HELPING BLACK MOTHERS TO HELP THEIR DAUGHTERS EXERCISE

Study findings have shown that Black girls need more support from their parents to overcome barriers to physical activity than White girls. Black mothers are often single parents and responsible for the family's well-being. It is important to work with these mothers to help them help their daughters. Very little is known about Black mothers' beliefs about physical activity. Also little is known about how important they believe an exercise program is for their daughters. We wanted to know more about how Black mothers' beliefs may or may not make a difference on their daughters' exercise patterns.

This study found that most Black mothers and pre-teen daughters had high levels of obesity or overweight. This put them at-risk for getting high blood pressure, diabetes and heart disease later in life. Mothers and daughters in this study believed that physical activity was enjoyable and good for their health. They had good intentions to exercise regularly. However, most of the daughters exercised less than the recommended levels of 60 minutes a day. The desire to be physically active appeared to be connected to family income and the number of people living in the household.

Most of the mothers were heads of single-parent households. They were very busy with work-related activities and household chores. They had little leisure time. These daily life activities may have made it difficult for the mothers to have time to directly support and encourage their daughters to exercise regularly. Differences were noted in values for physical activity and cultural preferences for certain types of physical activity. This may have also made it more difficult for mothers to participate in exercise activities with their daughters.

With these facts in mind, the researchers of this study recommend tailored prevention programs. These should be aimed at identifying and addressing the barriers that keep Black mothers from being involved in their daughters' physical activity.

Source: Relations of Black mothers' and Daughters' Body Fatness, Physical Activity Beliefs and Behaviors
Gloria J. Nichols-English, PhD; Christian R. Lemmon, PhD; Mark S. Litaker, PhD; Sheree G. Cartee, BS; Zenong Yin, PhD; Bernard Gutin, PhD; Paule Barbeau, PhD

MANAGING AND TREATING DIABETES

More than 150 million people throughout the world have diabetes. Within the next ten years, 17.5 million Americans will have diabetes. In addition, more ethnic minorities have type 2 diabetes than do Whites. Compared to Whites, African Americans have diabetes 2 to 2.5 times more often than Whites and the rate of diabetes is 2 to 4 times higher in Hispanics, and 2 to 2.5 times higher in Asian Americans and Pacific Islanders.

Researchers have found that minority populations in the United States, including immigrants from non-European countries, have a higher rate of diabetes compared to Whites. Among immigrants, the increase in diabetes happens immediately. It is likely that both genetic and environmental factors add to the higher incidence of diabetes in ethnic populations.

People are born with genetic factors, which are difficult, if not impossible, to change. On the other hand, environmental risk factors are gained. As such, they can be changed. These factors include non-active lifestyle, overeating, and weight gain. Studies have reported lower levels of physical activity in minority populations than in White US populations.

Ethnic minorities also experience other conditions and death caused by diabetes more often than Whites. The incidence of eye disease from diabetes, which can lead to blindness, was 46% higher in non-Hispanic Blacks and 84% higher in Mexican Americans than in non-Hispanic Whites. Kidney disease and leg amputations also occur more often in ethnic populations with diabetes. As a result of the increase in complications, death rates for people with diabetes are higher for Blacks than for Whites.

People with type 2 diabetes have high blood sugar (glucose) levels. The ideal treatment for type 2 diabetes should correct insulin resistance and lower blood glucose levels. It should also prevent, delay, or reverse other conditions caused by diabetes. Nondrug treatments, such as lower calorie intake and increased physical activity, are important steps for effective diabetes care. The benefits of improved diet and exercise have been shown in many studies.

In addition to these types of lifestyle changes, medications (either insulin or oral medications) are often needed to successfully control diabetes. Oral medications, such as the thiazolidinedione class of drugs, treat the key underlying problems in patients with type 2 diabetes. Thiazolidinediones improve sensitivity to insulin and lower blood glucose levels. These drugs have been shown to maintain control of glucose levels across all ethnic populations. Furthermore, by improving sensitivity to insulin, thiazolidinediones may improve cardiovascular risk factors and lead to a decrease in complications (for example, heart disease, stroke). These benefits are expected to be particularly important among ethnic minority patients, who tend to have greater resistance to insulin compared with Whites.

