members so they can be supportive of the patient. The whole family gets support and education.

"Our chronic disease prevention strategy is to fully engage the community as partners, mount comprehensive interventions, and emphasize policy change at the community, state, or even national levels," said Joel Meister, PhD, Co-Director for Community Programs. "And so far it's working!"

REACH 2010

Communities participating in CDC's Racial and Ethnic Approaches to Community Health (REACH 2010) project are encouraged to be creative in their search for successful programs to end health disparities, particularly interventions that can be replicated in other settings. "Racial and ethnic disparities have been resistant to traditional change strategies," noted Pattie J. Tucker, DrPH, RN. She is responsible for data collection and evaluation activities for REACH 2010, which oversees 37 demonstration projects across the country.

Grantees include universities, hospitals, community-based organizations, and health departments. To spur new partnerships, community-based organizations are required to form coalitions with three other organizations, one of which must be a health department, university, or other

research organization.


The coalitions are urged to form new relationships that can strengthen the community. In Chicago, for example, REACH 2010 staffers worked with churches to encourage low-income women to seek screening for breast and cervical cancer. This effort brought together members of the African American and Hispanic communities.

Coalitions also have been successful in finding new ways to engage community members. In Lowell, Massachusetts, where cardiovascular disease and diabetes among the Cambodian community is targeted, older refugees were influential but isolated by language barriers. Forming a council of Cambodian elders has been an important step in increased community involvement.

The program's strong evaluation component adds value to project activities. "For example, in the Texas migrant health project, *promotores* [lay

health workers] are being used," said Imani Ma'at, EdD, Director of REACH 2010. "It's not a new idea, but it may not have been documented and evaluated as we are doing."

Making REACH 2010 results useful to others is just as important as developing strategies specific to communities. A data warehouse is being established to identify similarities among projects. "This will make it easier to pull out similar activities by topic or racial/ethnic group," noted Dr. Ma'at.

The next step is to develop a plan for translating and disseminating the REACH 2010 research findings so that others can use the information to develop effective interventions. Community involvement is an important part of the plan, said Dr. Ma'at, because REACH 2010 is "very much about community empowerment." 

Diversity in Asian American and Pacific Islander Communities Poses Challenge for Health Care Providers

Overcoming health disparities in Asian American and Pacific Islander communities often means delivering information and services in innovative ways—using non-English languages, for example—and recognizing the integral role that culture and tradition play in daily life. But how do you achieve these goals when the populations that you are trying to reach boast nearly 50 national or ethnic origins, more than 100 languages and dialects, and people of vastly different backgrounds?

The need to serve these communities in culturally sensitive and linguistically appropriate ways will only increase in the future. Although Asian Americans and Pacific Islanders make up only 4% of the U.S. population (10.9 million people), they are the fastest growing ethnic group in the United States—increasing 95% in the 1980s and another 43% in the 1990s. By 2050, these groups are expected to make up 9% of the U.S. population (37.6 million people).

Photo courtesy of AAPCHO



The Kalihi-Palama Health Center in Honolulu, Hawai'i, is one of six community health centers partnered with the Association of Asian Pacific Community Health Organizations (AAPCHO) to help reduce breast and cervical cancer mortality rates among Asian American and Pacific Islander women. This center currently focuses on outreach to Filipino women.

Asian Americans are often stereotyped as a “model minority” of overachievers with few problems or needs, but Asian American and Pacific Islander families are about twice as likely as whites to live in poverty. Some subgroups speak little or no English, which restricts their ability to access many services, including health care.

High rates of cancer, diabetes, and heart disease have been reported in both populations, as well as high rates of infectious diseases like tuberculosis and hepatitis among many new immigrants, particularly refugees from Southeast Asia. Health care professionals who serve these populations say the key to reducing disease rates is to clearly define target communities and their needs.

“I think it’s important always to look at the data available and target those populations that are most at risk and try to design programs that are going to be most effective with them,” said Ignatius Bau, JD, of the Asian and Pacific

Islander American Health Forum (APIAHF). “That’s not anything new, but I think we often try to either generalize or find a one-size-fits-all solution for this very, very diverse population.”

APIAHF is a national advocacy organization dedicated to promoting policy, program, and research efforts to improve the health and well-being of Asian Americans and Pacific Islanders. Researchers and health department officials frequently contact APIAHF and expect quick, easy advice on how to serve these communities, such as which language to use for their materials.

“People are often frustrated with our answers of ‘it depends’ and ‘you need to do more homework,’ ” Mr. Bau explained. “The language needs of a particular community may not be obvious. If the population is predominantly Filipino or Asian Indian, many of them speak English because it is common in their home country. So you have to dig a little deeper. Just because the dominant population in your area is Asian Indian, you wouldn’t automatically translate something into Hindi. Maybe there is a smaller Vietnamese population that doesn’t speak English as well as the Asian Indians do, so the language barriers are greater for them.”

New OMB Category to Help Define Populations

Understanding the characteristics of minority populations depends on having firm data, but data are not always available for Asian Americans and Pacific Islanders. Because 80% of people in these groups live in 10 states (California, Florida, Hawai'i, Illinois, Massachusetts, New Jersey, New York, Texas, Virginia, and Washington), most

states don't collect or report separate data. Instead, states lump these populations under "other." Thus, the true picture of these groups and their needs is largely invisible, particularly at the national level. To solve this problem, data need to be disaggregated, or broken down into more detail.

In 1977, the U.S. Office of Management and Budget (OMB) sought to improve the collection and comparability of federal data by establishing five minimum categories for reporting race and ethnicity. Prompted by criticism that the categories did not reflect the country's increasing diversity, OMB reviewed the standards and in 1997 issued new ones, which all federal agencies must begin using in 2003.

One of the biggest changes is separating Asians and Pacific Islanders into their own categories and recognizing Native Hawaiians as a distinct group. How the changes will affect these communities will depend on how organizations use and interpret the data, according to Jeffrey B. Caballero, MPH, executive director of the Association of Asian Pacific Community Health Organizations (AAPCHO).

"When you create smaller subgroups, in some ways, it diffuses the numbers in the community," Mr. Caballero said.

AAPCHO represents 14 community health centers dedicated to serving Asian Americans or Pacific Islanders. These centers are part of a network of 700 community health centers that provide primary and preventive health care services in medically underserved areas throughout the United States and its territories. The centers are funded by the Public Health Service Act and administered by the Bureau of Primary Health Care, Health Resources and Services Administration, Department of

Health and Human Services (HHS).

Now that the 2000 U.S. census and *Healthy People 2010* have used the new racial and ethnic categories, Mr. Bau hopes more researchers will follow suit. However, these changes will not necessarily solve an ongoing conflict between state and federal program needs. Although more detailed or disaggregated data are needed for state and local planning, federal agencies like CDC typically use aggregated data to make national policy and program decisions. So if data on small subpopulations are always being collapsed into broader categories at the national level—or not analyzed at all—the new categories will not improve identification of health disparities among these populations.

"We're very happy that *Healthy People 2010* is using the OMB categories," Mr. Bau said. "This is the first time that we've gotten a detailed level of knowledge about data gaps. And there's a long way to go to try to fill those gaps. But if the only place the data are collected are in national surveys, we're never going to get the information we need because the sample sizes at the national level simply aren't large enough."

Although Asians and Pacific Islanders will now be in different categories, groups like AAPCHO and APIAHF plan

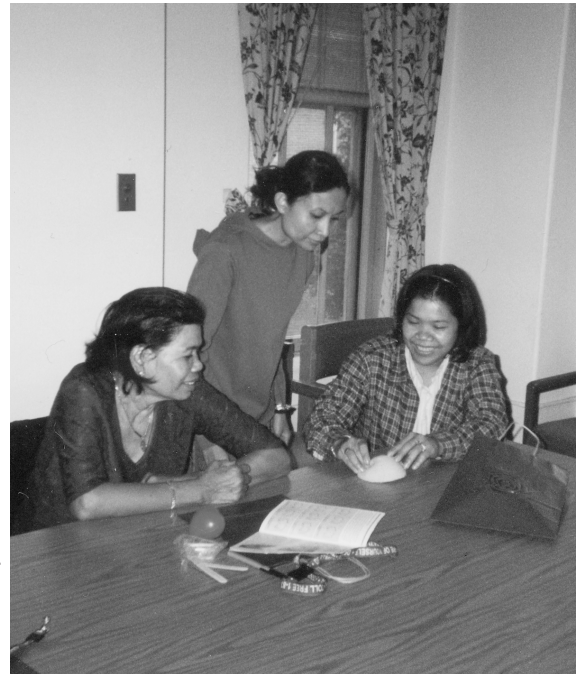


Photo courtesy of AAPCHO

The Family Health Center in Worcester, Massachusetts, works with Cambodian women to reduce their risk of dying from breast and cervical cancer. The center is part of the Association of Asian Pacific Community Health Organizations (AAPCHO).

to continue serving both populations. One reason is that Native Hawaiians and other Pacific Islanders often can't afford to travel to the continental United States to advocate for national policies and funding for their communities.

