



Harvard Journal of African American Public Policy

Health and the Black Community

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Again, we hope you will join the Harvard Journal of African American Public Policy in the fall.

Sincerely,

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Harvard Journal of African American Public Policy

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Editor's Remarks

Kendra Proctor
Ebony Bridwell-Mitchell

At the edge of the millenium, black communities have a unique opportunity to set the agenda of public policy priorities for the next generation. Health policy must be included in these priorities. The current inequalities in the health status of African Americans are a frightening testimony to a legacy of injustice. According to the Department of Health and Human Services, infant mortality rates are 2-1/2 times higher for African Americans than for whites. The rates of prostate cancer and heart disease among black males are nearly twice that of white males and Blacks continue to suffer from diabetes at a 70 percent higher rate than whites.

This past February, President Clinton announced that the legacy of the President's Initiative on Race will be the elimination of longstanding disparities in health status that affect racial and ethnic minority groups. We commend the Administration for breaking the silence and highlighting the importance of minority health. We must go further to build comprehensive health strategies for African Americans and many other communities who face similar health disparities.

In light of this national recognition of the glaring need for action, the *Harvard Journal of African American Public Policy* (HJAAPP) offers the following articles on the topic of health and the black community. As is the fundamental mission of HJAAPP, this journal will contribute to the formulation of public policy, in this case health policy, augmenting the national debate and thereby creating meaningful improvements to the lives of black people. The articles in this issue explore a wide range of health concerns including those that have often been ignored in mainstream health policy. This issue addresses questions such as: What is the relationship between race and appropriate mental health diagnoses? How can alternative strategies to communication and relationship building improve the health awareness of black males? If barriers to access continue to plague black communities, what are the current innovations in health care provision? In sum, our authors not only develop a portrait of the diversity of African American health epidemics, problems and strategies, but also offer solutions.

In this issue, author Sharon Parsons argues that in the field of mental health, the diagnoses of psychiatrists and clinical psychologists are replete with stereotyping and racialized decision-making, the result of which is the mistreatment and over-treatment of many Blacks.

Yvonne Bronner, Johns Hopkins University, explores the policy implications of the diet and lifestyle practices of African American males. In a comprehensive study, Bronner finds that black males are suffering from poor health outcomes. She offers several public policy solutions ranging from the development of black male specific diet and lifestyle information to mandating awareness programming in the health care system to the crisis facing African American males.

Following the theme of black male health, Deborah A. Wilcox of Confluency Consultants offers a unique mechanism for engaging African American males in the difficult topics of health care and self-assessment. The overwhelmingly negative indicators of black male health support Wilcox's claim that new and creative techniques must be adopted if we are to increase health awareness among black males. Utilizing a concept known as the study circle, she suggests that black men, young and old, create new knowledge through generative learning about critical health and life style issues.

For some members of the black community, a lack of access to health care is a result of cultural and generational barriers. Claude-Alix Jacob, director of Community Affairs for the Sinai Community Institute in Chicago, explores the social-cultural issues which plague the utilization of health care by elderly Haitians.

Barriers to quality health care are revisited in Janet Rami's article. In response to identified community health needs, the Southern University School of Nursing developed a mobile service system utilizing the expertise of nursing students and faculty. Rami, Dean of the Southern University School of Nursing, discusses this program as a model for combating disparities resulting from geographic and cultural isolation that threatens the health status of many black communities in the Deep South.

Nora Osmene of Texas Southern University addresses the epidemic of HIV/AIDS in the black community. Citing behavior, apathy and lack of community mobilization as key impediments to curbing new and untreated cases among African Americans, Osmene challenges political and religious leaders to develop public policy action steps.

Lisa Benton, Masters Candidate at the Harvard School of Public Health, argues for a re-examination of how public policy makers tackle the problems of violence among African Americans. She offers a public health framework for detailing the problems of violence, particularly among our youth, and identifying community-based solutions that are supported through governmental initiatives and practices.

Too overlooked as an integral component of necessary health care, Betty Sutton provides a concise description of recent efforts toward improving access to dental care among Medicaid recipients in North Carolina. Her examination of the North Carolina Medicaid Dental Programs' policy development and implementation is a useful example for Medicaid dental programs throughout the country.

We close this year's issue with a thought-provoking discussion with renowned author and psychotherapist Julia A. Boyd on the largely ignored crisis of depression among black women. Harvard Masters of Public Administration student Hazel T. Edney speaks with Boyd in this candid and informative interview. Boyd's contribution to HJAAPP underscores the multifaceted nature of health in the black community.

Race and Mental Health Treatment

Sharon Parsons
Southern University

William Payne
Louisiana Office of Mental Health

Abstract

This study examined racial disparity in mental health treatment and the influence of the race of the psychiatrist on diagnosis. Using data from the Louisiana Office of Mental Health, the analysis demonstrated an association between the race of the client and diagnosis. However, the race of the psychiatrist, in this public mental health system, was relatively unimportant to diagnostic decisions. Last, the results indicated that the race of the client was related to the distribution of services. White clients received more services than comparable black clients, controlling for diagnosis.

The implications are relatively clear. First, the inequitable distribution of public resources, while expected, was still a disconcerting finding. Second, because the results of this study suggest that institutional bias exists in this system, it must be confronted at the institutional level. Culturally specific training for mental health clinicians and administrators is one strategy for addressing the problem. However, such recommendations will not work unless mental health systems are willing to conduct a self-examination and to stop unquestioningly following the diagnosis and treatment habits of the past.

Introduction

The Deep South, until recent times, was an open harbor for racial inequality. Although the "whites only" signs have disappeared in the last 40 years, there is good reason to suspect that white preference remains. The long standing practice of racial discrimination or using race as a factor in the distribution of public services would logically persist in institutions even after the elimination of legally sanctioned inequality. However, institutional prejudice is elusive and proving or disproving such suspicions is often very difficult. As a result, few studies have empirically tested racial differences or bias in the distribution of public resources.

Using state-wide data of clients served by the Louisiana Office of Mental Health, this study represents a remarkable opportunity to investigate racial differences in mental health treatment while controlling for income¹ in one Deep South state. This research is also significant because few previous studies have focused

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William Payne is the Director of Inpatient Services for the Louisiana Office of Mental Health. He received his undergraduate degree from Louisiana State University and his MPA from Southern University-Baton Rouge, Louisiana.

completely on the public sector, analyzing the race of the client and the race of the treating psychiatrist together (Hu et al., 1991).

As a primary objective, this research will determine if the race of either the client or the psychiatrist makes a difference in mental health treatment decisions.

- Does the race of the psychiatrist influence treatment decisions? Are black psychiatrists just as likely, as white psychiatrists, to over-diagnose schizophrenia among African Americans?
- Does the race of the client matter in treatment decisions? Is there an equitable distribution of mental health treatment between different racial groups?

Secondarily, this study examines mental health diagnoses, by race, for clients served by the Louisiana Office of Mental Health.

Prevalence of Mental Health Disorders and Factors Related to Diagnosis

It is estimated that the total prevalence rate for mental and addictive disorders is 28.1 percent for the adult American population (Kovner, 1995). The Epidemiologic Catchment Area program, sponsored by the National Institute for Mental Health, estimated that major depression or other affective disorders are found in approximately 4 to 7 percent of the population, and schizophrenia was reported for 0.6 to 1.2 percent of Americans (Williams & Torrens, 1988). Those with schizophrenia represent only 4.9 percent of the population with mental disorders. (Pickett & Hanlon, 1990).

Prevalence rates vary by gender, age and race. The most frequent diagnosis for men (aged 18 to 64) is alcohol abuse with severe cognitive impairment becoming the most prominent diagnosis for men over age 65. While phobias are the most common diagnosis reported for women, drug abuse is the second most prevalent problem for younger women and major depression is more often cited by women ages 25 to 44 (Williams & Torrens, 1988). African Americans are disproportionately diagnosed with schizophrenia and under-diagnosed with affective disorders (Jones & Gray, 1986). Blacks are 63 percent less likely to be diagnosed with depression and 35 percent less likely to report a substance-abuse problem (Medical Sciences Bulletin, 1994). Racial and gender disparities exist not only in diagnosis and treatment but in the use of mental health services, as well (Wade, 1993; Singer, 1977; Hamilton et al., 1995; Hu et al., 1991).

Schizophrenia is the most common admission diagnosis in public mental health facilities while affective disorder is the most common diagnosis in private psychiatric hospitals (Williams & Torrens, 1988). Public mental health facilities also serve a disproportionate number of African Americans. In Louisiana, African Americans comprise approximately 31 percent of the population but constitute over 50 percent of the persons served by the Louisiana Office of Mental Health. Nationally, minorities have a higher admission rate to state-operated inpatient services and are generally over-represented in state-operated mental health facilities (Snowden & Cheung, 1990; Hu et al., 1991). African Americans are more

likely to be admitted with a primary diagnosis of schizophrenia than are whites and less likely to be admitted for alcohol-related disorders (Pickett & Hanlon, 1990).