Source: Role of Thiazolidinediones in the Management of Type 2 Diabetes: Focus on Ethnic Minority Populations
Guillermo E. Umpierrez, MD; Samuel Dagogo-Jack, MD

DOES INCOME LEVEL AFFECT LOW BIRTH WEIGHT?

Research has shown that, but not explained why, African-American women are twice as likely to deliver small (weighing less than 5 lbs 5 oz) infants as White women. Among African-American women, the risk of delivering small infants begins to rise among those in their late twenties and early thirties. The term "weathering" has been used to describe African-American women who experience poor health status related to pregnancy. The "Weathering Hypothesis" attempts to explain the physical consequences of social inequality on African-American birth outcomes.

In Chicago, as in other metropolitan areas, African Americans and Whites do not usually live in the same neighborhood. A large percentage of African-American women live in urban neighborhoods with poverty and high rates of violent crimes. For our study, we analyzed the 1992–1995 Illinois vital records, 1990 US Census income information, and the 1995 Chicago Department of Public Health data of African-American infants born to Chicago residents. We wanted to determine whether living in a high poverty neighborhood worsens the risk of low birth weight babies with advancing age among African-American women.

In our study population, 21% (n=21,811) of African-American women resided in non-impoverished neighborhoods; 23% (n=24,914) of African-American women lived in very poor neighborhoods. In non-impoverished neighborhoods, 30–34 year old women had a slightly greater risk of delivering small infants than women aged 20–24 years. In extremely poor neighborhoods, women aged 30–34 years were definitely more likely to deliver small infants than women aged 20–24 years.

These findings show that neighborhood poverty contributes to the "weathering" theory among urban African-American women. It strongly suggests that neighborhood factors contribute to the racial disparity in infant birth weight. Further research is needed to determine whether African-American mothers in higher income neighborhoods would have similar rates of low birth weight infants.

Source: Advancing Maternal Age and Infant Birth Weight Among Urban African Americans: The Effect of Neighborhood Poverty
James W. Collins, Jr, MD, MPH; Dyan M. Simon, MD; Tara A. Jackson, MD; Aimee Drolet, PhD

ADDRESSING CARDIOVASCULAR HEALTH DISPARITIES THROUGH COMMUNITY INTERVENTIONS

In this study, researchers looked at programs that have proven successful in reducing racial disparities in heart disease. Through this research, they also looked for strategies that might be missing from less-successful programs and suggested improvements for future programs.

To do this research, the scientists conducted a search on the Internet database, MEDLINE, which contains a complete record of articles published in major journals. They used the key words, "cardiovascular" (heart disease) and "African American." After reading through all abstracts, a group of programs targeted at reducing racial disparities in heart disease was selected for review.

Researchers reviewed the programs for these qualifications: type of program; group of people using the program; number of months (years) the program was conducted; and the effect the program had.

The researchers' results showed that cardiovascular health disparities were widely noted by existing studies. Specifically, African Americans were found to: receive below-standard physician services; have more communication issues with their physicians; have difficulties in getting to hospitals; use fewer prescription drugs; and undergo fewer surgeries for heart disease than those in the general population.

Cardiovascular diseases were found to be more common and severe in African Americans. African Americans also develop heart disease earlier than Whites and are more likely to die from them. Most of the documented programs focus on lifestyle risk factors (such as exercise, diet habits, smoking, alcohol consumption, etc), and changing or modifying attitudes toward those risk factors.

The researchers found several problems with the programs reviewed. To date, there is a lack of prevention programs to improve patient, physician, system adherence and the interactions among these three factors. Also, existing programs do not seem to have built on collaborations between communities, clinical serving systems at the forefront of delivering medical care, and large scale medical research institutions that may be more removed from the day-to-day issues of patients.

Based on their findings, the researchers of this study concluded that the impact of intervention programs has been short-term. Long-term programs, possibly through community partnerships, are needed. As long as community medical institutions, minority-serving systems, and other medical centers operate as individual provider systems, there is a suboptimal potential to reduce disparities in heart diseases, even with improved physicians' adherence to guidelines and patients' compliance with treatment plans. The best approach to reducing cardiovascular disparities has to rely on support both from community and institutions, starting at the community level. Institutions are well-positioned to take a leadership role and establish a model for a "community of care."