Health Disparities Must Be Addressed

Predictably, when people do not have adequate access to primary or preventive care services, their health suffers. Since 1980, cancer has been the leading cause of death for Asian Americans. Liver cancer rates are 12 times higher among Vietnamese men than among white men, and cervical cancer rates are five times higher among Vietnamese women than among white women. Breast and cervical cancer screening rates for Asian American and Pacific Islander women are the lowest in the country, and Cambodian, Laotian, and Samoan American women have low rates of early prenatal care.

Smoking rates are particularly high among Southeast Asian men—for example, 70% of Laotian and Cambodian American men smoke. Rates of heart disease, obesity, and diabetes are high among many Asian American and Pacific Islander groups, and mental health problems are common among Southeast Asian refugees who came to the United States after the Vietnam War.

These disparities can be linked to many factors, including low socioeconomic status, language barriers, lack of access to care, and racism. In some communities, a large proportion of immigrants—sometimes as high as 40%—have little economic or

political power. Although Asian Americans have the highest median household income of all racial/ethnic groups, they also have the highest number of wage earners per household. Nearly 70% of Laotian Americans live below the poverty level, and most Korean and Vietnamese Americans are self-employed (earning an average of \$14,000 a year) or work for small businesses that do not provide health insurance.

Approximately 70%–80% of the people who visit AAPCHO facilities are uninsured or underinsured, and nearly 90% are not proficient in English. Such barriers can create a complex and confusing environment for new immigrants and prevent them from seeking health care at all.

Discrimination also creates barriers to care. A. Sam Gerber, MS, RD, a public health analyst in CDC's Office of the Associate Director of Minority Health, said she has experienced racism when seeking health care for herself and when working as an advocate for other immigrants.

"I took a Buddhist monk for help in getting medication because he had no income or insurance," said Ms. Gerber, a U.S. citizen who emigrated from Thailand more than 30 years ago. "The person who was interviewing us said, 'What right do you have to come to my country and try to siphon off of us?' So I told him that his ancestors once came from another country and faced the same issues."

Even when people are not directly discriminated against, they may fear rejection or reprisal through immigration laws or because of past events like the internment of thousands of people of Japanese ancestry during

World War II. Many people still view Asian Americans and Pacific Islanders as perpetual foreigners who are not “real” Americans.

Culture Is a Two-Way Street

Even when health care planners recognize the need to address language barriers in Asian American and Pacific Islander communities, they often neglect to ensure that their programs are culturally appropriate. Successful programs value the cultural diversity of the populations they serve and understand that cultural differences can affect health and the effectiveness of health care delivery.

For example, some Cambodians believe that if you do not talk about a disease, you will not get it. The Hmong, a tribal group from Laos, use a term for epilepsy that translates literally as “the spirit catches you and you fall down” because they believe epilepsy occurs when an evil spirit steals your soul from your body. Many Asian Americans and Pacific Islanders, particularly women, will not talk openly about personal subjects with people outside their communities. In addition, some immigrants are accustomed to taking directions only from community or tribal leaders.

Another difference between many Asian American and Pacific Islander cultures and Western culture is the use of alternative medical practices such as herbal remedies and acupuncture.

“Culture is a two-way street,” Mr. Bau said. “Western medicine itself is a culture. Western medical providers should understand that many people will turn to traditional remedies first rather than thinking of making an

appointment with the doctor. And instead of trying to force a change in that, providers should integrate other healing practices into the system of care.”

The U.S. approach to prevention, which emphasizes disease screening and national health recommendations, is uncommon in Asian and Pacific Islander cultures. That’s why education programs that target these groups must be culturally and linguistically appropriate.

“Some cultures believe immunization is bad for your immune system,” said Ms. Gerber. “How do we get the message across that they need immunization to protect them from harmful diseases?”

Although cultural and language barriers can make eliminating health disparities in minority populations a challenge, Mr. Bau believes these factors often just add to the existing barriers created by the complexity of the U.S. health care system.

Building trust in target communities is critical. A good example of this is AAPCHO’s Community Approach to Responding Early (CARE) program, a CDC-funded program that seeks to lower breast and cervical cancer rates among Asian American and Pacific Islander women. To account for the diversity of these populations, AAPCHO partnered with six project sites to implement culturally tailored strategies to encourage women to get screened for breast and cervical cancer. Community health center workers at these sites worked with community volunteers and translators, made multiple home visits, offered help with transportation, and used visual aids for women who did not speak English.

Culture is a two-way street . . . Western medicine itself is a culture.

Barriers Are Not Insurmountable

To eliminate health disparities in any population, health officials have learned that affected communities must be included when interventions are planned and implemented. One way to involve communities is to form partnerships among community leaders and organizations, businesses, and government agencies. Together, these partners can build new infrastructures or draw on existing ones.

“If people are struggling, for example, with how to overcome language barriers, we often suggest using community-based organizations that have that language capacity,” Mr. Bau said. “Use ethnic media that are obviously printing and broadcasting in those languages. You don’t have to reinvent the wheel.”

AAPCHO’s community health centers are governed and operated by members of the communities they serve. At the national level, AAPCHO advocates for policies and services that are community-driven, financially affordable, linguistically accessible, and culturally appropriate. These goals are achieved through national and regional projects that build community resources and infrastructures; provide technical assistance and training; and conduct media campaigns, research projects, and community and provider education programs.

For example, the CDC-funded BALANCE (Building Awareness Locally and Nationally through Community Empowerment) Program for Diabetes works collaboratively with CDC and the National Institutes of Health’s National Diabetes Education Program (NDEP) to increase awareness about diabetes among Asian Americans and Pacific

Islanders. AAPCHO assessed the health care needs of Asian Americans and Pacific Islanders with diabetes in California, Hawai’i, Massachusetts, New York, and Washington. The results were used to develop strategies for disseminating culturally and linguistically appropriate diabetes information to these populations.

AAPCHO partnered with the NDEP to (1) develop and implement a national media campaign targeting Asian Americans and Pacific Islanders, (2) review and develop diabetes educational materials published in Asian and Pacific Islander languages, and (3) recruit multiple partners for community activities and projects. In addition, the organization established a recommended list of materials that are culturally and linguistically appropriate and scientifically current (available at <http://www.aapcho.org/>).

“Culturally and linguistically appropriate strategies are extremely important when serving Asian American and Pacific Islander communities,” said Nina L. Agbayani, RN, AAPCHO’s Director of Programs. “Because we’re trying to reach numerous ethnic communities, one universal model of health education and prevention simply won’t work.”

BALANCE is a good model for other projects because it is well coordinated at the national level, said Mr. Caballero. When several federal agencies get involved in one community, efforts can be duplicated and resources wasted.

Looking to the Future

Providing necessary health care services to Asian Americans and Pacific Islanders is not always easy. Many

communities lack the basic resources and infrastructure to share information and improve access to services, so even when groups like AAPCHO develop effective interventions, they do not always reach the intended audiences.

“Some people say there are more American Samoans in California than there are in Samoa, but the current community infrastructure is inadequate to effectively serve this community,” Mr. Caballero explained. “More effort needs to be made to provide technical assistance and capacity-building opportunities in some of these communities because their numbers are growing very rapidly.”


The challenges will be particularly acute in states where Asian and Pacific Islander populations have been small in the past but are now growing rapidly. In Georgia and North Carolina, for example, several counties reported 200% increases in their Asian populations during the 1990s. Although existing community health centers are a valuable resource for underserved populations, many have limited expertise in serving Asian Americans and Pacific Islanders. Fortunately, the federal government supports doubling the number of community health centers in the near future, and AAPCHO intends to take full advantage of this political climate to increase access to services for their populations.