The over-representation of African Americans in the public mental health system is logically due to the over-representation of this group among those in poverty. The mission of the Louisiana Office of Mental Health is to serve the indigent, and African Americans represent approximately 60 percent of Louisianans living in poverty. While the over-representation of African Americans in the public system can be more easily rationalized, the prevalence statistics are more difficult to explain.

Why are African Americans disproportionately diagnosed with schizophrenia? Why do African Americans accessing psychiatric treatment have a significantly higher risk of being labeled schizophrenic than their white counterparts (Jones & Gray, 1986)? The answer lies, at least in part, in the fact that mental health treatment decisions may be influenced by a number of factors such as gender, ethnicity, and race (including both the race of the client and the race of the psychiatrist) that are subjective and independent of the presenting symptoms. Although Glass and Vergare (1994) note there have been marked improvements in the reliability of psychiatric diagnoses, Pickett and Hanlon (1990) consider psychological diagnosis to still be in a relatively primitive state. As a result, according to Pickett and Hanlon, there is little useful information about the prevalence of mental disorders by race or ethnic group.

We assume that institutional biases, in psychiatric education and/or in mental health systems, contribute to the disproportionate diagnosis. In fact, preconceptions about race may distort the psychiatric treatment process at every stage, including the criteria for patient acceptance, availability of facilities, form and length of therapy, the patient-therapist relationship, therapeutic goals, and judgment about outcomes (Thomas & Sillen, 1972). Such biases would be more evident in the diagnosis of schizophrenia because, of all diagnoses, it is the most likely to reflect political and social influences (Wade, 1993). The diagnosis of schizophrenia, in particular, may be indicative of society's negativism toward African Americans.²

Our assumption is based upon the current diagnostic practices and the criticism of these practices in the literature. African Americans are more often misdiagnosed than are white clients. Too frequently, African American patients showing symptoms of psychosis with mood changes are diagnosed as schizophrenic, without other diagnoses being considered. This results, in particular, in a consistent pattern of over-diagnosis of schizophrenia and an under-diagnosis of affective disorders among African Americans (Adebimpe, 1981).

Various studies have shown that African Americans have been misdiagnosed with schizophrenia rather than organic brain syndrome related to alcohol abuse (Bell, Thompson, & Lewis, 1985), or manic-depressive disorder (Bell & Mehta, 1979; Jones, Gray & Parson, 1981; Mukherjee, Sukla, & Woodle, 1983). One

study, which controlled for age, sex, and socioeconomic status, found that white patients were diagnosed more often as depressed and African Americans as schizophrenic, even though the clinical features of depression were similar for both samples (Raskin et al., 1975). Other research in the last two decades has found no evidence to support the claim that African Americans have manic-depressive illnesses less frequently than whites. In fact, some studies have reported higher rates of manic-depressive illnesses among African Americans and low income groups than among whites and higher income groups (see Jones & Gray, 1986).

Plainly, the research indicates that the diagnosis of African Americans is often racially prejudiced (Wade, 1993), statistically biased, and based upon stereotypes that Blacks rarely suffer from depression or bi-polar disorders and that such disorders are upper and middle-class illnesses (Jones & Gray, 1986). That may be because many psychiatrists do not regard the psyches of African Americans as being as complex as those of whites (Gardner, 1990; Spurlock, 1985); therefore, the same symptoms that would be labeled as schizophrenia among African Americans would be diagnosed as an emotional or affective disorder among whites (Solomon, 1992).

If institutional biases exist, we expect not only that black clients would be disproportionately diagnosed with schizophrenia but that white clients will receive more services, regardless of diagnosis. We base this hypothesis on the historic and entrenched habit of using race as a factor in the distribution of other public resources. If race could influence the distribution of roads, sewers and so forth in the South in last half of this century (see *Shaw v. Town Shaw* [MS] (1971) cited in Johnson, 1992; Walton, 1994), then logically other public services could be subject to racial considerations. A mental health system in the Deep South is certainly an appropriate place to test the hypothesis.

Further, if biases exist in institutions (psychiatric education or mental health systems), then we expect the race of the psychiatrist will not matter. *In other words, black psychiatrists will be just as likely, as white psychiatrists, to over-diagnose black clients with schizophrenia.* The literature on this subject is inconclusive. Some suggest that race does matter. For example, Pickett and Hanlon (1990) note that white professionals have difficulty in defining and identifying mental disorders in "people unlike themselves." Jones (1982) adds that white therapists, more so than black therapists, generally rate their black clients as more psychologically impaired.

On the other hand, Mukherjee, Shukla and Woodle (1983) report, in a study of misdiagnosis of schizophrenia in bipolar patients, that of the 18 misdiagnosed black patients, eight had at some time been treated by black psychiatrists. Similarly, Hispanic patients were not protected from misdiagnosis by having a Hispanic or Spanish speaking psychiatrist. This may be due to the fact that even when both patient and clinician come from similar cultural, social or ethnic backgrounds, the largely subjective matter of the data collected by the clinical impression could be a constant source of error. Further, most often black professionals, during their

training, are supervised by whites, and the majority of their patients are white. Thus, what is learned during the clinical training is from a white perspective (Adebimpe, 1981).

Methodology

Within this study, we utilize the Louisiana statewide data base allowing us to examine the entire adult mental health recipient population. Data were provided by the Louisiana Office of Mental Health Management Information System (MH/MIS) and the Louisiana Patient Information Program (PIP). Because of the limitations of the data, we confined our study to those consumers served by the MH/MIS community mental health centers and acute psychiatric units during the fiscal years 1994–95 and 1995–96. Due to the nature of this study, only African American and white consumers are specifically identified. Other ethnic groups have either been excluded from the study or are included in the 'Other' category.

Data Analysis

In this research, we first examine differences in diagnosis according to race of the consumer in the community system and inpatient admissions and then differences in diagnosis by race of psychiatrist (controlling for race of the consumer). Last, we analyze the effect race plays in length of stay in outpatient treatment, and quantity of outpatient services (controlling for diagnosis).

Diagnoses

Table 1 presents the breakdown by race of schizophrenia and major affective disorders for recipients of clinical services in the Louisiana Office of Mental Health during 1994–95. During this period, African Americans represented 50.3 percent of the total population served in the community system; however, they account for 63 percent of those diagnosed as schizophrenic and 37.7 percent of those diagnosed with a major affective disorder. On the other hand, whites, who comprise 49 percent of the population served in the community system, account for 36 percent of those diagnosed with schizophrenia and 61.5 percent of those diagnosed with a major affective disorder. As witnessed in the analysis, there is a significant correlation ($p < .0001$) between the race of the consumer and the diagnosis of the Louisiana mental health system. The race of the consumer appears to be linked to the diagnosis.

**Table 1. Louisiana Office of Mental Health
Diagnosis by Race (1994–1995)**

Diagnosis	African American	White	Other
Schizophrenia	35.06%	20.83%	28.47%
Major Affective	20.52	34.32	31.60
All Other	44.42	44.85	39.93
TOTAL	100% (n = 23,338)	100% (n = 22,707)	100% (n = 288)

$X^2 = 2,686.62$

df = 24

pr = .0000

(Other is a combination of 9 less severe diagnoses and undiagnosed cases.)

Inpatient Admissions

Prior research has found that, for inpatient admissions, the rate of diagnosis of schizophrenia was almost twice as great among African Americans as for whites; yet this pattern was almost exactly reversed in regard to major affective disorders. Our data (Table 2) is consistent with this earlier finding. We find that of the Louisiana Office of Mental Health acute psychiatric unit admissions for schizophrenia, 67.66 percent were African American, while only 31.46 percent were white. Conversely, of the admissions for major affective disorders, only 35.39 percent were African American, while 53.59 percent were white.

Table 2. Acute Psychiatric Unit Admission By Diagnosis (1994–95)

Diagnosis	African American	White	Other
Schizophrenia n = 1917	67.66%	31.46%	.88%
Major Affective Disorder n = 1198	35.39%	63.77%	.84%
All Other n = 1560	45.51%	53.59%	.90%

Race of the Psychiatrist

Previous research (Wade, 1993) has asserted that one possible cause of the racial disparity in diagnoses is the cultural differences between black patients and white psychiatrists. Adebimpe (1981) asserts that, as the sociocultural distance between the patient and the clinician increases, the rapport needed for a thorough evaluation decreases. To examine the question of whether the race of the clinician

affected the diagnosis, a comparison of the race of the recipient and the race of the psychiatrist was conducted. The psychiatrists selected were those in the permanent employ of the Louisiana Office of Mental Health.³ Their race was identified from the personnel reporting system.

Thirty psychiatrists with a combined caseload of 9,898 patients were included in this aspect of our research. Each psychiatrist's caseload was defined in our research as those cases in which that psychiatrist had performed the most recent clinical assessment. Thus, the cases represent the active patients of each of the psychiatrists in the permanent employ of the Office of Mental Health. The percentage of schizophrenic and major affective disorder diagnoses was virtually identical to that of the entire population of patients within the Louisiana public mental health system.