Source: Addressing Cardiovascular Disparities through Community Interventions
Fadia T. Shaya, PhD, MPH; Anna Gu, MA; Elijah Saunders, MD

HOW ANXIETY AFFECTS HEALTH AND QUALITY OF LIFE FOR THE GROWING ELDERLY POPULATION

Anxiety is the most common mental disorder in the United States. It includes generalized anxiety disorder, phobias, post-traumatic stress disorder, obsessive-compulsive disorders and panic disorders. Of the five disorders, panic disorder has the strongest genetic basis. The other four disorders are more commonly associated with stressful life events such as being a victim of crime or living in chronic poverty. Personality also plays a role, as individuals with low self-esteem or poor coping skills are at risk for anxiety. However, research indicates that no single situation or event causes anxiety. Instead, the development of anxiety involves some combination of life experiences, environmental situations, psychological traits, and genetic factors. In late life, up to 20% of the population may experience symptoms of anxiety. Despite the high rate in late life, anxiety remains a poorly studied problem.

The current study examined relationships among sociodemographic, physical, mental and functional health characteristics and anxiety in older adults. Also, because anxiety research in older populations has been mostly limited to White non-Hispanics, we included minority populations in our research. Our study group included non-Hispanic Whites (n=176), non-Hispanic Blacks (n=177), and Hispanics (n=153) aged 75 or older. They were interviewed in-person by trained interviewers who spoke two languages. Nearly one in three interviewed reported anxiety. About half reported clinically significant anxiety.

Predictors of anxiety included being married, number of medications for other health problems, and depressive symptoms. Past studies have found several things happen when anxiety occurs with depression. People are at a greater risk for functional disability, they increase their use of health care resources, and have longer recovery times after illness than if either anxiety or depression occurred alone.

We also found that anxiety was about twice as common among non-Hispanic Whites than either non-Hispanic Blacks or Hispanics. Finding a lower rate of anxiety among non-Hispanic Blacks and Hispanics may be important as it has the potential to contribute insights into why some individuals from minority populations do well and others do poorly in the face of health challenges or other life stressors.

Anxiety in older adults is common and under-recognized. Studies further recognize that low forms of anxiety could have an impact on the health of the older individual. With the population of those 65 years of age and older expected to increase from

approximately 35 million in 2000 to an estimated 71 million in 2030, and the number of individuals aged 80 and older to more than double, there is a need to better understand anxiety and how it affects health and quality of life.

Source: Anxiety in Persons 75 and Older: Findings from a Tri-Ethnic Population
Glenn V. Ostir, PhD; James S. Goodwin, MD

STRESSFUL LIFE EVENTS ADD TO POOR QUALITY OF LIFE FOR YOUNG BLACK MEN WITH HIGH BLOOD PRESSURE

Inner-city young Black men with high blood pressure face special challenges, not only because of their disease, but also because of where they live—usually neighborhoods where poverty and crime are common. We interviewed 210 young Black men in inner-city Baltimore, Maryland who were participating in a high blood pressure management study. We collected stressful life events experienced by these men over a four-year period. We also examined how long-term stressful life events affected alcohol and drug use, depression, and quality of life at 48-month follow-up.

The men reported several types of stressful life events. These included death of a family member or close friend (65.2%); having a new family member (32.9%); change in residence (31.4%); difficulty finding a job (24.3%); and fired or laid off from work (17.6%). One third of the men reported that they had been involved in crime or legal matters during the 4-year period.

In this study, those who had more stressful life events also had higher rates of depression and lower quality of life. We did not find a link between stressful life events and substance use. This could be due, in part, to the fact that the majority of our participants were using drugs at the time of the study and were already exposed to combined burdens of poverty and a stressful living environment with poor housing, frequent moving, and a high rate of crime.

Our study findings suggest that clinicians and researchers should pay more attention to the behavioral and psychosocial aspects of high blood pressure care, particularly in young Black men, for whom resources are often very limited. Future programs should focus on assisting individuals in managing stressful events with necessary community resources.