In addition, HHS is spearheading other national efforts to improve the

quality of life for these populations, including support of the White House Initiative on Asian Americans and Pacific Islanders (WHIAAPI). This initiative aims to improve research and data collection, promote greater access to government services (including language programs), and increase outreach and partnerships with community groups.

In May 2002, the WHIAAPI President’s Advisory Commission conducted a public meeting to hear testimony from community organizations, individuals, and federal agencies. The commission also updated its 2001 Interim Report (available at www.aapi.gov).

Again and again, the same key point emerges: improved data collection is critical to eliminating health disparities among Asian Americans and Pacific Islanders. As the President’s Advisory Commission Interim Report notes, the lack of specific and timely data make it difficult to identify problems, track trends, pinpoint solutions, or enforce civil rights laws.

“The first step is to disaggregate the data to show the needs of the Asian American community and the Native Hawaiian and other Pacific Islander communities,” Ms. Gerber said. “Until we can do that, we won’t have adequate programs or dollars going to the people who need them.” 

Overcoming the Challenges of Eliminating Disparities in Tobacco Use

CDC Guide Will Help Health Departments Eliminate Disparities in Tobacco Use and Tobacco-Related Disease

Although tobacco use prevention and control efforts are regarded as a major public health success, racial and ethnic disparities in tobacco-related health outcomes remain a concern (see sidebar, page 14). These disparities exist when

- A community has rates of tobacco use or disease that are far greater than in the majority population.
- A community lacks research, surveillance data, health services, and other types of capacity and infrastructure that are critical to preventing and controlling tobacco use.

CDC funds all state health departments to support efforts to reduce tobacco use. Because eliminating disparities is an important part of this effort, CDC's Office on Smoking and Health (OSH) is developing a resource guide to help health departments and their partners identify and eliminate disparities among population groups.

"Although the primary focus of the resource guide is African American, Native American, Asian and Pacific Islander, and Hispanic or Latino communities, it also serves as a framework for health departments to assess all population groups," said Robert G. Robinson, DrPH, OSH's Associate Director for Program Development. For example, the same framework could be used for assessing disparities among gays and lesbians, rural residents, or migrant workers.

Barriers to Eliminating Disparities in Tobacco Use

Dr. Robinson is encouraged that public health agencies are committed to reducing health disparities, but he warns that immense challenges lie ahead. These challenges are created by the following factors:

Disparities are institutionalized.

Disparities in communities and population groups are not the result of individual behavioral patterns. Rather, they result primarily from the inequitable distribution of resources and services at the institutional level—for example, programs to help people stop smoking in wealthy communities may not be available in low-income communities across town.

Disparities cannot be solved with an incremental, piecemeal approach. Major resources required to eliminate disparities must be applied comprehensively. For example, enabling a community-based organization to provide services to help community members quit smoking is only one part of the solution because the community needs the capacity to address the broad range of problems associated with tobacco use. This strategy is contrary to the classic approach of solving problems through small-to-moderate changes.

Disparities among population groups are not compartmentalized but involve all public sectors. Thus, we can no longer rely on the standard approach of

assigning priorities to an agency that deals with only one specific aspect of the problem, such as health, education, housing, employment, or justice. Eliminating disparities requires a cross-cutting approach involving all of these public agencies.

Often, the importance of race in health disparities is understated, and factors such as poverty and low levels of education are considered better predictors of disparities. Analyses of race often understate the importance of race in health disparities because researchers use methodologies that prevent them from viewing race holistically or contextually and taking into account experiences shared by community members because of their race. Race is understated when interventions are developed solely on the basis of population risk assessments, which tend to focus on indicators other than race. For example, a program might use poverty status to identify risk and then proceed to develop an intervention focusing on poverty status. But if the proposed intervention needs to be communitywide to be effective, then race is critically important.

Most research is based on a disease-centered model that measures illness in terms of collections of individuals and not in terms of the social systems or communities in which they live. Eliminating disparities will require a health promotion approach that emphasizes strengthening capacity and infrastructure in communities, building supportive environments, and promoting political action and policies that improve health.

To overcome these challenges, Dr. Robinson and colleagues have developed a model that has three primary components: (1) community

competence; (2) capacity and infrastructure, and (3) community prevention strategies that broaden traditional public health approaches to prevention and control.

Community Competence

Community competence reflects the complexity of communities, groups, strata, and individuals. It is integrative because community competent interventions will mirror a population's historical, cultural, contextual, and geographical experiences. By taking the time to understand the experiences and circumstances that have shaped a community, a program can be more effective in reaching people who are hurt by health disparities.

For a program or publication to be community competent, it must take into account the following facets of a community:

- **History.** For example, slavery is part of African Americans' history, and European conquest is part of Native Americans' history.
- **Culture.** Shared values such as religion.
- **Context.** Realities of the here and now such as racism, homophobia, environmental injustices, and lack of health insurance.
- **Geography.** The unique qualities of a geographic area.

According to Dr. Robinson, community competence is not a specific amount of history, culture, context, or geography. Rather, he said, "community competent protocols contain varying amounts of these determinants, seeking out what is important to achieve effective outcomes." Community competence also includes other criteria: salient imagery, positive imagery,

Racial Disparities in Tobacco Use

Tobacco use has serious health consequences among all four major U.S. racial and ethnic minority groups: African American, American Indian/Alaska Native, Asian American/Pacific Islander, and Hispanic. These four groups make up about one-fourth of the U.S. population and are growing rapidly. By the year 2050, members of these racial and ethnic minority groups will comprise close to one-half of the U.S. population. According to *Tobacco Use Among Racial/Ethnic Minority Groups: A Report of the Surgeon General* (1998), cigarette smoking is a major cause of death and disease in all four groups.

- African American men bear one of the greatest health burdens of the four ethnic groups, with death rates from lung cancer that are 50% higher than those of white men.
- In 1997, the prevalence of smoking among adults in the United States was highest among American Indians and Alaska Natives (34.1%) followed by African Americans (26.7%), whites (25.3%), Hispanics (20.4%), and Asian Americans and Pacific Islanders (16.9%).
- In 1997, 37.9% of American Indian and Alaska Native men smoked, compared with 27.4% of white men. The smoking rate among American Indian and Alaska Native women was 31.3%, compared with 23.3% among white women.
- Smoking is responsible for 87% of lung cancers. African American men are at least 50% more likely to develop lung cancer than white men.
- Smoking significantly elevates the risk of cerebrovascular disease, which is twice as high among African American men and women as among white men and women.
- About three of every four African American smokers prefer menthol cigarettes, compared with about one of four white smokers. Menthol may increase the absorption of harmful ingredients in cigarette smoke.
- A higher percentage of whites (50.5%) than African Americans (35.4%) have smoked at least 100 cigarettes and quit.

appropriate language and literacy levels, multigenerational perspectives, and diversity.

The *Pathways to Freedom* program is a good example of a community competent intervention that reflects all of these criteria. *Pathways to Freedom* is a state-of-the-art tobacco cessation guide for the African American community that encourages African

American organizations to institute smoking cessation programs and enables mainstream organizations to reach community residents and their leaders. Launched in Philadelphia a decade ago, it offers tips for helping blacks quit smoking and community activities to promote policy change. Philadelphia's black churches, tenant groups, and Masonic organizations helped put together the *Pathways to Freedom* guide, which was published by the Fox Chase Cancer Center with support from the National Cancer Institute and disseminated by the American Cancer Society and CDC.

The *Pathways to Freedom* guide includes images that are salient and compelling, such as photos of a baby's healthy lung next to a mildly diseased lung and a severely diseased lung. It also features many positive images such as the photo of a smiling mother with a quote about her success in quitting smoking. The guide also gives readers a geographic connection to the material by featuring examples of tobacco industry promotions in and around Philadelphia.

Another strong aspect of the guide is its use of multigenerational images. For instance, "Introducing the Freeman Family" is a color illustration of three generations of a family. The surname Freeman reminds people of their shared history of freedom from slavery. Next to each family member's name is a note about their smoking status—"used to smoke," "trying to quit," "never smoked," or "smoker." The *Pathways* guide is currently being revised to be more diverse by including text and imagery responsive to non-Christian faiths and to members of the community who are gay, lesbian, bisexual, or transgender.