The results of the multiple regression analysis are presented in Table 3. The dependent variable is those African American patients diagnosed with schizophrenia; independent variables are the race of the psychiatrist and the diagnosis of other patients. The findings of our analysis point to several factors that might contribute to African Americans being diagnosed with schizophrenia. The first factor contributing to this diagnosis is the number of African Americans diagnosed with a major affective disorder. In other words, the number of African Americans having major affective disorder in the caseload has a positive relationship to the number of African Americans with a schizophrenic diagnosis. This indicates that the larger the number of African Americans in a physician's caseload, the more likely that African Americans will be diagnosed with schizophrenia. For every African American diagnosed with a major affective disorder, we can predict that 3.59 African Americans will be diagnosed with schizophrenia.

The second factor leading to a schizophrenic diagnosis in African Americans is the number of whites in the caseload with a schizophrenic diagnosis. Analyzing this variable, the overall size of the caseload influences the schizophrenic diagnosis. In other words, for psychiatrists who have a larger number of whites diagnosed with schizophrenia, they will also tend to have a larger number of African Americans diagnosed with the same disease.

A third factor shown to be associated with a schizophrenic diagnosis among African Americans is white patients with diagnoses of major affective disorders. The negative coefficient indicates that, for those physicians who have less of a tendency to diagnose whites with a major affective disorder, they have a greater likelihood of diagnosing African Americans with schizophrenia.

The overriding implication of this aspect of our analysis is that some psychiatrists are predisposed to make a diagnosis of schizophrenia. An analysis of African Americans diagnosed with major affective disorders produces similar findings. The number of African Americans with a schizophrenic diagnosis is positively related to the number of African Americans with a major affective disorder. Other contributing factors include the number of white consumers with a major affective disorder and white clients with schizophrenia. In this case, also, the race of the psychologist was the least influential factor in the diagnostic decision.

Table 3. Effect of Race of Physician and Diagnosis of Other Patients on African Americans Diagnosed with Schizophrenia

Independent Variables	Coefficient (Standard Error in Parentheses)
Constant	5.40 (14.83)
African Americans Diagnosed with Affective Disorder	3.59 * (.51)
Whites Diagnosed with Affective Disorder	-.74 ** (.31)
Whites Diagnosed with Schizophrenia	.83 * (.18)
African American Psychiatrist	1.68 (17.91)
White Psychiatrist	- 6.43 (12.58)

n = 30

r² = .778

* denotes significance at p < .05 level

** denotes significance at p < .01 level

Outpatient Length of Stay

We were also interested in determining whether there was any racial differential in outpatient length of stay. Length of stay is important because longer time spent in mental health treatment settings have been typically associated with better outcomes (Takeuchi et al., 1995).

Our examination of the data, contained in Table 4, reveals that, among other notable features, African Americans comprised 62.6 percent of those individuals who remained in treatment for more than 10 years, while whites were only 37.3 percent of this cohort. At the opposite end of treatment length, those who only remained in outpatient treatment for less than 6 months, African Americans constituted 48.2 percent and whites 51.2 percent. A close look at Table 4 reveals that more evident racial disparities are at the extreme, those lengths of stay of longer than 10 years. Why do African Americans tend to remain in treatment longer than whites? Perhaps the diagnostic decisions already discussed might be one reason.

Table 4. Length of Treatment by Race

Length of Treatment	African American	White	Other	TOTAL
less than 6 months	48.25%	51.18%	.56%	n = 1776
6 months to 1 year	51.26%	48.06%	.68%	n = 1469
1 to 2 years	53.98%	45.6%	.42%	n = 2638
3 to 5 years	51.39%	47.87%	.74%	n = 4598
6 to 10 years	54.46%	45.08%	.46%	n = 4168
10 or more years	62.61%	37.2%	.18%	n = 4333
TOTAL	54.68%	44.83%	.48%	100%
	n = 10,380	n = 8,510	n = 92	n = 18,982

$X^2 = 177.2$ $p < .001$

Quantity of Outpatient Services

Aside from length of stay, another clinical decision that may be affected by the race of the consumer is the quantity of services made available. We might expect that, since the majority of clients are African Americans and that they remain in treatment for a longer period of time, they would also receive concordant services. We find instead that African Americans receive only 41.49 percent of outpatient services, while whites receive 57.33 percent. Also, of all the services offered, we find that African Americans receive less than expected compared to their white counterparts in virtually all categories (see Table 5).⁴

For those diagnosed with schizophrenia, of the eighteen different categories of services available to consumers, we find that African Americans are underserved compared to whites in fifteen of them. Although African Americans make up 63.37 percent of those diagnosed (compared to whites) with this illness, they only receive 56.9 percent of services. Only for art therapy, court group, and psychosocial evaluation, do African Americans receive more than what we would expect if the services were assigned without regard to race.⁵ For those diagnosed with major affective disorders, the case is even more emphatic. Although African Americans make up 38.06 percent of those diagnosed with major affective disorders, they receive only 31.77 percent of services. Only in the category of music therapy do African Americans receive a greater share of services than if they were assigned by chance.

Table 5. Services Received (in Percentage) by African Americans as Compared to Whites¹

	Schizophrenia		Major Affective Disorder	
Art Therapy	70.79%	(n = 558)	32.26%	(n = 465)
Collateral Counseling	57.26	(n = 1963)	28.72	(n = 2176)
Couple Counseling	38.10	(n = 21)	16	(n = 25)
Court Group	86.67	(n = 15)	0	(n = 1)
Family Counseling	55.06	(n = 1769)	28.73	(n = 1810)
Group Counseling	56.33	(n = 15266)	33.49	(n = 15056)
Group Screening	56.38	(n = 94)	21.57	(n = 153)
Individual Screening	55.88	(n = 29412)	30.84	(n = 30451)
Medical Evaluation	54.04	(n = 1497)	24.87	(n = 1677)
Medication Injection	60.32	(n = 13600)	31.83	(n = 6425)
Medical Management	56.49	(n = 31504)	30.58	(n = 30097)
Music Therapy	51.98	(n = 404)	46.46	(n = 551)
Occupational Therapy	27.81	(n = 151)	0	(n = 102)
Other Evaluation	58.42	(n = 303)	33.06	(n = 248)
Psychiatric Evaluation	58.13	(n = 3002)	34.05	(n = 3515)
Psychological Evaluation	64.61	(n = 178)	25.67	(n = 187)
Psychosocial Evaluation	59.80	(n = 1428)	32.85	(n = 1848)
Recreation Therapy	56.08	(n = 6150)	37.03	(n = 4467)

df = 17

t (schizophrenia) = -2.310*

t (major affective disorders) = -3.96**

* significant at < .05

** significant at < .001

1. Of those whites and African Americans diagnosed with schizophrenia, African Americans comprise 63.37 percent. Of those whites and African Americans diagnosed with major affective disorders, African Americans comprise 38.06 percent.

Conclusion

This study investigated race and treatment in one public mental health system. First, diagnosis was examined. Not surprisingly, the race of the client was linked to diagnosis. African American clients served by the Louisiana Office of Mental Health were disproportionately diagnosed as schizophrenic and under-represented among those with an affective disorder in both inpatient and outpatient settings.

Next, the influence of the race of the psychiatrist on treatment decisions was tested. The dependent variable used was African American clients diagnosed with schizophrenia. Larger numbers of African American clients in psychiatrists' case-loads influence the decision to diagnose African Americans with schizophrenia. According to the analysis, for every African American diagnosed with an affective disorder, 3.5 African Americans will be diagnosed with schizophrenia. Also, some psychiatrists appear predisposed to diagnose their clients as schizophrenic. If they

have a larger number of whites with schizophrenia, they will also tend to have a larger number of Blacks diagnosed with schizophrenia. If their caseload includes fewer whites with affective disorders, these psychiatrists have a greater likelihood of diagnosing African Americans with schizophrenia.

Last, we expected that the race of the client would matter in treatment decisions. Lacking data to assess the quality of care, we tested the hypothesis by a count of the services provided, by diagnosis and race. Even though they stayed in treatment longer than whites, African Americans received less services than white clients in virtually every category. This inequitable distribution cannot be explained by geographical variation.

The results of this study lend credence to the concern of many researchers about institutional prejudice in mental health diagnosis and treatment. We confirmed not only that race was associated with diagnosis, but that inequities, based upon race, exist in the distribution of public resources. This uneven playing field is probably the most telling finding of this study.

Recommendations

Each public mental health system must be open to the same type of self-examination undertaken by the Louisiana Office of Mental Health. If public mental health systems truly want to pursue the objective of providing sufficient and appropriate mental health services, first they must become sensitive to the problem of racial bias in diagnosis and treatment, and be aware that institutional biases may exist in their very own system.

Second, mental health professionals must consider it important to objectively investigate the issue. Each organization should generate reports examining race and treatment on a system-wide and individual clinician basis. This necessitates that public mental health systems invest in management information systems that are user-friendly and readily provide this type of critical data. Physicians in other health care settings are provided with reports on utilization and patient care, and this should become a standard practice in public mental health systems, as well. Psychiatrists should be made aware of their own patterns of diagnosis and treatment.