Source: Effects of Stressful Life Events in Young Black Men with High Blood Pressure
Hae-Ra Han, PhD, RN; Miyong T. Kim, PhD, RN; Linda Rose, PhD, RN; Cheryl Dennison, PhD, RN; Lee Bone, MPH, RN; Martha N. Hill, PhD, RN

THE USE OF ANTIBIOTICS AMONG ASIAN AND PACIFIC ISLANDERS

The use of antibiotics for common colds and other upper respiratory infections is ineffective because these drugs don't work against viruses. Such use exposes patients to side-effects and increases the likelihood of resistance to antibiotics. Certain antibiotic medications that were previously very effective against bacterial germs are now useless in the treatment of serious bacterial diseases like pneumonia.

Interventions that decrease the inappropriate use of antibiotics have been effective in different settings. Little is known about ways that ethnicity and culture influence antibiotic knowledge, attitude, and use.

We wanted to gain a better understanding of how people's values, background, country-of-origin, and belief systems affect their use of antibiotics for common colds.

Using survey data our research explores the links between knowledge of antibiotics and a patient's perceived need for antibiotic treatment in the face of upper respiratory infection. We also assessed personal history of antibiotic use in the previous year.

We found that there were major differences in ethnic groups. Filipinos had lower levels of antibiotic knowledge, expressed higher perceived need for antibiotics, and reported more frequent use in the previous year. White people in our sample were at the opposite end of the scale on all of these measures with other Asian Americans (Japanese and Chinese) and Hawaiian/Pacific Islanders in between the Filipinos and the Whites.

Another purpose of the study was to design a program that increases patient understanding of when antibiotics are useful while also improving patient satisfaction with the overall care and attention they received

from their doctor. Other studies indicate that increased communication between patient and physician about appropriate antibiotic use results in higher patient satisfaction and less misuse of the medication for common colds.

However, our study suggests that Filipinos' preference for minimal sharing of information and decision-making with their doctor may make successful interventions less likely. Hence, interventions to increase appropriate antibiotic use within this ethnic group and others with similar orientations toward patient-physician decision-making are likely to benefit from consideration of ways to increase two-way communication between patients and their doctors.

Source: Antibiotics and Upper Respiratory Infections: The Impact of Asian and Pacific Island Ethnicity on Knowledge, Perceived Need, and Use
Dana L. Alden, PhD; Alan Tice, MD, FACP; John T. Berthiaume, MD, FACP

BARRIERS AND SOLUTIONS TO MOTIVATING MEN TO UNDERGO PROSTATE CANCER SCREENING

Although prostate cancer is the most frequently diagnosed cancer and the second leading cause of cancer death among African-American men, African-American men are screened for this cancer less often than Caucasian men. This study conducted focus groups with four African-American male groups to assess their knowledge, attitudes and beliefs about prostate cancer screening.

Recognizing the influence women have on the health of the men in their lives, the researchers also conducted two focus groups with female significant others of African-American men to assess the same information. Male and female focus group participants were recruited in the Harrisburg, Pennsylvania area through flyers and a television interview about the study.

Each participant completed a short questionnaire and was asked to talk about the topic of prostate cancer screening, including the prostate specific antigen (PSA) blood test and the digital rectal exam (DRE). The discussions were tape-recorded and led by questions from a group facilitator.

In one of the male groups, there was confusion between screening for prostate cancer and screening for colon cancer. Additionally, some of the men had never heard of screening for prostate cancer. When the women were questioned as to what they knew or had heard about the PSA test, the women mentioned several times that the physical exam or DRE was a turn-off to being screened for prostate cancer.

The groups mentioned several factors that would be successful in motivating men to be screened: early education; an understanding of the benefits; and the influence of a female significant other. One male focus group participant commented, "Even though we feel macho, we do listen to our wives and obey."

Ways of promoting screening included churches, sporting events, media, peer influence and physician influence.

The study brought to light the personal feelings of these men as it relates to prostate cancer screening. Doctors should also take note about the anxiety African-American men experience during screening. The focus groups uncovered much information that can help in easing the screening process, both physically and emotionally. In the end, however, the responsibility rests with the men themselves to take an active role in maintaining their own health.

