

FOR THE PATIENT

VIEWS ON US HEALTH CARE BY IMMIGRANT WOMEN IN MICHIGAN

Primary care doctors often treat patients with different cultural backgrounds and who have come from other countries. The immigrant population in the United States continues to grow and, in March 2003, there were 33.5 million people who were born in other countries (foreign-born) but were now living in the United States. Living conditions, income levels, and jobs deeply affect immigrant women at both family and individual levels and it is important for doctors to understand these conditions in order to provide the best patient-centered care.

We conducted a survey to find out how women in Hamtramck, Michigan felt about

health care. We asked women patients age 18 years of age and older to answer questions about how they received health care and how satisfied they were with the healthcare system in the United States.

One hundred fifty-six women patients participated. Sixty-seven (43%) were immigrants from three ethnic groups: Bangladeshi (61%), Yemeni (19%) and Bosnian (13%). Most of the women in the study had been in the United States for eight years. Foreign-born women born more often reported a household income of less than \$15,000 compared to US-born women. Although they had the same rates of health insurance, for-

foreign-born women were more likely to receive Medicaid than US-born women.

Foreign-born women were more satisfied with the US healthcare system, were more likely to visit their doctor when feeling sick, and more likely to bring a friend or relative to help talk with the doctor than the US-born women. Compared to the US-born women, more foreign-born women said they would like to have a female doctor, and especially a doctor who was from the same cultural background. When asked if health care in the United States was different from what they received in their home country, 54% said yes, with comments

such as: "There is better technology, more doctors and more research in the United States."

In conclusion, our study suggests the need for doctors to be culturally sensitive to the needs of foreign-born women patients. A patient-centered approach is needed in which the doctor treats each patient as an individual, understands each patient's own background, and is able to talk with the patient easily.

Source: Healthcare Attitudes and Behaviors of Immigrant and US-Born Women in Hamtramck, Michigan: A MetroNet Study

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UNDERSTANDING HOW LIFESTYLE CHOICES AFFECT CHRONIC DISEASE IN MONTREAL

Cancer, cardiovascular disease, and stroke vary among persons from different ethnic backgrounds. It is thought that lifestyle behaviors, such as smoking, obesity, physical inactivity and poor diet, might explain these differences, at least in part. In this study, we looked at lifestyle risk factors for chronic disease among adults of differing ethnicity.

We studied a total of 2033 adults whose average age was

40 years. Most were first-generation immigrants and all lived in low-income neighborhoods in Montreal, Canada. Each adult answered questions on their height, weight, lifestyle behaviors and other characteristics. Based on their answers, we found out which groups reported unhealthy behaviors most often and which groups reported these same behaviors least often.

The prevalence of smoking and poor diet was highest among

people of French Canadian background. Although physical inactivity was high across ethnic groups, it was highest among participants of Portuguese, Italian and Haitian family origin. Obesity was highest among Europeans. The prevalence of smoking was lowest among Haitians; poor diet was lowest among South Asians; and physical inactivity was lowest among East Europeans. Obesity was lowest among Asians, with the excep-

tion that more than half the South Asians were overweight or obese. Compared to French Canadians, adults from all other backgrounds were less likely to have two or more lifestyle risk factors.

This current description of risk factors across ethnic groups helps scientists find out which groups are more at risk of certain diseases. Although we know that groups, such as South Asians, are more likely to have chronic

disease, this study showed that other groups, including Haitians, Middle East/North Africans and Italians, may need

healthcare programs, too. Prevention programs should take these differences by ethnicity into account.

Lifestyle Risk Factors for Chronic Disease across Family Origin among Adults in Multiethnic, Low-income, Urban Neighborhoods

Jennifer O'Loughlin, PhD; Katerina Maximova, MA; Ye Tan, PhD; Katherine Gray-Donald, PhD

SPIRITUAL PROGRAM PROVEN TO REDUCE HIGH BLOOD PRESSURE

This article describes a study of 23 primarily Asian, Hawaiian and Other Pacific Islander adults with high blood pressure (hypertension or prehypertension) who attended an intervention class on *Self Identity through Ho'oponopono*. This was a first-time study to find out if high blood pressure would improve after a patient learned the process known as *Self Identity through Ho'oponopono* and added it to his or her regular blood pressure treatment.

This process is an approach to develop a better working relationship among the conscious, subconscious, and superconscious minds (representing the mind, body, spirit) allowing individuals to understand themselves better. For this study, we wanted to find out if, when the mind, body and spirit work together, the individual would release sources of stress, tension, and conflicts that may affect health and thus improve blood pressure control.

In our study, participants attended a class, which included a series of lectures, discussions, problem-solving interactions, sharing of processes or tools, and question and answer periods as teaching methods. Participants were taught simple processes such as breathing exercises, prayers, and meditation. Two months following the class, the participants' blood pressure was reduced. The results suggest that this program may work to control blood pressure control.