Third, mental health organizations must strategically address the problem of institutional prejudice. The implication of not confronting the problem is quite clear. Misdiagnosis translates into inappropriate treatment and, thus, unresponsiveness to the treatment. Even if a small percentage of the client base is misdiagnosed, the economic and human cost would still be massive.

One recommended strategy for addressing this problem is to provide culturally specific training. Training in diversity should be emphasized for those in psychology, nursing, social work, psychiatry and administration. Cultural sensitivity training should promote an awareness of the unique circumstances and experiences of African Americans and other minorities. This suggestion is based, in part, on the observations of psychiatrists in key administrative positions within the Louisiana Office of Mental Health. In support of this recommendation, Takeuchi

(1995) reported that programs that conducted treatment in a more culturally sensitive manner and used culturally appropriate treatment styles were more successful in strengthening a clients' commitment to treatment.

Although our results did not indicate that the race of the psychiatrist matters in treatment decisions, there is strong agreement that increasing the presence of minority professionals, clinical and administrative, is essential (Wade, 1993). Involvement of racial/ethnic minorities in program planning may also be important.

There is much more to be learned about race and treatment. In particular, a more extensive review of the influence of the race of the psychiatrist is warranted due to the small number of black psychiatrists included in this study. We also recommend that future research investigate other issues not analyzed in this present study, for example, rediagnosis, referral sources, psychopharmacology, utilization rates, appropriateness of treatment, and quality of care. More research is needed to understand the extent that prejudice permeates treatment decisions.

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Endnotes

1. In many respects, the Louisiana Office of Mental Health is the service of last resort in mental health treatment. This Office serves a very chronically disabled population with very limited financial resources. Therefore, the clients served by OMF are generally homogenous in terms of income. For example, according to Louisiana Office of Mental Health data (dated June 30, 1995), 91.3% of their clients earned less than \$15,000 (household income). Those that reported household incomes above \$15,000 represented only 3,143 persons out of the total cases of 35,925.
2. If institutional biases exist, there may be a tendency to value clients based upon racial group membership. Therefore, more care may be taken in the diagnosis (or re-diagno-

sis) of white clients, or African Americans may be systematically labeled with "harsher" diagnoses. Although all mental illnesses can be devastating, schizophrenia is one of the most harshest or disheartening diagnosis in terms of prognosis and treatment. If the over-diagnosis of schizophrenia is the result of a negative image of African Americans, then such diagnostic practices may be punitive and/or may be the result of preconceptions about the relative worth of African Americans in the economic sector. Pickett and Hanlon (1990) state that disorders have different values as public health problems. While depression is a cost in terms of lost productivity ("major cause of academic and work related problems"), schizophrenia is a problem "in terms of the services required and the cost of providing those services" (p. 460). There are current and historic examples of the use of mental illness diagnoses to further an agenda of oppression. To illustrate, the first report of mental illness among African Americans appeared in the 1840 Census. This report, showing that the rate of mental illness among free Blacks in the North was significantly higher than those Blacks living in the South, was promptly used to "prove" southern arguments that African Americans lacked the mental attributes to live as free men (Williams, 1986). As a current example of the discriminatory use of mental health assessment, Chung, Mahler, and Kakuma (1995) found that African Americans with high socioeconomic status, regardless of previous diagnosis, were more likely to be tested for the use of alcohol or drugs through urine screens and were more likely to receive a diagnosis of alcohol or substance abuse disorders than comparable whites, despite similar rates of positive urine screens in the two racial groups.

3. The total caseload of the psychiatrists included in the analysis (those in classified or unclassified positions) represent 21 percent of the total recipient population.
4. In total, there were 511,533 services for all diagnostic categories provided within that time frame. For the purpose of the analysis, other races and services for clients with diagnosis other than schizophrenia and major affective disorders were excluded from the analysis. (Included in the analysis: $n = 107,243$ for services for Blacks and whites with a schizophrenia diagnosis; $n = 99,166$ for services for Blacks and whites with a major affective disorder diagnosis.)
5. Gender biases must also be investigated. The fact that clinical disorders may present differently in women than men is well known but often unheeded (Rudden et al., 1983).

Diet and Lifestyle Practices of African American Males

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Abstract

Many African American males have dietary and lifestyle practices and beliefs that place them at increased risk for poor health outcomes with excessive personal and health care costs. The purpose of this paper is to guide the formation of policy and program recommendations through a better understanding of contemporary African American male health behaviors and dietary patterns. Data from the United States Department of Agriculture Continuing Survey of Food Intakes by Individuals (USDA-CSFII) 1994–1996 were used for this analysis. The authors evaluated and used this information to estimate the effect of diet on the risk of high blood pressure and ‘any disease’ (physician identified and patient reported). Results show that most men exceeded 100 percent of the dietary standard for fat—nutrients associated with poor health outcomes and that less than 70 percent had recommended levels of carbohydrates or fiber—nutrients associated with good health outcomes. Based on these results, the following policies are recommended: 1) health education messages and graphics which demonstrate racial disparities between African American and the white population in disease, 2) healthy diet and lifestyle practices for African American males should be developed and used in health care programs, and 3) primary health care providers of African American males should emphasize the relationship between diet, disease, physical activity, and smoking to their patients.

Introduction

The Healthy People 2000 health objectives were designed by the U.S. Department of Health and Human Services (U.S. Dept. of Health and Human Services, 1998), to promote health and reduce chronic disease risk, as well as disease progression, debilitation, and premature deaths for all Americans (U.S. Dept. of Health and Human Services, 1998). One of the goals of the Healthy People 2000 initiative is to “close the gap” in disease prevalence and risk factors for disease, as well as health care service availability and accessibility for minority populations. Healthy People 2010 has an even more ambitious goal of “eliminating the gap” (U.S. Dept. of Health and Human Services, 1998).

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African American males are documented to have the shortest life expectancy in the U.S. population (66.1 years—seven years less than that of all men), and are disproportionately affected by many diet-related chronic diseases (Davey et al., 1988; Aubert). They experience excessive mortality, and disease specific survival is also significantly less than among Hispanic and white males (U.S. Dept. of Health and Human Services, 1998; Bridges et al., 1998). For example, in 1995, the death rate from high blood pressure was 78 percent lower in white than black males (NIH, 1995). The death rate from cardiovascular disease was 49 percent higher in African American males than in white males and the coronary heart disease (CHD) death rate was 7 percent higher for African American males than for white males (American Heart Association, 1995). Diabetes occurs 2.3 times more frequently in African American adults than in white adults. Since African Americans are the largest minority group, comprising 12.7 percent of the United States population, improvement in their health status may help minority groups as a whole narrow the gap.

Much of this excess mortality and morbidity among African American males may be associated with diet and other modifiable lifestyle risk factors such as physical inactivity, alcohol consumption, and smoking (Brunswick & Messeri, 1986). While the relationship between these health behaviors and chronic disease is complex, causal links have been established for diets high in saturated fat and low in fruits, vegetables and fiber; alcohol and tobacco use; as well as physical inactivity (Kuller, 1997; Slavin, Jacobs & Marquart, 1997; Weisburger, 1998; Segal, 1998; Coakley et al., 1998).

Despite the high prevalence of these diet-related diseases among African American males, very few studies have been conducted to investigate these relationships. The purpose of this paper is to guide the formation of policy and program recommendations through a better understanding of contemporary African American health behavior and dietary patterns. This paper will use data from the United States Department of Agriculture—Continuing Survey of Food Intakes by Individuals, 1994–1996 (USDA-CSFII) to investigate the diet and lifestyle practices of African American males. It will assess the relationship between their nutrient consumption patterns (energy, fat (total and saturated), cholesterol, carbohydrate, protein, fiber, sodium and calcium), demographic characteristics, body mass index, disease (physician identified, patient reported); as well as lifestyle variables such as alcohol consumption, smoking, and exercise level.

Methods

The USDA-CSFII (1994–1996) database contains information on the food intakes, demographic, and lifestyle factors, as well as proxy indicators of disease, for a sample of individuals in the United States collected between January 1994 and January 1997. The database was created using a nationally representative sample of non-institutionalized persons of all ages residing in the United States. Data were obtained through in-person interviews and 24-hour dietary recalls (Tip-

pett & Cypel, 1998).¹ The USDA-CSFII database was used for this study because it is a contemporary database that has comprehensive data on nutrient intakes of a large sample of Americans as well as information on foods consumed. While this paper will describe nutrient intake patterns, subsequent papers will link these findings to foods consumed.

Data on 479 African American males 19 years of age and older were extracted from the CSFII 1994–96 database for this study. The relationship between nutrient intake patterns, disease history, lifestyle practices, and demographic characteristics were evaluated. Nutrient intakes were estimated using the average of two consecutive days of dietary intake data. Nutrients assessed in this study were energy, fat (total and saturated), cholesterol, carbohydrate, protein, dietary fiber, sodium and calcium.

The adequacy of nutrients consumed was assessed in comparison to recommended values from the Nutrition Labeling and Education Act of 1990 (NLEA) (U.S. Dept. of Health and Human Services, PHS & FDA, 1990). The NLEA recommended levels were used as reference instead of the 1989 Recommended Dietary Allowances (RDA) because these levels were created to provide information on the intake of nutrients related to chronic disease risk and contemporary nutrition problems in the United States. The NLEA cut-off points used in this study are: energy—2500 kilocalories, total fat—80 grams, saturated fat—25 grams, cholesterol—300 milligrams, carbohydrate—375 grams, protein—65 grams, fiber—30 grams, sodium—2400 milligrams, and calcium—1000 milligrams.