Source: An Evaluation of the Knowledge, Attitudes, and Beliefs of African-American Men and Their Female Significant Others Regarding Prostate Cancer Screening
Chanty R. Webb, RN, BSN; Linda Kronheim, BS; James E. Williams, Jr., COL (Ret); Terryl J. Hartman, PhD, MPH, RD

WHAT KEEPS AFRICAN-AMERICAN WOMEN FROM EXERCISING?

African-American women are known to exercise less frequently than White women. Researchers of this study wanted to find out why. They thought that the barriers to exercising for African-American women may vary by weight or body mass index (BMI) status. Therefore, they reviewed the association of obesity and physical activity barriers in a church-based population in the Baltimore area.

Participants in this study took part in Project EXE-L (Exercising Ladies Excel), a six-month church-based study of moderate intensity physical activity. Participants were African-American women who attended one of the participating churches, had friends who were church members, or who lived in neighborhoods near one of the churches. Individuals who were between the ages of 25 and 70 years, were not regularly physically active (defined as not engaging in moderate-intensity activity more than three times per week), and were able to participate in moderate intensity activity were eligible to participate in the study.

The researchers found the most commonly reported barriers to physical activity were "no time" and "lack of motivation." These two barriers were reported by more than half of all participants, while the other 12 possible barriers were reported infrequently.

One hundred twenty women were classified as normal weight (BMI: <25 kg/m^2), overweight (BMI: 25–29.9 kg/m^2), or obese (BMI: ≥30 kg/m^2). Obese women were more likely to report "lack of motivation" as a high barrier compared with normal weight participants (63% vs. 31%). Normal weight and overweight participants were more likely to report no barriers compared with the obese participants.

The fact that only two of the possible 12 barriers examined in this study were reported suggests that African-American women may have additional unique barriers that were not examined in this study. Additionally, barriers for African-American women may vary by BMI status. By defining these unique barriers and understanding why each barrier exists (for example, what is causing "little motivation"), effective physical activity programs can be developed.

Source: Does Weight Status Influence Perceptions of Physical Activity Barriers Among African- American Women?
Jeanine M. Genkinger, PhD, MHS; Megan L. Jehn, PhD, MHS; Marcella Sapun, MS; Iris Mabry, MD, MPH; Deborah Rohm Young, PhD

TOBACCO ADDICTION DIFFERS BETWEEN AFRICAN-AMERICAN AND WHITE TEENAGERS

Cigarette smoking is a major preventable cause of death and disease in the United States. Scientists have shown that ethnic differences exist in how people smoke and how much of a risk they have for developing serious health problems, like lung cancer and heart disease.

Nicotine is the main drug responsible for cigarettes being so addictive. When people are addicted to cigarettes they must keep smoking to keep the levels of nicotine in their body. However, scientists have found that not everyone's body breaks down (metabolizes) nicotine at the same speed. In fact, African Americans and Whites breakdown nicotine at different rates. As a result, people of different ethnic groups may end up smoking more or less in order to keep the same level of nicotine in their body. Some studies have shown that smoking mentholated cigarettes can cause a person's body to process nicotine at a slower rate.

A recent study of 92 teenage smokers showed that even though African-American teenagers smoked fewer cigarettes than White teenagers, they still had the same amounts of nicotine in their bodies. Scientists found out that the African-American teens were actually breaking down the nicotine at a slower rate. This may be because of genetic differences in how enzymes (molecules in a person's liver) break down nicotine. Because the African-American teens were breaking down the nicotine from cigarettes more slowly, they didn't have to smoke as many cigarettes to have the same levels of nicotine. But, just because they were smoking less, doesn't mean that they were any less addicted. In fact, because African-American teens may be exposed to higher levels of nicotine from a single cigarette, they may actually be at a higher risk of becoming *addicted* to smoking, even after just one cigarette.

It is also important to realize that, depending on who you are, smoking just a few cigarettes may expose you to a lot of nicotine and make it more difficult to quit. Your doctor may recommend medication to treat your tobacco addiction only when you report smoking a certain number of cigarettes a day. Quitting smoking is one of the most important things you can do to improve your future health and the quality of your life right now. If you smoke at all, even just a little, you should talk to your doctor today about some of the options available to help people quit smoking.