The process of *Self Identity through Ho'oponopono* can be easily scheduled into one's life. It is low-cost, readily accessible and carries no known risks. This program may also help people with other health conditions.

Source: Self Identity Through Ho'oponopono as Adjunctive Therapy for Hypertension Management

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OBESITY, URIC ACID, AND HIGH BLOOD PRESSURE

Because many Black people suffer from high blood pressure, we wanted to find out how uric acid was connected with high blood pressure among Blacks. We recruited 217 Black and White women from South Africa. We measured their uric acid levels, blood pressure levels, and took their weight, height and waist measurements.

We found that the Black women had higher blood pres-

sure levels compared to the White women. At the same time, their uric acid levels were lower than that of the White women. We conclude that Black women in this study were more sensitive to changes in uric acid levels than the White women.

To make things even worse, uric acid levels affect blood pressure even more when the person has more body fat, especially around the waist. This

excess body fat is known as obesity, which is a major health problem around the world. According to the World Health Organization (<http://www.who.int/mediacentre/factsheets/fs311/en/index.html>), at least 400 million adults are obese. They also predict that by 2015 approximately 700 million adults will be obese. That is a lot of unhealthy people!

Knowing that uric acid levels have a great impact on blood

pressure in Black women helps doctors understand ways to control blood pressure.

A Comparison of Uric Acid Levels in Black African vs Caucasian Women from South Africa: the POWIRS Study

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HOW HEALTH DISABILITIES AFFECT AMERICAN INDIANS AND ALASKA NATIVES

Older American Indians and Alaska Natives (AIANs) are more likely to have disabilities compared to all other major racial/ethnic groups in the United States. They are also more likely to become disabled at an earlier age. In contrast to other racial/ethnic groups where women are more likely to have disabilities than men, there is no difference among AIANs by sex. Furthermore, older AIANs are more likely to die from injuries and chronic conditions than most other racial/ethnic populations in the United States. On the average, AIANs have live nearly five years less than the rest of the US population.

In this study, we used data from the 2003–2005 Behavioral Risk Factor Surveillance System

to estimate and compare disabilities, health-risk behaviors, obesity, and long-term conditions among older AIANs with that of other racial/ethnic groups including Whites, Blacks, Asians, and Hispanics. Of the more than 435,000 adults aged 50 years or older who were surveyed, 29.7% reported disabilities, including:

- 17.9% said their activities were limited because of a physical, mental, or emotional problem
- 3.1% reported using special equipment because of their disability (for example, cane, wheelchair, special bed, special telephone)
- 8.8% said their activities were both limited and that they used special equipment.

We found that more AIANs in the study reported disabilities than any other ethnic group. Also, both AIANs and Blacks reported limited activity and use of special equipment more than other ethnic groups.

Older AIANs with disabilities were younger than those in other racial/ethnic groups and were equally as likely to be male as female. Of the health-risk behaviors and chronic conditions examined, AIAN men and women with disabilities more often reported smoking, heart disease, and asthma compared to other groups. On the other hand, Blacks were more likely to have high blood pressure than AIANs. Compared to older men with disabilities in other ethnic groups, AIANs more often reported heavy and binge drinking, not consum-

ing fruits/vegetables 5+ times/day, obesity, and arthritis. Among older women with disabilities, AIANs and Blacks reported stroke most often.

Our findings should assist health agencies, tribes, and AIANs with disabilities in planning prevention efforts that begin early in life, are culturally sensitive, and that target racial/ethnic disparities in health-risk factors and chronic conditions.

Source: Disability Among Older American Indians and Alaska Natives: Disparities in Prevalence, Health-Risk Behaviors, Obesity, and Chronic Conditions

Catherine A. Okoro, MS; Clark H. Denny, PhD; Lisa C. McGuire, PhD; Lina S. Balluz, ScD; R. Turner Goins, PhD; Ali H. Mokdad, PhD

STROKE SURVIVORS: REDUCE RISK OF HEART DISEASE BY WALKING AND TREADMILL EXERCISE

In our study, we wanted to find out if Black and White stroke survivors had different levels of physical fitness and walking ability after stroke. To do this, we evaluated fitness by measuring the amount of oxygen used by the body while walking on a treadmill. We also evaluated walking ability by measuring the total distance walked in six minutes.

The results showed that the Black and White stroke survivors have the same fitness level and walk the same distance at similar speed. These results are different from other studies that suggest Black stroke survivors are more disabled than Whites. We believe our difference may be due to the fact that we used physical activity measurements while oth-

er studies used reports from the patients.

Other studies in our laboratories show that treadmill exercise training improves fitness levels and walking ability for months to years after stroke in both Black and White older stroke survivors. These activities may help lower the risk of heart disease, repeat stroke and even

more disability in stroke survivors.