“So you see, community competency forces us to look more broadly and more complexly at the population,” said Dr. Robinson. “If we’re going to develop programs and materials that are community competent, we’re going to have to take all of these aspects into account. It is really a matter of degree and intensity as to how community competent criteria will be applied to groups, strata, and individuals.”

Capacity and Infrastructure

The second component of the model addresses the importance of developing capacity and infrastructure in populations and communities. This component relies on a perspective that views the community holistically and views strata within the population as part of the community. Such an approach acknowledges the complexity of a community because it views population groups in the context of the communities in which they live. According to Dr. Robinson, the challenge for public health is to be able to respond to this complexity. He notes that public health interventions often pose a choice of “either/or” when in fact a “both/and” approach is needed. People living in poverty require specific interventions, but the communities in which they reside also require the capacity and infrastructure to serve them appropriately.

Communities and populations experiencing disparities in tobacco use require the capacity and infrastructure with which to counter tobacco industry strategies and to engage in tobacco prevention and control initiatives at all levels (e.g., planning, coordination, program development, implementation, evaluation).

According to Dr. Robinson, a community or population group has high levels of capacity and infrastructure if it possesses the following:

- Research that not only addresses its particular needs but also includes researchers who represent the community or the interests of the population.
- Community competent programs that reflect the community or population.
- Tobacco control leaders representative of the community or population.
- Organizations able to represent the community’s or population’s tobacco control interests and provide related services.
- Networks representing the community or population that facilitate communication, planning, policy analysis, coordination, and agenda setting.

The tobacco industry has well-defined strategies for specific communities and populations that are based on long-standing relationships with community organizations and leaders, Dr. Robinson said. “Developing capacity and infrastructure will enable communities to defend themselves against these strategies,” he noted.

One means of developing capacity and infrastructure, according to Dr. Robinson, is by funding minigrants to stimulate the development of tobacco prevention and control programs at the community level. In addition, community programs can be further empowered by funding networks of researchers, leaders, experts, and organizations to provide technical assistance, develop strategic plans, establish priorities, and make

recommendations related to the tobacco prevention and control needs of specific population groups or communities. “For example,” said Dr. Robinson, “the American Legacy Foundation, a national, independent public health foundation established by the 1998 tobacco settlement, used networks to develop strategic plans for tobacco control among racial and ethnic communities, populations defined by sexual orientation, and population groups defined by low socioeconomic status. As with community competence, capacity and infrastructure are needed by all population groups, and differences are a matter of degree and intensity.”

Community Prevention Strategies That Broaden Public Health Approaches to Prevention and Control

The third axis of the model developed by Dr. Robinson and colleagues relates to public health applications and incorporates the concepts embodied in the other two axes. The underlying assumption of the model is that the more homogenous the population, or relatedly, the more relevant the constructs of history, culture, context, and geography that shape the community and distinguish it from a group or strata, the more likely the community will require interventions that support capacity and infrastructure development. Population groups that are less determined by history, culture, context, and geography and are thus less easily described as whole communities may still require capacity and infrastructure support, but not at the same level of intensity. “Community prevention strategies combined with public health approaches to prevention


and control provide a continuum along which all populations groups and interventions appropriate to their needs can be placed,” Dr. Robinson explained.

According to Dr. Robinson, community prevention involves broadening traditional public health approaches to prevention and control to include an explicit focus on community development. “Traditionally, the success of prevention and control efforts is determined by one dimension: time. If the intervention is early and successful, then some event has been prevented,” he stated. “Control strategies occur downstream and are intended to lessen the consequences of an event or to provide a cure. Community prevention relies on two dimensions: time and geography. Geography provides a way for strategic planners to envision communities and not just populations or individuals at risk.” Including geography reinforces the principles of community competence and capacity and infrastructure development. It enables planners and policy makers to envision the community as the defining unit and not just aggregations of individuals.

Dr. Robinson stresses that community prevention distinguishes between working “with” communities and working “in” communities. “Establishing a program on a street corner that reaches out to the homeless or other strata has merit but should not to be confused with community development or a holistic approach to community competence,” he said. For example, Africans Americans of low socioeconomic status require specific interventions, but given the likelihood that they live in black communities, it is also important that these communities are enabled to better serve their needs. Dr. Robinson also pointed out that this

analogy is applicable to other strata or population groups at high risk.

The resource guide that CDC is developing to help communities use the model to eliminate disparities in tobacco use will be available later this

year. For further information, please visit CDC's Office on Smoking and Health Web site at <http://www.cdc.gov/tobacco/> or call 770/488-5705 and press 3 for a publications specialist. 

We Must Identify the Gaps Before We Can Close Them

Health departments must have timely, reliable data if they are to get a clear picture of a community's health disparities and design programs that work. "If you don't have data, you're just assuming there's a gap," advised CDC Health Educator Alexandria L. Stewart, MS. "Programs must be driven by scientific data and not assumptions."

But gathering the necessary information and translating it into interventions that target health disparities can be complicated and expensive. "Health departments are betwixt and between because they want to do something about health disparities, but they don't know what to do," noted Robert G. Robinson, DrPH, Associate Director for Program Development for CDC's Office on Smoking and Health (OSH).

Dr. Robinson, Ms. Stewart, and others at CDC are developing guidelines on how to collect, analyze, and use data to eliminate health disparities and how to strengthen these activities by involving communities. Moreover, communities participating in CDC's Racial and Ethnic Approaches to Community Health (REACH 2010) project are collecting data and developing new community-driven strategies to eliminate health disparities. This 5-year demonstration project is one of the first programs to

target health disparities associated with race and ethnicity.

Gathering Baseline Data

At 21 of the REACH 2010 sites, surveys are under way to help each community learn more about its risk factors for certain chronic diseases. The National Opinion Research Center (NORC) at the University of Chicago is collecting data on behalf of CDC.

"We have taken about 60 questions from CDC's Behavioral Risk Factor Survey to create the REACH 2010 Risk Factor Survey," explained CDC Evaluation Coordinator Pattie J. Tucker, DrPH, RN, who is responsible for the project's data collection and evaluation activities. "These questions address the health behaviors and practices that are specific to three of our priority health areas — breast and cervical cancer, diabetes, and cardiovascular disease." The surveys ask adults about

- Their general physical and mental health.
- Recent visits to health care providers.
- Exercise or physical activities.
- Smoking history.
- Eating habits.
- Weight and height.

- Income.
- Screening for cardiovascular disease.
- Screening for breast and cervical cancer.

By using the same survey at all sites, REACH 2010 communities can serve as comparison communities for each other. For example, the communities striving to eliminate racial and ethnic disparities in breast and cervical cancer will serve as comparison communities for those communities targeting diabetes and cardiovascular disease. Thus, the communities can see how they compare with other communities that have not implemented the specific strategies, track local changes in risk factors over time, and plan more effective programs.

Before the surveys are conducted, NORC staff work closely with local REACH 2010 coalitions to identify community boundaries and understand the needs of each community. For example, in communities where many homes have no phones, interviews are conducted in person. Local residents are recruited and trained to conduct the door-to-door interviews.

Community members will be involved every step of the way, noted Dr. Tucker. “These data will be shared with the coalitions. We must be respectful of community members, and we work hard to gain their trust. This is the first time many of our REACH 2010 grantees have had community-level data collected.”

Getting to the Root of the Problem

Although surveys can provide a snapshot of what is happening in a

community from year to year, they cannot capture the detailed information that face-to-face discussions are so effective in gathering. Therefore, REACH 2010 coalitions are using focus groups and interviews to collect qualitative data.

“Focus groups and in-depth interviews really help you get to the root of the problem,” said CDC REACH 2010 Director Imani Ma’at, EdD, EdM, MCP. “For example, in Nashville, the REACH 2010 grantee conducted numerous focus groups to see what is contributing to the high rates of death from cardiovascular disease and diabetes among African American women. Many of the women said that they did not have time to exercise or that they were under a lot of stress because of work and family responsibilities,” she noted. The grantee also discovered that “plump is considered good” by many of the African American women in this community.

Such detailed comments from women in the focus groups allowed the Nashville REACH 2010 Coalition to develop culturally appropriate messages that will reach and motivate women in the target community to take charge of their health. “You’ll only get that level of detail in a focus group,” noted Dr. Ma’at.

