Is Watching TV Linked to Overweight Children in South Carolina?

In this study of 4-year-old children in Head Start schools in South Carolina, researchers wanted to find out if watching TV could be linked with being overweight. Most of the children in the study were African-American.

The parents were asked to complete a questionnaire on their child’s TV viewing habits. The height and weight of the children were measured at the school. A special measure, known as the body mass index (BMI), was found by using these two measurements. Each child’s BMI was then compared to national averages for children of the same age.

Nearly all parents reported that their children watched TV during the week and on the weekend days. The average BMI was 16.9; and the range was from 13.2 to 28.0. Nearly one out of every four children was overweight.

As BMI increased, TV-viewing time also increased. Also, few overweight children watched less than 2 hours of TV a day. In contrast, nearly half of the children who were not overweight watched less than 2 hours of TV a day.

Hours spent watching TV means time sitting still instead of being active. And, it means exposure to food ads that may promote extra snacking. Research has shown that more TV watching is associated with higher intake of fats and sweets.


drivers and patients are products of a social and cultural system

differences may be linked to these differences.

For example, one study recorded a doctor with a patient complaining of chest pain. In the study, the race and sex of the patient were changed to see if the doctor had different treatment recommendations. The results showed that men were more often given cardiac diagnostic testing than women and Whites were more often given the testing than African Americans. This study showed that the doctor took into account the race and sex of the patient before making a decision. Both doctors and patients are products of a social and cultural system that has shaped (based on who they are) their beliefs, attitudes, and expectations.

The findings of this study are important because African Americans have higher rates of heart disease than Whites and die from heart disease more often than Whites. If doctors do not refer African Americans for testing, harmful results are likely to occur.

Other reasons for differences in treatment may be differences in the way people communicate and differences in attitudes about African Americans. Institutional racism, or discrimination that has become part of the economy, the medical profession, or other parts of society, may affect treatment. For example, as late as the 1950s, some doctors and researchers believed that heart attack and the presence of chest pain were rare among African Americans. Even today, a recent survey from Harvard University reports that a majority of both Hispanic and African-American medical students believe that, compared to Whites, minority patients will not get medical advice or treatment because of they do not trust doctors.

To correct these problems, Congress is funding a program called the “Initiative to Eliminate Racial and Ethnic Disparities in Health.” Through education and public awareness, the initiative expects to improve the doctor-patient relationship, to promote extra snacking. Research has shown that more TV watching is associated with higher intake of fats and sweets.
FOR THE PATIENT

improve patient trust in the medical system, empower patients, and ultimately improve health care for all Americans by 2010.

Source: Racial Disparities in Coronary Heart Disease: A Sociological View of the Medical Literature on Physician Bias

HIV/AIDS Education: It Works But We Need More of It

As an African-American woman and an obstetrician/gynecologist, this researcher is personally and professionally interested in the health of women of color. Turning her interest into a research study, Elizabeth Bonney, MD and fellow researchers tell of their results of an HIV/AIDS study in this article.

Here in the United States, HIV/AIDS is one disease that threatens the health of many of our nation’s women. Those who keep track of information about HIV say that the group of people with the most new infections every year is African-American women. Although we have made important progress in identifying and treating HIV/AIDS, many women cannot make use of this progress for one reason: they do not get tested for HIV.

Many health leaders want to find out: 1) how to get women to understand how behaviors, such as unprotected sex, put them at risk for HIV; and, 2) how to get women to accept testing. Most groups have focused on pregnant women. In this study, Dr. Bonney chose to work with non-pregnant, poor women of color who may not be connected with the healthcare system. This group was chosen because it is likely to have differences in health care for all kinds of social, political and economic reasons. In this study, the researchers wanted to see how we could get women to get tested for HIV again, even if they had been tested previously. Why? Because if a woman continues to be at risk for getting infected, she should continue to get tested.