Source: Reduced Cardiovascular Fitness and Ambulatory Function in Black and White Stroke Survivors

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EXERCISE CAN IMPROVE YOUR HEALTH

Patients who visit their regular doctor often do not exercise enough and have health problems that would improve if they did. Health professionals interested in helping patients exercise more need to understand things that affect how much a person exercises.

Because of this, we studied a group of patients during their visit to the doctor. We measured the factors linked with exercise in this group. We also compared whether these factors differed for African American when compared with Caucasian patients.

Almost 400 patients were interviewed about how much exercise they did over the past

year. Exercise done at work or as part of household chores was not studied. The interview also asked about things that might influence a patient's decision to exercise. We asked questions about how sure a person was that they could exercise when faced with barriers and how sure that they could carry out specific activities such as running or climbing stairs. Patients were also asked if they thought exercise would benefit them or if they thought they faced a lot of barriers to exercise.

Information about the patient's age, race, income, body weight, and arthritis was also collected. If a person felt surer that they could carry out exer-

cise, they exercised more. This was true for both Caucasian and African American patients. Feeling that exercise was beneficial was not related to more or less exercise. This may be because patients, as a group, already knew a lot about the benefits of exercise. We found that older patients who were African American were less likely to exercise, while overweight or obese patients who were Caucasian were less likely to exercise.

Our study suggests ways to help patients exercise more. Less time should be spent on teaching about exercise benefits. Instead, raising a patient's belief in their physical ability to exercise is important. This could be done

by starting with low-intensity, limited-time exercise programs. Exercise intensity and time spent exercising could be slowly increased over time. Having an exercise specialist, physician, or nurse provide advice may also help. When helping patients exercise more, extra effort should be made to address the special needs of African American patients who are older or are obese.

Source: Racial Differences in Physical Activity Associations among Primary Care Patients

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BLACK WOMEN WITH PREECLAMPSIA/ECLAMPSIA STAY LONGER IN FLORIDA HOSPITALS THAN WHITE WOMEN DO

For women who are pregnant, preeclampsia and eclampsia are disorders that involve high blood pressure, the presence of protein in the urine, and swelling. Between 6% to 8% of all pregnant women are diagnosed with preeclampsia.

In our study, we examined the hospital records of 5495 women who were treated for

preeclampsia or eclampsia in hospitals throughout Florida during 2001. About 8% of the patients in our study had diabetes. The maternal age ranged from 12 years to 50 years. Mothers in the youngest and oldest age groups, regardless of their race, were at the highest risk of developing preeclampsia or eclampsia. Less than half of

the 5495 patients had commercial health insurance.

We were interested in knowing how long these patients stayed in the hospital. After accounting for the patient's age and other factors, we found that Black women were 20% more likely than White women to stay in the hospital longer (more than five days). Women who had severe pre-

eclampsia were more than twice as likely as women who had mild or unspecified preeclampsia to stay longer in the hospital.

Source: Descriptive and Clinical Epidemiology of Preeclampsia and Eclampsia in Florida

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DIABETES-RELATED DEATHS IN LAGOS, NIGERIA

Diabetes is a disorder that brings much suffering to individuals around the world but is especially difficult for people in developing countries where health services are not good. Unfortunately, infectious diseases are the priority areas in most developing countries, leaving prevention and treatment resources for diabetes very limited.

In our report, we discuss the current status of patients treated for diabetes in hospitals in Lagos, Nigeria.

We wanted to examine reasons for deaths linked to di-

abetes and to find out how long diabetes patients stayed in the hospital. This study took place during January –December 2006 in the Lagos State University Teaching Hospital in Lagos, Nigeria. This hospital has three medical wards, two for males and one for females with 38 beds for males and 25 beds for females. Patients in these wards were 12 years of age and older. For our study, we looked closely at records of patients admitted to the hospital with diabetes.

A total of 1,327 patients were admitted to the medical wards

during the study time and 11% of all the admissions resulted in deaths. Of the total patients admitted, 206 (15%) came to the hospital with diabetes. Thirty-three (or 16%) of the patients with diabetes died while in the hospital. The most common reasons for being admitted with diabetes were poorly controlled diabetes (88 patients or 40% of all diabetes patients) and high blood pressure (44 patients or 21%). The most common causes of death were poorly controlled diabetes (hyperglycemia) for 15 patients, diabetes foot ulcers for 10 patients.

Twenty-five percent of diabetes patients died from stroke. Patients with diabetes foot ulcers stayed in the hospital longer than those with other complications. They stayed between 15 to 122 days.

We concluded that diabetes foot ulcers, hyperglycemia, and stroke are some of the factors that may lead to deaths in diabetic patients in the hospital.

Source: Prognostic Indices of Diabetes Mortality

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