Mapping Out Goals

The REACH 2010 communities are excited about being able to see positive trends at the local level, but they know that 5 years is not long enough to witness any declines in illness and death. “They will be able to see incremental changes in healthy behaviors,” said Dr. Tucker. “For

example, in Year 4 of the program, people might be more physically active than in Year 1. Or in Year 4, people might be eating more fruits and vegetables than in Year 1.” Collecting data to track incremental changes will be essential when the REACH 2010 grantees evaluate their efforts to eliminate health disparities.

To help communities set intermediate and long-term goals and monitor their progress in meeting those goals, REACH 2010 staff have developed a logic model. “It’s what we think is a logical approach to eliminating disparities,” Dr. Tucker noted. “Our logic model asks communities to consider what other partners and service providers are doing as well. So it’s not just about the REACH 2010-funded communities but about all partners. Arrows on the logic model point back and forth to show how these interactions happen continuously in a community.”

For example, a REACH 2010 coalition that is targeting high rates of diabetes in a community might be working with a local clinic to educate health care providers about patients’ need for regular eye and foot exams. “At the same time, there might be a medical association at the state level that wants to educate providers about exams that are important for patients with diabetes,” explained Dr. Tucker. The logic model helps communities look beyond their efforts and see how these dual education programs could work together to end disparities.

CDC is developing a Web-based information system that each coalition can access to enter data about their capacity-building activities, interventions, and changes that have occurred because of their efforts. From

these data, communities can create local reports to justify the need for programs targeting health disparities and to promote passage of health laws and policies.

The REACH 2010 project will conclude in 2004, after rigorous evaluations to identify which approaches are most effective. Details about successful strategies will be disseminated widely. “The goal is to make interventions more community-specific,” Dr. Tucker said. “Community X might say, ‘We will use some of the lessons learned from Community Y, but we’ll do it differently.’ So they might develop a hybrid program or just change the application. For example, they might take an intervention originally based in clinics and instead deliver it in the community barbershop because that’s where people in Community X get their health information.”

Helping Health Departments Collect Good Data

Lessons learned from the REACH 2010 communities will be shared when evaluations are completed. In the meantime, Dr. Robinson and colleagues are publishing a resource guide on eliminating health disparities (see “Overcoming the Challenges,” page 12). The guide describes a number of strategies that health departments can use to collect good data on populations hard hit by chronic disease — for example, aggregation of data, oversampling, biannual sampling, and community assessments.

“Oversampling can be used to ensure sufficient numbers,” explained Dr. Robinson. “Population groups with

substantially low representation in the state or territory can be targeted at sample levels appropriate for statistical analysis. This may be an especially good strategy if the health department wants to accumulate data on ethnic communities, groups, and population strata with low numbers.”

Reaching Diverse Populations

When planning data collection, health departments need to think about the various groups of people potentially affected by health disparities. Here are some of the groups to consider:

- African Americans, Asian Americans and Pacific Islanders, Hispanics and Latinos, and Native Americans.
- Women.
- Young people.
- Gays, lesbians, bisexuals, and transgender people.
- People with low incomes and little education.
- Rural residents.
- Blue-collar workers.
- Migrant workers.
- People with mental illness.
- People with physical disabilities.
- People in prison.
- Homeless people.

“Moreover,” said Dr. Robinson, “attention should be given to groups not identified but nevertheless present who may possess distinct community characteristics and experience disparities, such as Cajuns in Louisiana, cowboys or cowgirls in the West, or African American tobacco farmers.” Collecting detailed data from these populations is expensive and complicated, but the data are essential if a health department is to understand

the disparities it must target and develop the needed interventions.

Using the Right Tools

The tools used to collect data on health disparities must be community competent, Dr. Robinson emphasized (see page 13). Community competence involves thinking about the experiences and circumstances that have shaped the community and then working with community members to incorporate these concepts into the surveys, focus groups, and interviews, he said.

“Related to community competence is the matter of assessing behavior unique to specific population groups,” he stated. “For example, surveys will need to distinguish between the traditional and nontraditional use of tobacco by Native Americans to ensure that interventions reflect their different cultural patterns.”

People in the community must be involved when surveillance strategies are planned, when data are collected, and when evaluations are designed and carried out, Dr. Robinson emphasized. Community members have their own ideas about what health problems are most pressing and how those problems should be addressed. By encouraging community involvement, the health department will have stronger data as well as the community’s trust and support.

Knowing What to Measure

Before collecting data on disparities, health departments should consider what they will measure to determine if their efforts are indeed closing the gaps.

For instance, if the disparity is a higher rate of tobacco-related disease and death for African Americans than for whites, here are some of the indicators a community could measure, Dr.

Robinson suggested:

- Tobacco use rates, quit rates, and relapse rates in the community.
- Rates of various types of tobacco-related disease (not just cancer), 5-year survival rates, death rates, and years of potential life lost.
- People’s knowledge, attitudes, and practices regarding tobacco use.
- Prevention services, treatment, and quality of care provided as well as the tobacco industry’s marketing strategies in the community.
- Capacity and infrastructure data—for instance, research projects and tobacco control programs in the community.

By assessing a community’s ability to address the problem, one might discover that “the community has not been engaged in tobacco control services because they lack resources to address the problem,” said Dr. Robinson. Baseline assessments will identify community levels of capacity and infrastructure and facilitate strategies to increase these levels. And that will allow the community to participate in the critical decisions regarding setting priorities and allocating resources.”

Looking at Outcomes and Process

Health departments that focus their surveillance and evaluations on outcomes and ignore the process often end up with too little information to

determine why a program worked, what components of a program should be replicated, or what problems associated with implementation ought to be solved, Dr. Robinson warned.

“For example, merchant education programs in San Diego were effective in lowering sales of tobacco products to youth in Latino and Asian communities but not in African American communities,” he recalled. Process evaluation would have enabled program evaluators to describe differences in how the program was implemented in the Latino, Asian, and African American communities, barriers to implementation, and solutions. “Those answers would help us determine how to provide more effective programs targeting African Americans,” he said.

Thus, Dr. Robinson recommended that health departments collect a combination of process and outcome data that

- **Define the population.** For example, how prevalent is a risk behavior in the target population?
- **Measure how well the intervention has been developed and conducted.** Was the intervention successfully planned and developed? Have good programs been launched in the target community?
- **Measure successful achievement of the goal.** Have risk behaviors declined in the target population since the intervention was launched? What about rates of disease and death?

Communities and states are encouraged and excited when they see declines in risk behaviors just a few years after launching a prevention program. “It gives people hope that

their efforts are making a difference,” said Ms. Stewart. “For example, data from the 2001 Youth Risk Behavior Survey show that smoking among high school students declined from nearly 35% in 1999 to below 29% in 2001 — that’s a 16% decline. This is great news, and we believe it’s largely the result of price increases from manufacturers of tobacco products, increases in excise taxes, and the fact that more states are conducting tobacco use prevention programs. These data tell us that we need to continue doing what we know

works — comprehensive programs, excise tax hikes, and smoke-free environments.”

Such efforts will eventually lead to declines in disease and death. “This will require sustained effort over time and a planned commitment,” noted Dr. Robinson. “There’s nothing simple about this problem. But eliminating health disparities is the only way we’re going to achieve the America we all dream about.” 🌻

Lesbians Face Many Barriers to Good Health Care

For lesbians in America, getting good health care can be a challenge. Consider the young woman who has been told by a nurse practitioner that she doesn't need a Pap smear because she is a lesbian. Or the woman who confides in her doctor that she is a lesbian and is told, “I don't treat people like you.” These scenarios play out every day in clinics and private offices across the country. The results can be devastating and deadly.

The Mautner Project for Lesbians with Cancer is dedicated to bringing down the barriers that block lesbians from getting regular cancer screenings and cancer treatment. By educating lesbians and health care providers, the project aims to help this country eliminate health disparities, according to Cheryl B. Pearson-Fields, MPH, the project's health education and research director. The project also conducts research on lesbian health issues and provides health care services to lesbians with cancer, their partners, and their caregivers.

The project is named after Mary-Helen Mautner, who died of breast

cancer in 1989. She had a network of friends and family to help her manage the challenges of daily life while she battled cancer, but she realized that other lesbians were not so fortunate. Ms. Mautner left behind notes outlining the foundation for the organization that would later bear her name.