Source: Adolescent Nicotine Metabolism: Ethnoracial Differences Among Dependent Smokers
Eric T. Moolchan MD; Frederick H. Franken, BS; Maria Jaszyna-Gasior MD, PhD

FACTORS THAT COULD IMPROVE CONTROL OF HIGH BLOOD PRESSURE AMONG KOREAN AMERICANS

Many Korean immigrants, and especially the elderly, often face many barriers to managing long-term (chronic) disease, often because they do not speak English and may have cultural differences.

High blood pressure (hypertension) is a chronic disease found often in Korean Americans. We looked at the data from 146 hypertensive Korean-American elderly, 60 years of age or older, to see how well they managed their hypertension. We were also interested in what factors determined good control or bad control of hypertension.

Our study found that many in this group were not taking medicines for hypertension and did not have a good control of hypertension. Those who did not have health insurance were less likely to take medication and more likely to have uncontrolled hypertension.

Patients in the study group reported difficulty in finding Korean-speaking doctors and this factor was linked to poorer care of hypertension. To overcome the lack of good care, many in the study group visited Oriental medicine doctors, but the visits did not lead to successful control of hypertension.

Source: Barriers to Care and Control of High Blood Pressure in Korean-American Elderly
Jeong Hee Kang, PhD, RN; Hae-Ra Han, PhD, RN; Kim B. Kim, PhD; Miyong T. Kim, PhD, RN

ARE CURRENT MEASURES OF OBESITY ACCURATE FOR ALL POPULATIONS?

Being overweight or obese is linked to increased risk for diabetes and heart disease because of extra body fat. It is important that those who have excess body fat, which may put them at risk for future disease, be identified so that prevention and/or treatment can begin.

The most common measures used to determine overweight or obesity are measures called the body mass index or BMI. It is a formula based on weight and height, and the measurement of the waist, or waist circumference. Scientists have determined specific levels for both BMI and waist circumference that place an individual in the overweight and obesity category. These target levels are based primarily on White populations.

Some research suggests that these targets are not appropriate for those of Aboriginal and Asian background. These populations may require lower targets. The Multicultural Community Health Assessment Trial will identify the relationship between ethnic background and excess body fat in people of Aboriginal, Chinese, European and South Asian background. For the study, 200 men and women from each of the four ethnic groups will be assessed for total body fat, waist circumference (abdominal body fat) and risk factors for diabetes and heart disease. The results will be reviewed to find out if the amount of abdominal body fat differs among the four ethnic groups.

We believe that this study will show differences in where members of each group store body fat and, if this is true, it will mean that target measures of body mass index and waist circumference should be changed for non-European populations.

Source: Study Design of the Multicultural Community Health Assessment Trial (M-CHAT): A Comparison of Body Fat Distribution in Four Distinct Populations
Scott A. Lear, PhD; C. Laird Birmingham, MD; Arun Chockalingam, PhD; Karin H. Humphries, PhD

REVIEWING THE HEART DISEASE RISK OF MULTIRACIAL POPULATIONS

In this study, we compared race-specific estimates of self-reported high blood pressure and high blood cholesterol from 1999 and 2001 as found in the Behavioral Risk Factor Surveillance System data.

Our study showed that, in 2001, there were more multiracial adults who had high blood pressure than adults of

all other races except non-Hispanic Blacks. Since more multiracial adults had high blood pressure, programs to help prevent or reduce high blood pressure should target multiracial people. The new multiracial race category allows researchers to examine an emerging group who have health risk profiles similar to those of other minority groups. Our research indicates that most of those who reported that they were multiracial in 2001 would have previously reported themselves as non-Hispanic White in 2000 when only given one choice.

With these new categories used in 2001, we found an increase in high blood pressure and high cholesterol levels among non-Hispanic Whites, even though they had less disease than those from other racial groups. In addition, there was an even larger increase in high blood pressure among Asian/Pacific Islanders and non-Hispanic Blacks, which tells of a long-term and growing problem in these communities.

Even though high blood pressure usually has no signs or symptoms, it can be harmful if left untreated or uncontrolled. Preventing and managing high blood pressure are major public health challenges. The occurrence of heart disease, renal disease, and stroke could be greatly reduced if increases in blood pressure were prevented.