We asked women questions in face-face interviews to find out what stopped them from getting tested and what would encourage them to get tested, even if they had been tested in the past. One hundred forty-three women (95.4% African American) participated in the study. Women said they would not get tested for HIV again if they still had the same partner since the last time they were tested or, if they had a negative test in the past year. We did not ask these women how they knew they could trust their partner. Unfortunately, many of the women said they would not get tested because they could not pay for it or because they could not handle a positive test result.

Women also pointed out some things that would be help them get testing. One thing was knowing that it was an important part of keeping themselves and their sexual partners healthy. They also said that the tests available now are reliable and safe, and that testing early increases the chance of staying healthy longer, even if their test was positive.

In summary, the good news is that much of the messages about HIV/AIDS and testing is reaching poor women of color. The bad news is that there may be much more to do. Studies such as this may help lead healthcare givers by showing the importance of education to break down barriers and to offer ongoing support to encourage women to get tested for HIV and stay healthy.

Source: Repeat HIV Testing Among Low-Income Minority Women: A Descriptive Analysis of Factors Influencing Decisional Balance
Elizabeth A. Bonney, MD, Richard Crosby, PhD, Lydia Odenat, BS

Is Race Linked to Health and Food Choices?

Most people in the United States understand that eating the right amount of fruits and vegetables could reduce their risks for cardiovascular- and cancer-related deaths, the two leading causes of death in the country. Even though individuals seem to understand that diet could help a person live a longer, more healthy life, less than one-half of the population in the United States eats the recommended five fruit or vegetable servings a day. Researchers of this study wanted to find out why people don’t do what they know is best for them.

Recent research has looked at how life and social experiences may be linked to food choice beliefs and behavior. As an example, the choice to make sure that a meat dish is served daily may be linked to that fact that at an earlier point in life, meat was not affordable. In this case, social history and experience act with personal beliefs in choosing food dishes. The research reported in this article shows how race-related experiences, in particular experiences of race discrimination, may be one of the ways that our social context can point to when personal beliefs will predict behavior.

The central idea of the study was that race discrimination may affect one’s choice to eat a healthy diet even if a person believes a healthy diet is important. Telephone surveys were conducted with 308 Washington DC residents. The survey showed that those who reported race discrimination were less
likely to follow a healthy diet (for example eating vegetables daily) than those who did not report discrimination.

Based on their study, the researcher recommend: 1) the creation of programs that encourage buying healthy foods (for example, church sponsorship of a four-week competition for buying dark green leafy vegetables); and 2) using respected community leaders to serve as role models for eating well. The authors recommend that promotional programs should show that an individual can take control of his or her life by making healthy food choices.

Source: Perceived Race Discrimination Moderates Dietary Beliefs’ Effects on Dietary Intake
Ron Carmichael Manuel, PhD

RUSSIAN-SPEAKING IMMIGRANTS ARE AT HIGH RISK FOR DIABETES

Immigrants from the former Soviet Republics, such as Georgia, Russia, and Ukraine, are a growing part of foreign-born populations in the United States. They are often identified as “Russians,” because they are fluent in the Russian language. These Russian-speaking immigrants are alike in other ways: they tend to be older, live in cities, and many receive public assistance, as many have entered this country as refugees. The researchers thought that the risk of diabetes among Russian-speaking immigrants could be high because there have been reports that obesity and heart disease, two major conditions closely related to diabetes, are common in this population.

The study authors reviewed data from a community-based adult diabetes prevention program offered across New York state. Using self-reported place of birth, languages used at home, and age, 1,008 Russian-speaking immigrants aged 40 years and older were identified. Nearly all of the study group members lived in New York City. More than half had at least some college education and almost 85% had Medicaid coverage.

The researchers collected information on each person’s health behaviors, medical conditions, and body measurements. In the group, almost 17% had diabetes. Among the women, nearly 19% had diabetes compared to only 14% of the men. Women also had a higher rate of being overweight: 71% of the women were overweight, compared to only 33.2% of the men. In addition, women were more likely to be obese (42.3%) compared to men (20.8%). For high blood pressure, men had a higher rate (70%) compared to women (54%). These rates were among the highest in the state. The study also found that among the Russian-speaking immigrants, women, those who lived in a city, those with less than high school of education, and Medicaid recipients were more likely to be at risk of diabetes.