Removing the Barriers

The Mautner Project tackles many of the barriers that block lesbians' access to good care, according to Ms. Fields. Discrimination is a major problem. Many lesbians delay seeking health care services because they have previously been refused care, received substandard care, or endured derogatory comments, hostility, or undue roughness during physical exams.

“It's not bleak everywhere,” noted Ms. Fields. “Lesbians in larger cities tend to have an easier time than those in smaller, rural towns. For example, breach of confidentiality can be a major problem in a small community. You tell a

doctor you are a lesbian, and the nurse reads your chart and says, ‘Oh my gosh. I didn’t realize Suzi was a lesbian.’ Knowing that they could lose their child or job if people in the community find out is enough to keep many lesbians away from clinics and doctors’ offices or deeply closeted when they do go for care.”

Another common problem is misinformation and inaccurate assumptions about lesbian’s health risks and need for screening—for example, the belief that lesbians don’t need to get Pap tests because the human papilloma virus, which causes cervical cancer, is transmitted when a woman has sex with a man.

The misconception is that lesbians have never had sex with men. In fact, a very large percentage of lesbians have had sex with men at one time or another. Some may even identify as lesbian but still have sex with men, Ms. Fields explained. So the problem arises when any provider makes assumptions that all lesbians behave in a certain way.

Educating providers is a first step, said Ms. Fields. Mautner’s “Removing the Barriers to Accessing Health Care for Lesbians” is a CDC-funded project aimed at building the skills of health care providers and promoting change in health care institutions through training and technical assistance. Some of the project’s objectives are to

- Define the principles of culturally competent medical care.
- Identify individual, structural, and institutional factors that affect access to health care and result in barriers to screening for breast and cervical cancer among lesbians.
- Describe ways in which a culturally competent approach can reduce or eliminate those barriers.


Why Are Lesbians at Greater Risk for Cancer?

There are several reasons why lesbians have a greater risk for cancer than heterosexual women:

- **Access.** Lesbians access health care less frequently than heterosexual women because of past negative experience with a heterosexist health care system.
- **Childbearing.** Lesbians are more likely to be childless or to delay parenting until after 30. Bearing children and breastfeeding before age 30 reduces a woman’s risk for breast cancer.
- **Screening.** Lesbians are less likely to receive routine gynecological services such as birth control and prenatal care. Thus, they are screened less often for breast and cervical cancers.
- **Insurance.** Lesbians are more affected by women’s lower earning power and do not benefit from spousal health insurance coverage.

- Demonstrate the application of principles of cultural competency to the medical practice.
- Implement a plan to help providers locate resources for ongoing education and skill-building in providing optimal care to lesbians.

These are subjects not often covered in medical school, she noted, and many providers want to break down these barriers. “Sometimes it’s not that they’re homophobic,” said Ms. Fields. “Most providers want to provide the best services they can, and they want to be welcoming. But they just need the knowledge.”

For more information about the Mautner Project or the “Removing the Barriers” training program, please contact Cheryl B. Pearson-Fields, MPH, Director of Health Education and Research, Mautner Project for Lesbians with Cancer, 1700 L Street, Suite 500, Washington, DC 20036; telephone 202/332-5536; fax 202/332-0662; E-mail: cfields@mautnerproject.org. 

Comprehensive Approach Needed to Eliminate Diabetes Disparities

Disparities in diabetes are a top public health concern because of the alarming rate at which Americans are developing the disease. Diabetes is increasing most rapidly in racial and ethnic minority populations, and some geographic areas are hit harder than others. Regional disparities are troubling because high concentrations of people with diabetes can create overwhelming health and economic consequences. A comprehensive strategy is needed to control diabetes and prevent or delay its onset for people most at risk.

Blacks, Hispanics, and Native Americans are hurt by diabetes far more than whites are, the Institute of Medicine (IOM) recently reported, and the gap appears to be widening. Causes are not clearly understood, possibly because of the complexity of the problem, the lack of certain data, and the overlapping of health disparity variables (e.g., socioeconomic status, race/ethnicity, gender, age). Even after controlling for other factors, including income, education level, and insurance coverage, some racial and ethnic groups are still more likely to develop diabetes and its more serious complications.

Not getting good care is one cause, and it can have devastating consequences. For example, among people with diabetes, blacks are *less* likely than whites to receive lipid testing, eye examinations, and flu shots, and are 3.6 times *more* likely than whites to have diabetes-related lower-limb amputations, according to a study of Medicare beneficiaries.

Race is a social classification, *not* a biologic descriptor, pointed out Camara

Jones, MD, MPH, PhD, Research Director on Social Determinants of Health within NCCDPHP. “Race is an excellent measure of exposure to racism,” she explained. “Perhaps this aspect of race is what most profoundly impacts health and results in race-associated differences in health outcomes.” In other words, racism may be a distinct cause of the disparities.

More attention must be paid to identifying and addressing the fundamental causes of health disparities. These reasons include the policies and practices that result in people of color being overrepresented in poverty, so that their neighborhoods are less conducive to leisure-time physical activity and their food options are less healthy. These causes also include societal norms that may contribute to discrimination in health care.

Research on health disparities among women with type 2 diabetes shows that differences in health status can partially be explained by differences in access to care, quality of care, cultural attitudes and behaviors, and environment. The socioeconomic status (SES) of women with diabetes is lower than that of women without diabetes, according to 2000 Behavioral Risk Factor Surveillance System data. SES, measured by educational attainment, occupation, or income, plays a major role in health status. One SES-related reason for health disparities may be lack of adequate health insurance coverage, explained CDC Senior Service Fellow Gloria L.A. Beckles, MD, MSc. Also, women may not be able to afford health care expenses or costs associated with

health-promoting behaviors—for example, eating nutritious foods and being physically active. In addition, daily financial concerns can make health care a low priority for some women. *Diabetes and Women’s Health Across the Life Stages: A Public Health Perspective* discusses how SES affects women’s ability to get recommended health care services and manage their diabetes (see box, page 26). Some of the observations also apply to men and to diseases other than diabetes.

Insurance Insufficient for Access to Care

“Disparity in health insurance coverage is a major problem; millions of people in this country have no access to preventive care even if they were inclined to follow it,” stated Dr. Beckles. About 40 million people in the United States do not have insurance coverage. Some poor people rely on Medicaid and Medicare, which mostly cover acute care needs. People younger than age 65 who cannot afford private health insurance may apply for Medicaid, but eligibility and coverage vary greatly by state. Medicare coverage is standard throughout the United States, but coverage begins at age 65, typically after much of the damage of diabetes has occurred. As a result, patients are more likely to be hospitalized and have higher medical costs. In addition, Medicare does not pay for prescriptions, so only those who can afford supplemental private insurance or who qualify for Medicaid can obtain medicine and other services not covered by Medicare. “Medicare is a good example of insurance coverage that is not adequate to meet the needs of people with chronic diseases such as diabetes,” commented Dr. Beckles.

Even those with insurance face obstacles in obtaining health services for diabetes. For instance, health insurance for employees of large corporations varies greatly from that available to employees of small companies, part-time workers, and those who work intermittently or are self-employed. Small companies may offer health insurance; however, the premiums may not be affordable or the covered services may be extremely limited.

Emphasis on Prevention—Key to Better Care

Once people gain access to health care, the quality of care they receive is vitally important. Research indicates that physicians do not consistently follow recommended treatment practices for people with diabetes. This problem is especially pronounced for racial and ethnic minority populations and poor people. Some clinicians say time constraints limit their ability to provide optimal care for their patients. Also, physicians face communication barriers and may be reluctant to take the time to understand their patients’ needs.

Studies indicate that bias in physician attitudes and behavior may account for some of the disparity in treatment. Discrimination in health care practice, whether intentional or unintentional, has been documented in physicians’ treatment of people of racial and ethnic minority populations. “There’s no excuse for differential care, and we need to hold health care providers and the health care system accountable,” stated Dr. Jones.