Demographic variables selected for this study were: educational level attained, “poverty threshold,” and geographic location. The “poverty threshold” variable available in the database was used as a proxy measure for economic status or income level. It is based on the calculated relationship between reported household income and household size (Tippet & Cypel, 1998). Categories used were: 0–130 percent—*low*; 131–350 percent—*medium*; and >350 percent—*high*. The physical variable selected was Body Mass Index (BMI) [wt(kg)/ht(m)²], calculated using self-reported weights and heights available in the database. A categorical variable was created for BMI based on the 1998 NIH obesity guidelines: BMI <25—*normal*; 25–29.9—*overweight*; >30—*obese*. The presence or absence of high blood pressure, or ‘any disease’ was also included as proxy indicator of health status. The ‘any disease’ variable included all participants who reported they had ever been informed by a physician that they had any of the diseases mentioned in a list provided. Physical examination or medical record review to assess disease status would have been more reliable and definitive for this study, however, information from these sources was not available in this database. Alcohol consumption and smoking habits were self reported.²

Results

The characteristics of African American males included in this study are presented in Table 1. The majority of males in this study (66 percent) were less than 50 years

Table 1. Demographic and Health Status Profile of African American Males >19 years in the Continuing Survey of Food Intakes of Individuals, 1994–1996 (N = 479).

Variable	Proportions
Age	
19–49	66.0%
50+	34.0
Education	
<High School Graduate	23.4
High School Graduate	42.1
Above High School Graduate	34.5
Poverty Category “Poverty Threshold”	
0–130 percent (Low)	26.1
131–350 percent (Medium)	47.7
>350 percent (High)	26.2
BMI wt(kg)/ht(m) ²	
<25 (Normal)	33.5
25.0–29.9 (Overweight)	46.1
>30.0 (Obese)	20.3
Region	
Northeast	24.7
South	48.2
West and Midwest	27.1
Disease (physician identified, patient reported)	
Hypertension	29.7
‘Any’ disease	36.1

of age with 77 percent attaining an educational level of high school and above. About half of the study sample (48 percent) was from the south with 26 percent designated poor according to the federally established ‘Poverty Threshold Index.’ Sixty-six percent of this sample was overweight or obese (NIH-NHILBI, 1998). Using physician identified and/or patient reported disease as a proxy measure, the disease of highest prevalence was heart disease at 11.4 percent. Altogether, 36.1 percent of the study population had at least one of the diseases listed.

A majority of men in the sample met NLEA requirements for energy and total fat. However, for the remaining nutrients, African American men in the sample consumed too much of those related to poor health outcomes (saturated fat, cholesterol, protein, sodium) and too little of those related to good health outcomes (carbohydrate, fiber, and calcium). In addition, the range of intakes in the distrib-

ution was such that when the men were grouped by any of the demographic variables, mean intakes by group exceeded NLEA recommendations (See Figures 1-3).

Evaluation of lifestyle factors revealed that 26 percent were having daily exercise with 34 percent indicating that they were smokers at the time of the survey (Table 3). Of smokers, 52 percent were *light smokers* (10 or fewer cigarettes/day), 41 percent—*moderate smokers* (11 to 20 cigarettes/day) and 7 percent were *heavy*

Table 2. Percentage of Study Participants with Specified Nutrient Intake Levels Compared to the Nutrition Labeling and Education Act (NLEA, 1990) standards (N = 479)

Nutrient	Percent of Participants
Energy—(Kcalories)	
<2,500	64.6%
≥2,500	35.4
Total Fat (grams)	
<80	50.1
≥80	49.9
Saturated fat (grams)	
<25	44.8
≥25	55.2
Cholesterol (milligrams)	
<300	45.3
≥300	54.7
Carbohydrates (grams)	
<375	82.4
≥375	17.6
Protein (grams)	
<63	24.7
≥63	75.3
Fiber (grams)	
<30	94.6
≥30	5.4
Sodium (milligrams)	
<2,400	22.0
≥2,400	78.0
Calcium (milligrams)	
< 800	69.4
≥800+	30.6

Table 3. Percentage of Study Subjects Participating in Specified Health Behaviors—Exercise, Smoking and Alcohol Intake (N = 479)

Health Behavior	Percent of Subjects
Exercise	
Daily	26.3
Some	39.2
Rarely/never	34.5
Smoke—ever > 100 cigarettes	
Yes	56.2
No	43.8
Smoke—now	
Yes	34.4
No	65.6
Alcohol: any in year	
Yes	59.1
No	40.9

smokers (> one pack/day). Fifty-six percent of the study sample indicated that they had smoked 100 cigarettes or more during their lives, and 59 percent reported having consumed some alcohol during the past year (86 percent—beer, 47 percent—wine, and 86 percent—liquor).

Regardless of educational level, BMI category or economic status, mean level of nutrient intake exceeded 100 percent of the NLEA recommendation for protein, fat (total and saturated), cholesterol and sodium. However, study subjects consumed less than 70 percent of the recommendation for carbohydrate and fiber. Only men in the low "Poverty Threshold" category consumed adequate calcium (Figures 1 and 2).

Men who exercised daily often had high intakes of protein, fat (total and saturated), cholesterol, and sodium but less than 70 percent of the recommended intakes for calcium. However, men who rarely or never exercised consumed less calories and calcium (Figure 3). Carbohydrate and protein intakes did not vary with exercise level. In general, health promotional exercise patterns were not associated with better nutrient consumption patterns.

Both smokers and non-smokers met or exceeded the recommended intakes for protein, fat (total and saturated), cholesterol and sodium, but obtained less than 70 percent of the recommended levels for carbohydrate and fiber. Non-smokers consumed 70 percent of the recommended calorie intake but smokers obtained 70 percent of the recommended level for calcium.³ The pattern was similar for alcohol except that those who reported that they did not consume alcohol obtained 100 percent of the recommended levels of calcium.

Figure 1. Percent Nutrient Consumption of African American Males by "Poverty Threshold" Level Compared with the NLEA 1990 Standard (100%, 70%).



Figure 2. Percent Nutrient Consumption of African American Males by Body Mass Index (BMI = wt/ht²) Compared with the NLEA 1990 Standard (100%, 70%)