To address these problems, the authors suggest community-based programs to develop healthy lifestyles and to increase knowledge of diabetes. Increasing the number of Russian-speaking healthcare providers, providing training in Russian culture and customs to healthcare staff, and developing diets that allow for Russian food preferences are also needed to improve the health of this population.

Source: Diabetes and its Related Risk Factors Among Russian-Speaking Immigrants in New York State
Akiko S. Hailer, PhD; Thomas A. Melnik, DrPH; Maureen M. Spence, MS, RD

DOES A JAPANESE LIFESTYLE PROTECT AGAINST CANCER?

Our study compared the types and rates of cancer among Japanese migrants to Hawaii, Japanese in Japan, and Whites in Hawaii during 1960–1997. The cancer registries in Hawaii and in Miyagi, Japan have collected data for this time period. This study reviewed information on 5 common cancers: stomach, colon, prostate, breast, and lung cancer and also Hodgkin’s disease, Non-Hodgkin’s lymphoma, and cancers of the esophagus, pancreas, liver, uterine cervix, uterine corpus, and ovary.

Among the 5 more common cancers, the link between having migrated to Hawaii and cancer rates was strongest for colon and stomach cancer. Prostate and breast cancers were affected to a lesser degree, and lung cancer risk was not very different between Japanese in Japan and Hawaii. Migration led to lower rates of stomach, esophageal, pancreatic, liver, and cervical cancer, but to higher risks for all other cancers.

Scientists believe that stomach cancer rates are lower among Japanese in Hawaii because they eat less salt and more fruits and vegetables. Starting with the first generation of migrants to Hawaii, Japanese developed colon cancer at similar or higher rates than Whites. Possible causes include eating more food than needed, little exercise, and eating a lot of meat. Even though Japanese men in Hawaii reported smoking a lot, lung cancer was considerably lower than in Whites. Scientists think this difference may be explained by genetics.

For prostate and breast cancer, a gradual increase in incidence has been found among Japanese in Hawaii. More recently, breast cancer among Japanese women in Hawaii has reached the risk of Whites and is also rising in Japan. Prostate cancer in Japan has changed very slowly, whereas it has increased among Japanese in Hawaii, probably as a result of

Source: Proposed Chemoprevention Strategies for Immigrant Minority Populations
Alexandra T. Adami, MD; Susan P. Prentice, MD, PhD; Andrew J. Nortman, MD; Lisa M. Rates, PhD; Håkan Bergström, MD; Per Aronson, MD; Jack C. Westerlund, MD; Kenneth W. Pelletier, PhD; John M. D. Claxton, PhD; Robert R. Muñoz, PhD; Margaret S. Kubo, PhD; Cynthia Y. Lin, MD; T. S. A. Hailer, PhD; O. A. Melnik, DrPH; J. Han, PhD; K. M. Spence, MS, RD
screening and early detection efforts. The decline in esophageal cancer was the most striking and has been associated with reduced alcohol intake. For women, the dramatic increase in endometrial cancer is probably due to higher body weight and energy intake in addition to the use of estrogen-alone therapy to treat menopausal symptoms.

As Japanese migrants adopt more of a Western lifestyle, it is very likely that there will not be much difference in cancer risk between migrants and Whites. Studies that include different generations of migrants could help to identify protective factors that were part of a traditional Japanese lifestyle.

Source: The Effect of Migration on Cancer Incidence Among Japanese in Hawaii
Gertraud Maskarinec, MD, PhD; Jihae J. Noh, MPH

Scientists are interested in finding out why ongoing disease strikes some ethnic groups and not others. They know that some factors such as cholesterol levels and blood pressure differ between ethnic groups, but more needs to be known about differences in lifestyle choices and how they affect disease. This study reviews the lifestyle habits of children, aged 9–12 years, of ethnic groups living in low-income neighborhoods in Montreal, Canada.