Both doctors and individuals need to be aware of ways to prevent and control high blood pressure. Increasing physical activity, making nutritional changes (such as reducing salt and fat intake). Engaging in weight reduction or management, and reducing stress are a few activities that should be considered. Also needed are routine blood pressure screening among all US adults and treatment and control of high blood pressure among people with hypertension.

The increase in high cholesterol levels from 1999 to 2001 for non-Hispanic Whites is also troubling. High blood cholesterol is a risk factor for heart disease that can be prevented or controlled. The benefits of lowering cholesterol include a lower chance of coronary heart disease and fewer deaths among those with or without coronary heart disease.

Our study suggests that more state-level research on cardiovascular risk factors should be conducted in a multiracial population. Moreover, health professionals should be made aware of the health needs of multiracial people, a quickly increasing population in the United States. Public health professionals need to develop and conduct preventive programs that can address the cultural needs of this diverse group.

Heart disease remains a leading cause of death in the United States, and good programs for all populations are needed. To promote heart health, it is critical to focus on all groups who have been found to have high rates of high blood pressure and high blood cholesterol.

Source: Effect of Race Category Redefinition on Hypertension and Hypercholesterolemia Prevalence in the Behavioral Risk Factor Surveillance System, 1999 and 2001

Margaret Ochner, MPH; Carma Ayala, PhD, RN; Ruth Jiles, PhD

UNDERSTANDING BEST APPROACHES FOR SMOKING CESSATION PROGRAMS FOR AMERICAN INDIANS

American Indians smoke cigarettes more often than any other ethnic group in the United States and have more difficulty quitting. A successful program to help members of this group stop smoking has not yet been developed. Also, unlike other ethnic groups, American Indians use tobacco for traditional ceremonies and prayer.

Tobacco is considered a sacred plant by many American Indian nations. Because of tobacco's sacred nature, smoking cessation programs for this ethnic group cannot portray tobacco as all bad. Because of this, most smoking cessation programs will not be successful for American Indians. In our study, we looked at a smoking cessation program called "Second Wind," developed for American Indians.

We conducted six focus groups with adult smokers who are currently patients at the Haskell Health Center in Lawrence, Kansas, an Indian Health Service clinic that provides health care to many American Indians in Kansas. Our 41 participants discussed three major topics, including: 1) traditional uses of tobacco and how traditional use relates to smoking; 2) smoking and attempts to quit in the past; and 3) the "Second Wind" program and if it is appropriate for American Indians. Participants also filled out a brief survey about themselves and their experience with smoking.

Our participants were between 21–67 years of age and smoked an average of 13 cigarettes per day. About half had tried to quit in the past year, and 63% were daily smokers. The majority of smokers preferred the nicotine patch to help them stop smoking.

Our participants told us that traditional use of tobacco is very different from smoking and includes ceremonial use, spiritual use, and other uses. Traditional use is very important to

some people and not important at all to others. For those people who use tobacco traditionally, it can help them to limit their smoking. They explained that social situations and friends are a major barrier to quitting, as well as the cost of nicotine patches or gum. Our participants said that the "Second Wind" program could be changed to be more successful for American Indians. They said that the written information in the program should be more "Indian" and more attractive, with more pictures and less text. They also felt the program itself needed to honor the spirituality of tobacco more than it did. Our participants also wanted both group and individual counseling instead of the group-only counseling offered in the "Second Wind" program, as well as more group sessions when they first quit smoking.

Overall, our participants taught us that a smoking cessation program for American Indians could be developed that both honored the spirituality of tobacco and promoted quitting smoking. We provide several suggestions from our participants about how to develop a smoking cessation program that will be specific to American Indians and will help them to quit.