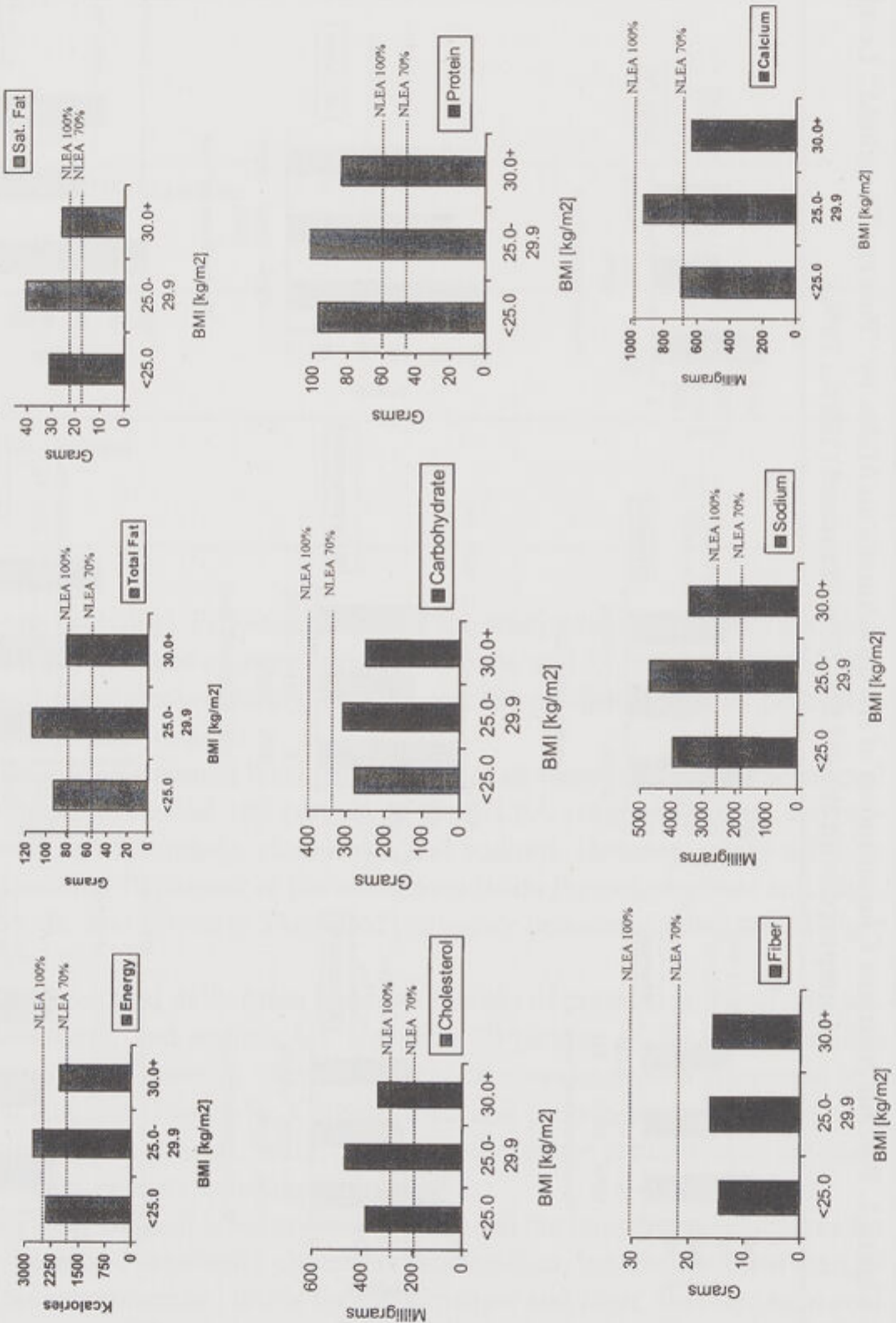
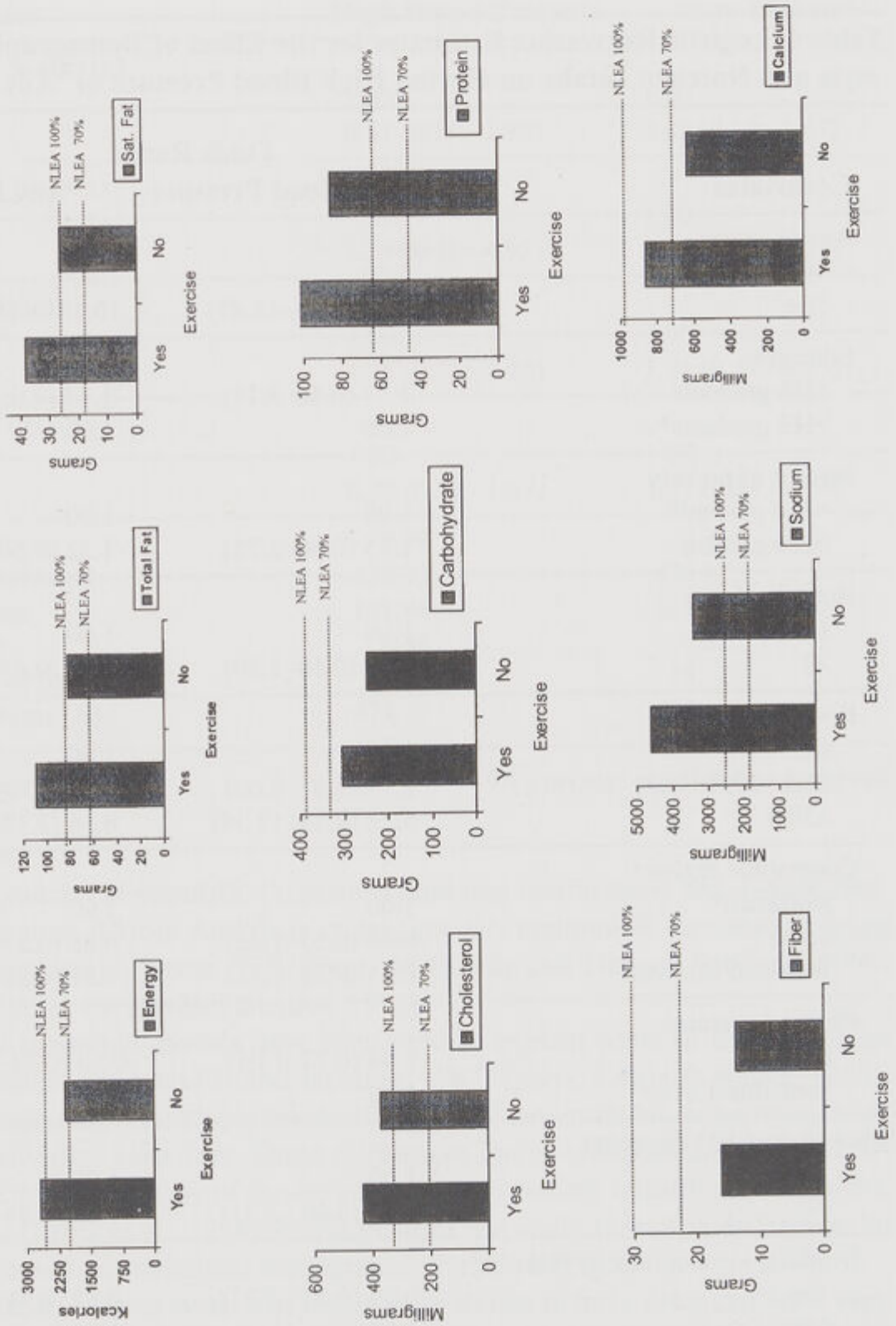


Figure 3. Percent Nutrient Consumption of African American Males by Exercise Compared with the NLEA 1990 Standard (100%, 70%).



Multivariate analyses showed that age and BMI were significantly associated with high blood pressure when demographic, dietary and lifestyle variables were controlled in a logistic regression model (Table 4). Age, BMI, and fiber intakes were also found to be significantly associated with 'any disease' in the model.

Table 4. Logistic Regression Estimates for the Effect of Demographics, Lifestyle and Nutrient Intake on Having High Blood Pressure or 'Any Disease'.

Covariates	Odds Ratios	
	High Blood Pressure	'Any Disease'
Age in years		
19-49*	1.00	1.00
50+	7.31 (4.66-11.47)	10.18 (5.69-18.21)
Education		
≤HS graduate	1.57 (0.80-3.11)	1.44 (0.66-3.13)
>HS graduate*	1.00	1.00
Percent of poverty		
<186 percent*	1.00	1.00
≥186 percent	1.35 (0.66-2.75)	1.32 (0.56-3.07)
Household size		
1-2*	1.00	1.00
>3	0.95 (0.50-1.80)	0.92 (0.45-1.86)
Body Mass Index		
≤25*	1.00	1.00
25.0-29.9	2.77 (1.67-4.60)	2.53 (1.36-4.70)
≥30.0	5.20 (2.19-12.38)	6.56 (2.12-20.27)
Geographic region		
Northeast*	1.00	1.00
South	0.66 (0.33-1.32)	0.85 (0.38-1.90)
West and Midwest	0.61 (0.28-1.31)	0.81 (0.28-2.36)
Physical exercise		
Daily*	0.48 (0.22-1.04)	0.50 (0.24-1.06)
Sometimes/never	1.00	1.00
Smoked ever 100 cigarettes		
Yes*	1.00	1.00
No	1.17 (0.60-2.31)	1.02 (0.45-2.34)
Drinking alcohol: any in year		
Yes	0.99 (0.44-2.27)	0.89 (0.39-2.06)
No*	1.00	1.00
Energy intakes (kcal)		
≤2500*	1.00	1.00
>2500	0.90 (0.41-1.99)	0.64 (0.27-1.53)

Table 4. (cont.) Logistic Regression Estimates for the Effect of Demographics, Lifestyle and Nutrient Intake on the Odds of Having High Blood Pressure or 'Any Disease' as Told by a Doctor to the Study Participants.

Covariates	Odds ratios	
	High Blood Pressure	'Any Disease'
Total fat intakes (g)		
≤80*	1.00	1.00
>80	0.51 (0.15 -1.70)	0.45 (0.12 -1.67)
Dietary fiber (g)		
≤30*	1.00	1.00
>30	1.54 (0.48 -4.93)	3.32 (1.56 -7.07)
Sodium (mg)		
≤2400*	1.00	1.00
>2400	1.25 (0.35 -4.46)	1.21 (0.37- 4.00)
Calcium (mg)		
≤800*	1.00	1.00
>800	0.79 (0.37 -1.67)	1.57 (0.54 -4.56)
Intercept	0.09	-0.11
-2 log likelihood	433.33	436.12
Chi-square	141.94	182.89
R-square	0.26	0.32
Degrees of freedom	16	16
Observations (N)	474	474

* Reference Category

95 percent confidence interval

Discussion

There is a paucity of scientific literature examining diet/lifestyle and disease relationships among African American males, yet data continue to demonstrate huge disparities in health status (U.S. Dept. of Health and Human Services, 1998; National Center for Health Statistics, 1995).

Health education models have been used to explain some of these findings (National Heart Lung and Blood Institute, 1987; Glanz, Lewis & Rimer, 1990). These models address multiple levels of the social environment, rather than focus only on individual behaviors. These differences in disease morbidity and mortality are due to a wider array of factors such as poor housing, hazardous jobs, stress, and racism (Lantz et al., 1998). Findings from this study show few differences in outcomes based on traditional demographic variables (Figure 1).