Reducing health disparities among people with diabetes requires that health care providers adhere to clinical

Women and Diabetes

Diabetes Across the Life Stages: A Public Health Perspective is the first major report to address the unique and serious effect of diabetes on women during the different stages of their lives—adolescence, reproductive years, middle age, and older years. Case studies for each age group are included to help readers understand the impact of diabetes on the daily lives of women and their families. This report provides comprehensive data on diabetes trends among women and addresses the public health implications. Compiled and edited by CDC Senior Science Fellow Gloria L.A. Beckles, MD, MSc, and Public Health Analyst Patricia E. Thompson-Reid, MAT, MPH, the report describes how diabetes affects U.S. women differently depending on their race/ethnicity and socioeconomic status or SES. To order single copies of the report or get other information about diabetes from CDC, call toll free 877/CDC-DIAB, E-mail diabetes@cdc.gov, or visit <http://www.cdc.gov/diabetes> (select Publications and Products).

guidelines and consistently provide routine preventive services such as flu shots. Many people with diabetes aged 65 or older are getting annual flu shots; however, other diabetes patients are not consistently receiving this simple intervention, which is known to prevent illness and death. By providing preventive services, clinicians can delay or greatly reduce complications.

Cultural Differences in Attitudes and Risk Behaviors

Some racial and ethnic populations may be more likely than others to develop diabetes and its complications because of differences in their attitudes and risk behaviors. For example, Native Americans, who have some of the highest diabetes rates, often believe that diabetes reflects a weak spirit. This self-blame and the cultural belief that family comes before one's own needs may hinder Native Americans from getting preventive care or taking steps to manage their diabetes.

“Good preventive health care is a learned behavior that should begin early in life,” commented Dr. Beckles. “Those who make routine visits for care, such as oral exams and teeth cleaning, immunizations, and health maintenance, develop a healthy lifestyle,” she continued. Other protective behaviors are often cultural, and public health professionals need to determine what these behaviors are, sustain them, and help other groups adopt them. For example, children born outside the United States are less likely to be obese than U.S.-born children of the same racial or ethnic origin. Research is needed to identify, develop, and maintain interventions to help immigrants with good health practices maintain these behaviors to safeguard their health.

Environmental Disparities

Recent studies in Europe and the United States have shown that where people live is as important an indicator of their health as their current education or income. A community's environment can be so unhealthy that it defeats any benefits of having access to health care. “There could be a clinic next door to a person suffering from diabetes, but if she lives near a toxic dump, the clinic will not be very helpful,” commented Dr. Jones.

Poor urban communities are home to many uninsured people who have high rates of disease and risk behaviors. Neighborhoods with no stores carrying nutritious foods or with no safe places to exercise are especially unhealthy for people with diabetes. Overcrowding, inner-city stress, and environmental toxins lead to poor health, causing

Measures to Eliminate Diabetes Disparities

CDC is working with partners across the country to improve the health of populations disproportionately affected by diabetes. To combat diabetes among underserved populations, CDC supports the following programs:

- Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together) is a community-based study in Raleigh, North Carolina, that involves the community in efforts to reduce diabetes among African Americans. The project seeks to identify those who have diabetes and to improve the quality of their health care. Researchers are testing interventions and developing strategies that can be applied nationwide. Programs that promote nutrition, physical activity, diabetes self-management, and health care quality are already improving the health of African Americans in this community. [See page 20, CDNR Winter 2002.]
- The Diabetes Collaborative is jointly supported by the Health Resources and Services Administration and CDC. Since the program began in 1999, more than half of the 700 federally funded health centers have adopted Diabetes Collaborative recommendations that have significantly improved patient care. Health center patients, mostly from low-income or racial/ethnic minority populations, spend less time in waiting rooms and more time with clinicians. They also have improved blood glucose control.
- CDC's Prevention Research Centers (PRCs) are testing various approaches to help populations hurt by high rates of diabetes. For example, the University of Illinois PRC is conducting research among Hispanics of different ages and using a peer education model to prevent diabetes and promote health. The University of Arizona PRC is working to understand how communities organize to improve and sustain their health. This PRC's diabetes control interventions target Hispanic and Native American populations. The University of New Mexico PRC is also addressing diabetes control among Native Americans. [See page 10, CDNR Winter 1999.]
- The U.S.–Mexico Border Diabetes Control and Prevention Program involves a partnership between CDC and four states that share a border with Mexico—Arizona, California, New Mexico, and Texas. The U.S.–Mexico Border Diabetes Collaborative Work Group (which includes the U.S.–Border Health Association and the Pan American Health Organization) is working to determine the true prevalence of diabetes, the extent of the higher number of diabetes-related deaths, and access to and use of health services for diabetes care by the region's mostly Hispanic population. [See page 14, CDNR Spring/Summer 1999.]
- Translating Research Into Action for Diabetes (TRIAD) is a prospective study—the largest of its kind—that focuses on the quality of treatment, costs, and outcomes of more than 10,000 patients with diabetes in managed care in the United States. TRIAD is designed to assess current diabetes treatments provided to different racial and ethnic groups, examine factors that might affect diabetes care, and explain why certain racial and ethnic minority groups have higher diabetes rates. Research questions also examine the effect of socioeconomic status on quality of care and health outcomes. The six centers—in California, Hawaii, Indiana, Michigan, New Jersey, and Texas—are now collecting data for a more comprehensive assessment of health disparities. [See page 4, CDNR Winter 2002; and page 15, CDNR Spring/Summer 1999.]

chronic diseases such as cancer and aggravating conditions such as asthma.

Narrowing the Gap in Health Outcomes

Although U.S. life expectancy has risen and exciting health advances have been made in the last century, some groups have been left behind. Effective treatments have not been universally prescribed or distributed, Dr. Beckles noted. “For example, there is not much difference in cancer death rates among people of different racial/ethnic groups for cancers with few or no treatment options,” she said. “Yet for highly treatable cancers, the death rates are much higher for blacks.” Public health needs to focus on conditions such as asthma, some cancers, and diabetes—diseases with highly effective treatments, added Dr. Jones. “We need to recognize that racism exists, document and monitor treatment practices and outcomes, and examine or create policy to ensure the best care

possible for all people,” she explained.

To eliminate health disparities, public health must push for environmental, legal, and policy changes, rather than concentrate on modifying individual risk behaviors or improving treatments and interventions. For example, legislation has significantly limited minors’ access to cigarettes. “Why not amend the constitution to make equal, high-quality health care a right of all U.S. citizens?” asked Dr. Jones. “Some of our focus must shift from individual care of sick people (high-risk approach) to modifying structural and environmental factors to promote and sustain health,” Dr. Beckles said. This transformation is necessary to close the gaps in health, whether they are based on race or ethnicity, socioeconomic status, age, geographic region, environment, or other factors. Until disparities in health care access and quality of care are eliminated, some people with diabetes will continue to experience poorer health status and reduced life expectancy. 🌟

Conferences

National Oral Health Conference

“Time for Action: Collaborating for Oral Health” is the theme of the next National Oral Health Conference to be held April 28–30, 2003, at the Hyatt Regency in Milwaukee, Wisconsin. This national meeting focuses on exchanging scientific and public health information on oral health, provides a forum for sharing innovative and successful oral health programs in a variety of settings, and promotes discussion of strategies for improving oral health through community, state, national, and foundation initiatives. The meeting is sponsored by the Association of State and Territorial Dental Directors, the American Association of Public Health Dentistry, CDC, and the Health Resources and Services Administration, Maternal and Child Health Bureau. For more information about the conference, visit www.astdd.org or www.aaphd.org.

Public Health Information Network Stakeholders Conference

The first Public Information Network (PHIN) Conference will be held May 13–15, 2003, in Atlanta, Georgia, at the Atlanta Hilton Hotel. The conference will include general sessions to discuss progress and the future evolution of the PHIN, opportunities for program input, and tracks for technical participants. For more information or to register, visit <http://www.cdc.gov/nedss> or call Ms. Trevia Brooks or Ms. Wendolyn Scott at 404/639-7860.

21st National Conference on Health Education and Health Promotion

The 21st National Conference on Health Education and Health Promotion will be held May 21–May 23, 2003, in San Diego, California. The conference theme is “Emerging Opportunities for Health Promotion and Health Education: Sailing Into New Waters.” Subthemes include “Policies and Environmental Interventions: Making Them Work,” “Addressing Multicultural Relevance and the Unequal Burden of Disease,” and “Creative Funding in Difficult Times.” The conference is sponsored by the Association of State and Territorial Directors of Health Promotion and Public Health Education and CDC. Exhibitors’ deadline: April 18, 2003. For more information, visit www.astdhpphe.org/nationalconference.

