

RURAL AFRICAN AMERICANS' DIETARY KNOWLEDGE, PERCEPTIONS, AND BEHAVIOR IN RELATION TO CARDIOVASCULAR DISEASE

Objectives: To determine the relationship of demographics to opinions and knowledge of cardiovascular disease, hypertension, obesity, and dietary intake and to evaluate the relationship of dietary knowledge and dietary behaviors in rural African American adults.

Methods: The cross-sectional study involved a sample of participants who attended one of three cardiovascular information seminars in rural Macon County, Alabama. A total of 127 African American men and women, aged 21–75 years, completed a self-administered 79-item questionnaire. Data analysis included Chi-square and Fisher's exact tests.

Outcome Measures: Agreement or disagreement with current scientific opinion regarding coronary heart disease, obesity, and dietary intake; agreement with statements of personal knowledge of heart disease, hypertension, and dietary intake; assessment and beliefs about the health risks associated with overweight/obesity; and congruence between dietary knowledge and dietary practices.

Results: Women and older respondents tended to agree more with current scientific knowledge about heart disease mortality than did men and younger respondents. Younger respondents reported knowledge but less personal concern about fat intake/heart disease and salt intake/hypertension associations than did other age groups. Participants generally believed that excess weight increased the risk of high blood pressure, diabetes, heart disease, and cancer "a lot." Knowledge of the salt content of processed foods was associated with decreased frequency of adding salt at the table, while those not concerned about salt consumption and hypertension were more likely to add salt and consume processed meats. Respondents with knowledge of the effects of fat intake on heart disease were more likely to consume low-fat dairy products.

Conclusions: The findings suggest that sex and age, in particular, require consideration in the development of community cardiovascular disease intervention programs aimed at southern, rural African American adults. (*Ethn Dis.* 2008;18:6–12)

Key Words: African American, Dietary Knowledge, Perceptions, Beliefs, Behavior, Cardiovascular Disease

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INTRODUCTION

CVD is a major health problem especially in the African American community in the rural Black Belt counties of Alabama. In Macon and Bullock Counties (contiguous Black Belt counties), for example, the death rate from CVD in 2005 was 561 per 100,000 and 461 per 100,000, respectively. These rates exceeded the state and national averages.¹ CVD prevalence in Macon and Bullock Counties is compounded by a high prevalence of many other CVD risk factors, such as high blood pressure and overweight/obesity. These statistics show the need for educational interventions in these communities.

Generally, low socioeconomic status, coupled with rural residency, contributes to greater disparities in nutritional adequacy and overall health. Often, knowledge of heart healthy diets, perception of the quality of one's diet, and actual dietary behavior and quality do not always agree. Assessing one's nutritional knowledge, food selection, and eating behavior are tools used to develop nutrition intervention programs. The gap is often wide between one's perceptions, opinions, and knowl-

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edge about CVD (and other chronic diseases) and actual dietary practices.^{2–6} Data on knowledge, perceptions, and behavior regarding CVD and obesity among African Americans are limited. Therefore, to inform community interventions aimed at reducing CVD risk in this population, the purpose of this study was to determine the relationship of demographics to opinions and knowledge of CVD, hypertension, obesity, and dietary intake and to evaluate the relationship of dietary knowledge and dietary behaviors in rural African American adults.

METHODS

Setting and Sample

All eligibility criteria were self-reported. Participants had to be African Americans 21–75 years of age with a history of high blood pressure or high cholesterol. Participants had to report an interest in health and nutrition education programs and generally good health. Persons who were current smokers or who drank alcohol were excluded. These groups (smokers and drinkers) were excluded because their behavior may have overtly influenced their food choices. The taste perceptions of these groups may have been impaired.^{7–8} A total of 127 participants were recruited