In general, African American males were shown to have diets that were very high in fat (total and saturated), cholesterol, protein and sodium—disease related nutrients, and low in carbohydrate, fiber and calcium—nutrients associated with disease protection. This profile of nutrient intakes is associated with increased risk of cardiovascular disease, cancer and high blood pressure. At the outset of this

study, it was hypothesized that diet and lifestyle practices would vary on the basis of level of poverty, education, geographic region, BMI, and disease status. However, in this study, no association was found between high blood pressure or 'any disease' and level of nutrient consumption, measures of socioeconomic status, and BMI.⁴

A particularly interesting finding of this study was that neither measures of socioeconomic status nor level of exercise was related to nutrient consumption patterns. In other words, in this study, neither increasing levels of education nor income were associated with improved nutrient consumption patterns or lifestyle habits, as reported for other races in epidemiological studies (Vogt et al., 1992; Berkman & Syme, 1978; Prewitt, 1997; Begeley et al., 1994). The exact mechanism by which social and economic factors impact the health of populations has not been definitively characterized. However, the strength and consistency of this relationship, across different disease outcomes, in different age groups, and different parts of the world has been remarkable (Guralnik & Leveille, 1997; Robert, 1998; Gorey & Vena, 1995; Kennedy, Kawachi & Stith-Prothrow, 1996). And yet, our study found such connections were tenuous at best with respect to the diet and lifestyle behaviors of African American males.

The hypothesis of a high prevalence of diet-related diseases associated with specific dietary and lifestyle practices was not supported since men who had high blood pressure were not the ones consuming high levels of fat (total and saturated) or cholesterol. As this study and the work of previously cited others suggests, the decision making process itself may impact individual health behavior. The Health Belief model of human behavior attempts to explain and predict health related behavior based on the assumption that a person must perceive that his/her health is in jeopardy; perceive the potential seriousness of the condition; believe that the benefits of changing habits, medical or surgical interventions outweigh the "costs" and be aware of a triggering event that precipitates action (Lawrence & Marshall). This model may explain why we did not find a relationship between poor dietary practices and the proxy measures of disease. It may be that men were more likely to report the diet that had been recommended by their health care provider.

Similar to the findings on the relationship between educational and socioeconomic status and nutrient intakes, level of exercise did not correlate with improved dietary habits. This suggests that at least among those who reported higher levels of exercise, it was not understood that improvements in diet were also important.

Despite the high prevalence of overweight/obesity in this study, 75 percent of subjects reported taking in less than the recommended 2500 calories per day. African American males with the highest BMIs were more likely to report lowest caloric intakes.⁵ Their low levels of physical activity may also help explain the high prevalence of overweight/obesity. Diabetes is another disease related to overweight/obesity that has high prevalence among African Americans (10.8 percent of

non-Hispanic Blacks vs. 7.8 percent of all non-Hispanic whites) (NIH/NIDDK, 1997). It is important to note that obesity and physical inactivity are two modifiable risk factors associated with Type II diabetes.

More than half of the study population had ever smoked (56.6 percent), with slightly more than a third continuing to smoke at the time of this study. These observations may explain the reasons for the reported high prevalence of lung cancer in this population. These statistics point to the need for culturally appropriate smoking cessation programs for African American males.

Conclusion

Among African American males, there is a high prevalence of health problems that have been associated in scientific literature with unhealthy lifestyle practices. These practices which include inappropriate dietary intake, smoking, and lack of exercise can all be modified. The nutrient intakes of men in this study exceeded the recommended level for those related to poor health outcomes (saturated fat, cholesterol, protein, and sodium) but fell below the recommended levels for those nutrients related to good health outcomes (carbohydrate, fiber, and calcium). It is imperative that culturally appropriate nutrition education messages and materials be developed to help these men achieve healthy diet and lifestyle goals. Additionally, evidence points to the need for uniquely designed weight management and smoking cessation programs for this population. Finally, it is essential that further qualitative research be conducted to specifically identify intervention strategies to enable African American males improve their diet and lifestyle practices.

Policy and Program Recommendations

In order to address the conclusions of this study and the overall health status of African American males, we suggest several targeted policy recommendations.

- 1. Health care providers should emphasize the relationship between disease and modifiable health behaviors such as diet, physical activity, and smoking as part of counseling during primary health care for African American males.**

Healthy People 2000 National Health Promotion and Disease Prevention Objectives: Progress Review for Black Americans released in October, 1998 documents the relationship between many of the behaviors and health outcomes discussed in this paper. What is missing is counseling during primary health care visits to help men become aware of these relationships and encourage them to begin changing behaviors to modify the influence of these behaviors on health outcomes. Ideally this would be done in the context of family health counseling so families could provide the support system necessary for successful behavior change.

2. Increase of the number of African Americans participating in the care and education of African American males.

The recent elimination of affirmative action policies at many institutions of higher education could result in a decrease in the number of students of color enrolling in the nation's medical, public health, and all other allied health programs. In addition, as the demographic profile of the population continues to change, reflecting an increase in the proportion of people of color and demand for minority healthcare providers, there is likely to be a shortage of minority health care providers. Having primary health care providers of all backgrounds is important to increasing the comfort level of clients accessing the system. It is, therefore, essential that immediate steps be taken to reverse this trend of decreased participation of minorities in the healthcare field.

3. Use culturally appropriate health education material to promote healthy lifestyle modification for African American males at community centers, barber shops, and other places where African American males are likely to gather.

There are many more government supported community-based health promotion efforts for women than for men. Even though some health education materials show positive visual images of minority families, the number with African American males as the target audience are limited. Greater attention to the health awareness concerns of men, African American males in particular, could provide the attention necessary to take preventative steps toward health care. Engaging community support for African American male health is a key strategy for addressing diet and lifestyle deficiencies. This could take the form of ensuring that leaders and service providers where men gather—barber shops, recreation centers and sports arenas—have appropriate health education materials and have been informed about health messages. The Hypertension Prevention Program sponsored by NIH is an example of the successful use of these strategies.

4. Develop health education graphics that clearly demonstrate racial disparities in disease and healthy lifestyle practices for African American males.

Information about disease disparities is not commonly available in African American communities. Engage churches, fraternal organizations and other civic groups to help make this information available in easy to access format (National Cholesterol Education Program, 1990). Black media such as—Black Entertainment Television, Ebony, Body and Soul, Emerge, and Black Enterprise—could be part of the partnership to help circulate such information.

5. Increase studies that identify the health needs of African American males.

Funding should be available to develop intervention studies that are culturally appropriate for African American males. Funding sources may be from governmental foundations or private industry. 'Healthy Start Male Services' has a model that might be replicated in other communities (Wallach & Lister, 1995). Even though this program was started as part of an infant mortality reduction initiative, the focus on family health is catching on and should be promoted to address other health promotion needs.

6. Develop programs and interventions that increasingly involve male community leaders.

This will enable researchers to both identify relevant community "norms" and capitalize on abilities of recognized community leaders, thus helping to promote the adoption of health enhancing behaviors within the community. Use of empowerment models of health education which focus on involving community leaders is a necessity. This is not only important to increase African American male involvement but also to advocate for accessible culturally appropriate services. Another advantage of this model is that it develops skills and capability within the community which remains beyond project specific funding. This is important since African American communities are strewn with the remains of research projects that created hope in the community only to end following a funding cycle.

Endnotes

1. A complex, multistage, area probability sampling design was used to select persons for interviews in the CSFII survey. The sampling design was based on a Westat master sample and included the selection of geographical primary sampling units (PSUs), area segments within the sample PSUs, households within the selected segments, and randomly selected individuals (sample persons) within households (WESTAT, 1985).
2. Univariate and bivariate analyses were conducted to describe nutrient intake patterns by age, BMI, disease status, economic status and geographic location in the United States, e.g. Northeast, Southeast and West. Logistic regression models were used to estimate the effect of nutrient intakes on the risk of high blood pressure and 'any disease' after controlling for the effect of other socio-demographic and behavioral covariates in the model. The results were weighted to provide population estimates and to adjust for possible under-coverage and non-response in the sample.
3. Data is not shown. Available from Investigator.
4. Data is not shown. Available from Author.
5. The observed low caloric intake by men with high BMIs may be due to under-reporting.

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Making Health Care Accessible: A Framework for Medically Underserved Rural and Inner-City Populations

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Abstract

This article describes a framework for making health care accessible to vulnerable populations residing in rural areas and inner-city neighborhoods. The emphasis of the framework is removal of three primary barriers to providing health care: systems, provider and personal barriers. In response to identified health needs, quality, cost-effective, community based primary health care services are offered through a collaborative practice model utilizing a stationary health clinic located within the Southern University School of Nursing in Baton Rouge, and a fully equipped mobile unit. Nursing students and faculty from the undergraduate and graduate nursing programs utilize the mobile health unit to deliver primary health care services to families in rural and inner-city communities. The mobile health unit covers a 50-mile radius surrounding the school, and provides access to health care in parishes that are designated as "Health Professional Shortage Areas," and to other medically-underserved populations. The stationary clinic serves clients from low-income neighborhoods in the nearby community.