5th Annual Public Health Prevention Service Conference

“Pulling the Pieces Together: Working Toward a Common Vision” is the theme of the 5th Annual Public Health Prevention Service (PHPS) Conference. The conference will take place June 9–12, 2003, at the Embassy Suites at Centennial Olympic Park in Atlanta, Georgia. The PHPS is a 3-year training and service program providing early career public health professionals with an opportunity to practice public health in various settings. The conference will provide a forum for prevention specialists and representatives from CDC, state and local health programs, academic institutions, national organizations, and private public health agencies to meet, network, and share innovative strategies and expand knowledge for addressing public health issues. For conference information, contact Gayle Daniels at GDaniels@cdc.gov or 404/639-3756. For additional information about the PHPS program, visit <http://www.cdc.gov/epo/dapht/phps.htm>.

12th World Conference on Tobacco or Health Global Action for a Tobacco Free Future

This conference will take place August 3–8, 2003, at the Helsinki Fair Centre in Helsinki, Finland. The conference will bring together some 2,000–3,000 professionals involved in tobacco control work and will address the global extent of the tobacco epidemic and the efforts being made to tackle it. A major theme will be the social process for a smoke-free world and the broad partnership needed to accomplish this. In addition, the implementation of the Framework Convention on Tobacco Control, initiated by the World Health Organization, will be discussed. More information can be found at <http://www.wctoh.org> or can be requested via E-mail at wctoh2003@concreator.com.

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ASTHO-NACCHO 2003 Joint Conference

The ASTHO-NACCHO 2003 Joint Conference will be held September 9–12 in Phoenix, Arizona, at the Hyatt Regency Phoenix. More than 800 local health officials, including state and federal public health agency representatives and members of national organizations, are expected to participate in the conference, whose theme is “Leveraging the Forces Shaping Public Health.” Cosponsors of the conference include the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO). For more information, visit <http://www.naccho.org/general665.cfm> or contact Ms. Francine Saucedo at fsaucedo@naccho.org or 202/783-5550, extension 212.

CDC's 2003 Cancer Conference

Held biennially since 1999, the conference will take place September 15–18, 2003, at the Marriott Marquis Hotel in Atlanta, Georgia. This year's theme is “Comprehensive Approaches to Cancer Control: The Public Health Role.” The conference will focus on the public health role for each of the major comprehensive cancer control elements: cancer prevention, early detection, treatment, rehabilitation, and palliation. Cosponsors of the event are the American Cancer Society, CDC, Chronic Disease Directors, the National Cancer Institute, and the North American Association of Cancer Registries. For more information about the conference, please visit www.cancerconference.net.

Communications

CDC's National Program of Cancer Registries

This fall, CDC's National Program of Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) registry program will jointly publish official federal cancer incidence statistics for all states that have high-quality data. This publication, *U.S. Cancer Statistics: 1999 Incidence*, is produced in collaboration with the North American Association of Central Cancer Registries. The report will provide cancer statistics for cases diagnosed in 1999 and will cover about 78% of cancers diagnosed in the United States that year. State-specific cancer statistics will be included for 37 states, 6 metropolitan areas, and the District of Columbia. October 2002 was the 10th anniversary of the passage of the Cancer Registries Amendment Act (Public Law 102-515), which authorized the establishment of the NPCR. Before the NPCR was established, 10 states had no registry, and most states with registries lacked the resources and legislative support to collect needed data. CDC now supports central registries and promotes the use of registry data in 45 states, the District of Columbia, and three territories. CDC's goal is for all states to establish registries that provide high-quality data on cancer and cancer care.

Atlas of Stroke Mortality: Racial, Ethnic, and Geographic Disparities in the United States

In February 2003, CDC released the *Atlas of Stroke Mortality: Racial, Ethnic, and Geographic Disparities in the United States*. This publication is the third in a series of CDC atlases related to cardiovascular disease, which have been published through a collaboration between CDC and West Virginia University. The *Stroke Atlas* provides, for the first time, an extensive series of national and state maps that show local disparities in county-level stroke death rates for the five largest racial and ethnic groups in the United States (i.e., American Indians and Alaska Natives, Asians and Pacific Islanders, blacks, Hispanics, and whites). The maps in the *Stroke Atlas* will provide health professionals and concerned citizens at the local, state, and national levels with information essential to identifying populations at greatest risk for stroke and most in need of tailored prevention policies and programs. In addition, the maps in this atlas will enable health researchers to develop new hypotheses regarding the determinants of the geographic patterns of stroke for each racial and ethnic group. An important finding in the *Stroke Atlas* is that geographic disparities in stroke mortality vary substantially among racial and ethnic groups. The *Stroke Atlas* is available at www.cdc.gov/cvh.

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Promising Practices in Chronic Disease Prevention and Control

In the recently released *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action*, CDC shares its vision of how states and their partners can reduce the prevalence of chronic diseases and their risk factors by instituting comprehensive statewide programs. The recommendations for achieving this vision are based on prevention effectiveness research; program evaluations; and the expert opinions of national, state, and local leaders and public health practitioners, including CDC staff. In addition to describing some of the most promising practices for reducing the burden of each of the major chronic diseases and their risk factors, the book provides numerous sources, including Web sites, that describe state and local examples of what can be achieved; state-of-the-art strategies, methods, and tools; and training opportunities. *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action* provides a framework that states can use to build new chronic disease prevention and control programs and enhance existing programs. To order, please contact the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K-40, 4770 Buford Highway NE, Atlanta, GA 30341-3717, telephone (770) 488-5706, E-mail ccdinfo@cdc.gov, or visit <http://www.cdc.gov/nccdphp>.

The Promise of Prevention

CDC's February 2003 publication *The Promise of Prevention* describes the seriousness of chronic diseases and the need to prevent them as a strategy to combat this epidemic and to reduce related health care costs. This document outlines the public health perspective and approach to reducing the health and economic burden of chronic disease: prevention. Graphs and maps that show relevant health-related trends, including the aging of the U.S. population, the increase in the number of obese Americans, and medical care costs, help illustrate the need to focus on preventing chronic disease. The document also provides a national chronic disease prevention agenda and outlines specific steps that can be taken to prevent chronic disease and improve people's health. To order, please contact the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K-40, 4770 Buford Highway NE, Atlanta, GA 30341-3717, telephone (770) 488-5706, E-mail ccdinfo@cdc.gov, or visit <http://www.cdc.gov/nccdphp>.

State Programs in Action

CDC's 2003 publication, *State Programs in Action: Exemplary Work to Prevent Chronic Disease and Promote Health*, provides examples of state-based programs that are making a sustained contribution to reducing the burden of chronic disease by reducing risk factors for chronic disease, expanding the use of screening for early detection of chronic disease, providing high-quality health education programs, or creating healthier communities. Selected programs—which range from small community-based projects to reform of state policies—show innovative approaches to research and practice. To order, please contact CDC, National Center for Chronic Disease Prevention and Health Promotion, Mail Stop K-40, 4770 Buford Highway NE, Atlanta, GA 30341-3717, telephone (770) 488-5706, E-mail ccdinfo@cdc.gov, or visit <http://www.cdc.gov/nccdphp>.

Dynamic Dollars to Mobilize Public Health Efforts: Preventive Health and Health Services Block Grant

The Preventive Health and Health Services (PHHS) Block Grant is a congressionally mandated grant provided annually to 61 grantees (all 50 states, the District of Columbia, 2 Native American Indian Tribes, and 8 U.S. Pacific Islands) to support the *Healthy People 2010* health objectives. CDC recently developed a brochure to increase awareness of the valuable role the PHHS Block Grant funds play to complement categorical and state funding to address and improve the public's health. For additional information, call 770/488-5645 or visit <http://www.cdc.gov/nccdphp/prevbloc.htm>.

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Oral Health, U.S. 2002

Oral Health, U.S. 2002 is a new resource that summarizes the oral health status of the United States population. Intended as a useful tool for researchers, clinicians, and policy makers, this databook provides comprehensive information drawn from national surveys to describe the current status of oral and craniofacial health. It includes information on demographic, health services, health economics, and environmental factors that affect oral health. The report can be viewed on the Web site of the National Institute of Dental and Craniofacial Research (NIDCR)/CDC Dental, Oral, and Craniofacial Data Resource Center (DRC) at <http://nidcr.row.com/report.htm>. It also is available as a CD-ROM or hard copy and can be ordered by contacting the DRC at 301/294-5594 or by sending an E-mail to oralhealthdrc@northropgrumman.com. ☀

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