Perhaps the most important finding is the high levels of smoking, physical inactivity, TV viewing and video game playing, unhealthy eating habits, and obesity among these young children, regardless of ethnicity. Overall, one in four children watched 6 or more TV programs per day, one in five had tried smoking, nearly 22% said they did not exercise, and more than 7% were obese.

These disturbing facts may forecast that, unless prevention efforts are conducted, heart disease, diabetes, and lifestyle-related cancers will continue to be a threat on North American society.

In this study, the authors found several facts that might point to areas for prevention programming. First, smoking rates were highest among European, Canadian, and South American children. Obesity was high among Salvadorian, Haitian, Italian and Portuguese children. These children also reported high rates of physical inactivity, TV viewing, eating junk food, and low rates of eating healthy food. Asian children, as found in other studies, tended to be inactive and to have high levels of TV viewing, but the obesity rate was low.

It is often believed that people who move to North America have healthier behaviors than those born in North America. However, except for smoking, Canadian children in this study reported healthy behaviors more often than children of other ethnic groups. This unexpected finding could show that the process of being accepted by a new society involves adoption of culturally dominant behaviors such as TV viewing, playing video games, and consuming junk food.

The proportion of children with two or more lifestyle risk factors was highest among children of Haitian, Portuguese, Other Central American/Caribbean, and Cambodian family origins. Having more than one lifestyle risk factor is of concern because new research shows that having several risk factors is linked with an increased risk of chronic disease.

Lifestyle habits are formed in childhood and influence health for years to come. They are linked with short- and long-term health. They can be changed by prevention approaches. Because of these facts, the information from this study should be a call to action to public health workers.

Source: Lifestyle Risk Factors for Chronic Disease by Family Origin Among Children in Multiethnic, Low-income, Urban Neighborhoods
Jennifer O’Loughlin, PhD; Gilles Paradis, MD, MSc; Garbis Meshefedjian, MSc; Ayelet Eppel, BSc; Slimane Belbraouet, PhD; Katherine Gray-Donald, PhD

Since the 1970s, the number of overweight and obese adults in the United States has grown at a steady pace. Indeed, by the year 2000, the majority of US adults were either overweight or obese. Researchers in this area are generally concerned with two related issues: 1) what causes obesity?; and 2) what does obesity cause? This second question is important because overweight or obese individuals have more health problems than someone of normal weight. For example, obesity increases the chance of having high blood pressure, heart disease, diabetes, and even certain types of cancer. Overweight or obese individuals will likely live a good portion of their lives with health complications.

The first question often receives less attention among both scientists. There are many reasons a person may be overweight or obese. For example, lack of exercise, poor diet, and biological factors (genetics, disorders of the endocrine system) play a part in whether a person is, or becomes, overweight or obese. Detailed information on overweight and obesity, including definitions and methods to determine if you are overweight or obese, is available at www.cdc.gov/nccdphp/dnpa/obesity/.
This article by Denney and researchers identifies racial, ethnic, and sex differences in the rates of overweight and obese US adults. For example, 55% of non-Hispanic Whites and more than 75% of Native Americans are overweight or obese compared to only 32% of Asian Americans. Moreover, there are important sex differences in these percentages for the racial and ethnic groups. Among Mexican Americans and non-Hispanic Blacks, more females than males are obese. Specifically, more than 15% of non-Hispanic Black females are extremely obese, compared to only 6% of non-Hispanic Black males. Knowing about these differences in overweight and obesity by race and sex is important because the causes and effects of overweight and obesity may be different across these groups.

In order to understand and effectively fight rising rates of obesity, there must be correct information on who is obese. Education about the dangers of being overweight or obese and methods for losing weight are effective preventative tools for males and females of all races and ethnicities. The authors encourage individuals to see a nutritionist or doctor, identify if overweight or obese, and take steps toward living a healthy and longer life. Indeed, overweight and obesity can be controlled by undertaking regular exercise and eating a healthy diet, thus preventing ill health and shortened life.

Source: Race/Ethnic and Sex Differentials in Body Mass Among US Adults
Justin T. Denney, MA; Patrick M. Krueger; Richard G. Rogers, PhD; Jason D. Boardman, PhD