Source: Beliefs and Attitudes Regarding Smoking Cessation Among American Indians: a Pilot Study

Won S. Choi, PhD; Christine Makosky Daley, PhD; Aimee James, PhD; Janet Thomas, PhD; Ryan Schupbach, PharmD, BCPS; Marcia Segraves, BS, CADCI; Randall Barnoskie, MPH; Jasjit S. Ahluwalia, MD

DIFFERENCES IN BEHAVIORS THAT PLACE US-BORN VS FOREIGN-BORN INDIVIDUALS AT GREATER RISK OF HEART DISEASE

Coronary heart disease (CHD) is the leading cause of death in the United States. Researchers have found that death rate due to CHD was lower in Blacks born outside of the United States compared to US-born Blacks and US-born Whites. The term, "African American (AA)" or "Black" has been used to describe all Black people living in the United States. Placing individuals in such broad categories does not consider subgroups/cultures within this Black population. Differences in attitude, knowledge and behaviors can lead to differences in the risk factors for CHD within the subcultures of this Black population. The challenge of preventing CHD lies in identifying and addressing the components of CHD most important to each ethnic group.

No study has been done to examine and compare the behavioral risk factors of CHD between foreign-born Afro Caribbeans (FBAC) and US-born Afro Caribbeans (USBAC), especially in South Florida, where there is a growing population. The FBAC may have different health perceptions, beliefs, behaviors, dietary habits and ability to report health/nutritional conditions compared to USBAC and AA. These differences may separate these groups and may influence other risk factors for heart disease in this population of African ancestry. The purpose of our study was to find out if there were differences in behavioral risk factors for CHD among FBAC, USBAC and AA adults in South Florida.

We found that half of the USBAC and a third of the AA males ate an unhealthy diet compared to the FBAC males. Also, one in five USBAC and one in three AA males compared to one in 15 FBAC males were obese. Although more USBAC and AA males smoked cigarettes and drank alcohol than FBAC, the differences were low. Among the female ethnic groups, only the AA smoked cigarettes.

Our study showed that the FBAC had better behaviors for preventing CHD compared to the US-born study group members. Health policy planners and health care providers in the United States should monitor the health status of immigrants, especially as the population of immigrants increases.

Source: Behavioral Risk Profiles for Coronary Heart Disease Among Apparently Healthy Individuals of African Ancestry

Errol E. Davis, PhD, CNS; Fatma G. Huffman, PhD, RD

WHAT WOMEN EXPERIENCING "THE CHANGE" SHOULD KNOW

As early as age 35, the ovaries of some women start to make less of the female hormone, estrogen. By age 47, most women make less estrogen, and will stop making it by age 52. This time of falling estrogen levels, called "the perimenopause" or "the change," causes most women to have various symptoms. Missed periods and hot flashes are the most common symptoms. However, one out of 10 women does not have any symptoms, and her periods stop without warning.

In America, record numbers of women are reaching age 40 each day, and the number among minority groups is growing. Researchers want to know how culture affects the foods, treatments, and other lifestyle choices women make during "the change." Their findings could help women stay healthy at this time and beyond.

In this study, researchers looked at how diet, body size, social standing, and health relate to race and culture during "the change" for 109 Black (Caribbean and African American) and White women in Florida. About one-third of the women had one or more of these symptoms: missed periods, heavy periods, low blood count (anemia), or depression. More White women than Black women had depression.

One-third of the women ate more food than is recommended for Americans, and seven out of 10 were too fat (overweight or obese). More Black women ate too much and were too fat. Also, the diets of more Caribbean women met the standards for fat, carbohydrate and fiber when compared to American women. Even though two-thirds of the women took vitamin and mineral supplements, one-third did not get enough iron, and two-thirds did not get enough calcium. However, more White women than Black women got enough calcium. More than half of the women said that they made "healthy" changes to their diets over the past 10 years, such as drinking less whole milk and eating less red meat.

In summary, the study is important to public health. It found that too many women did not get enough calcium and iron; ate too much food; and were too fat. It also found that women from each culture ate different foods. Not getting enough iron and calcium could further increase a woman's chances of developing osteoporosis (brittle bones) and anemia. This is so because changes in a woman's body during "the change" could cause bones to lose calcium and become brittle. Also, eating too much food could cause obesity, which is a national public health problem, especially for women in this age group.

This study highlights a need, during "the change," for nutrition programs that teach women about serving sizes of foods, and how to plan healthy meals from ethnic foods. Women should also learn how to cut down on the amount of fat in ethnic dishes without really changing the taste, looks, texture, and main ingredients by, for example, using low-fat milk to replace whole milk.

Source: Associations of Nationality and Race with Nutritional Status During Perimenopause: Implications for Public Health Practice

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