Analysis of Health Needs

Louisiana is recognized as one of the country's most unhealthy states. According to Morgan & Morgan (1997), Louisiana ranked 48th in the nation in health indicators. This stems from its high prevalence of smoking, high rate of violent crime, low high school graduation rate, high unemployment, low access to primary care, high worker disability status, high rate of heart disease, high rate of overall mortality and a high rate of premature death (LDHH, 1998).

The state of Louisiana is perennially at or near the bottom of all states in quality of health indicators (i.e. infant mortality rates, teen pregnancy rates, and age-adjusted death rates). This discrepancy in death rates exists for most of the major

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causes of death. To illustrate, Table 1 gives specific data on death rates comparing Louisiana and the U.S.

Table 1. Comparison of Age-Adjusted Mortality Rates

Age-Adjusted Mortality Rates (per 100,000)	Louisiana	U.S.
Diseases of the Heart	157.5	134.6
Cancer	151.1	129.1
Cerebrovascular Disease	32.2	26.5
Accidents and Adverse Effects	37.7	21.0
Diabetes	24.2	13.6
Homicide	19.4	7.8
HIV Infections	13.8	11.6

Source: Louisiana Department of Health and Hospitals (1998). *1998 Louisiana Health Report Card*. New Orleans: State Center for Health Statistics.

There are numerous other statistics that illustrate the poor state of health of residents of Louisiana. For example, Louisiana ranks 8th among states with the highest AIDS rates and among U.S. cities, Baton Rouge ranked 9th highest and New Orleans ranked 10th highest. In addition, Louisiana ranks 10th among all states for tobacco use, as almost 25 percent of the adult population are smokers. Almost 31 percent of Louisiana adults are considered to be 'overweight' based on body mass index (LDHH, 1998). Table 2 presents information comparing selected health indicators from Baton Rouge, the state of Louisiana and the United States.

Table 2. Comparison of Selected Health Indicators

Health Indicator	Baton Rouge	Louisiana	United States
Percent of Live Births to Teens	16%	19%	13%
Infant Mortality Rate	11.2/1,000 (17/1,000 for African Americans)	9.0/1,000 (15/1,000 for African Americans)	7.2/1,000 (14.2/1,000 for African Americans)
Tuberculosis	5.3/100,000	9.3/100,000	8.0/100,000
Gonorrhea Rate	187/100,000	273/100,000 (45 percent teens)	194.5/100,000

Source: Louisiana Department of Health and Hospitals (1998). *1998 Louisiana Health Report Card*. New Orleans: State Center for Health Statistics.

It should be noted that Louisiana's high rate of poverty (highest in the nation and 50 percent higher than the Southern average) is another factor which contributes to the poor health outcomes. As a result, Louisiana is 4th among all states in percent of uninsured individuals (20.5 percent uninsured). The dependence of these uninsured individuals on the public health system has resulted in concomitant increases in public health expenditures.

The lack of accessibility and availability of primary care practitioners poses a significant problem in the delivery of health care in the state. *The Federal Bureau of Health Care Delivery and Assistance* recognizes 75 primary care shortage areas in the state. In lieu of a primary care physician, many people seek care at hospital emergency rooms. In 1995, Louisiana ranked 14th highest nationally in the number of emergency outpatient visits to hospitals (LDHH, 1998). To further illustrate relative health indicators, Table 3 compares Louisiana with bordering states and the U.S. on several health care statistics.

Table 3. Louisiana Health Care Access Statistics – 1995

State	% of Population Lacking Access to Primary Care	% of Population Not Covered by Health Insurance	% of Population of Emergency Outpatient Visits
Alabama	17.7%	13.5%	49.4%
Arkansas	13.0%	17.9%	43.3%
* Louisiana	23.7%	20.5%	54.2%
Mississippi	27.6%	19.7%	51.5%
Texas	10.8%	24.5%	34.8%
NATION	10.5%	15.4%	38.0%

Source: Morgan, K.O. & Morgan, S. (Eds.). 1997. *Health Care State Rankings 1997: Health Care in the 50 United States*. (5th Ed.) Lawrence, KS: Morgan Quitno Press.

Officials in Louisiana have attempted to address problems associated with health professional shortages in many ways. State schools of medicine, nursing, and allied health professions have been strongly encouraged to collaborate with the Louisiana Area Health Education Centers, to improve and expand programs for rural and other health professional shortage areas.

To meet this challenge, Southern University School of Nursing (SUSON) developed an Outreach Health Services Program that would address the identified health needs of vulnerable populations residing in rural areas as well as inner-cities in south Louisiana. The purpose of the Outreach Health Services Program is to provide general health promotion and disease prevention interventions to medically underserved individuals in their own communities.

Conceptual Framework

The underlying principle which guided the development of the Outreach Health Services Program was eliminating "barriers" to meeting the health care needs of rural and inner-city populations. Clark (1995) described three categories of "barriers" to meeting health care needs of underserved populations; system barriers, provider barriers, and personal barriers.

A "system barrier" is an obstruction of a methodological approach to receiving health care and includes problems such as the monumental expense associated with health care. Underserved populations rarely have health insurance coverage

and typically cannot afford the "out of pocket" costs. Lack of transportation and long waits for health services are other problems associated with system barriers. A "provider barrier" is an obstruction of health care delivery and includes insensitivity to the needs and circumstances of the underserved by health care providers. This is particularly evident when the provider and the client are from different cultural groups. A "personal barrier" is an obstruction of receiving health care imposed by the client and addresses attitudes and fears that individuals place on themselves. Personal barriers are often determined by cultural, social and financial factors (Clark, 1995).

Program and Objectives. Southern University is a historically black college which has been educating students in south Louisiana since 1880. Today, Southern University (SU) is one of the world's largest historically black institutions of higher learning with more than 10,000 students and 950 faculty. The Baton Rouge campus is located on the Mississippi River in a predominately black neighborhood. Because of its long history in the area, SU is a very respected and vital part of the community.

SU began its undergraduate nursing program in 1986 and has graduated almost 500 students; it should be noted that about 85 percent of the graduates are African American. A graduate program focusing on Family Health Nursing was implemented in 1992, and in 1996, a Family Nurse Practitioner (FNP) option was added to the graduate program. The graduate program at SUSON is focused on preparing nurses who will deliver primary health care for individuals, families and communities, emphasizing underserved clients. This focus helps to eliminate "provider barriers" because the provider and the client are often from similar cultural groups. To apply this focus on primary health care, faculty and administrators from SUSON sought to discover how to best meet the health care needs of persons in the areas surrounding the school, as well as to reach out to serve others in nearby communities.

The objectives for the Outreach Health Service Program were to eliminate systems, provider, and personal barriers by:

1. Developing a culturally sensitive nursing intervention program to address the general health promotion and disease prevention health care requirements for the medically underserved rural and inner city populations in East Baton Rouge Parish and surrounding underserved Parishes.
2. Establishing collaborative, interdisciplinary teams, utilizing the expertise of SUSON faculty and other health personnel in the University and the community to address the identified health promotion and disease prevention needs of the populations being served.
3. Establishing networking and collaborative relationships with other area nursing programs.
4. Increasing the number of culturally sensitive health care providers who possess skills to effectively meet the health care needs of rural and inner city underserved individuals and families.

5. Designing an outcome evaluation program that examines the effectiveness and efficiency of the program.

Collaborative Partnership

To address the long-recognized health needs of Louisiana residents, the U.S. Department of Agriculture (USDA) launched outreach campaigns for development of health promotion, disease prevention, education and enrollment of residents in alternative health programs. The USDA and the Louisiana Department of Health and Hospitals recognized the efforts of SUSON and soon joined in partnership with the Outreach Health Service Program.

An important component of the project, and one that has greatly contributed to its success, was the establishment of a strong collaborative relationship with the USDA's Agricultural Extensions Agents. The Agriculture Extension Agents helped to eliminate "system and provider barriers" by gaining access and promoting acceptance within the rural and inner-city communities. These Agents have a long history of service to these populations and for decades have been a major source of advocacy for improvement of health services to rural and inner-city citizens. The Extension Agents facilitated SUSON's entry into the communities and served as a source of contact when the mobile health clinic was not present. Working with Extension Agents, SUSON staff met with leaders in rural communities to discuss the purpose of the mobile clinics and to receive feedback from the community. The goal was to address attitudes and fears associated with health care before the mobile unit arrived in the community.

Initially, the program provided outreach services to two rural parishes near the city of Baton Rouge which provided the base of operation. These were East Feliciana Parish and St. Helena Parish. These two parishes were without health promotion services and are designated as 'health professional shortage areas.'

Stationary Clinic

The Nurse Managers Health Clinic (NMHC) located at SUSON, provides full-service screenings, and diagnosis and treatment center for Medicaid and Medicare eligible and self-paying customers. The stationary clinic serves clients from low income neighborhoods in the nearby community. Its convenient location helps to eliminate "system barriers" such as lack of transportation.

The forty-foot mobile clinic is called the 'Jag Mobile'—named after the University mascot—is the second component of the SUSON outreach effort. The Jag Mobile is a full-service, handicap-accessible mobile unit and is staffed by a certified Family Nurse Practitioner (FNP) and ancillary staff.

The Jag Mobile is fully equipped with medical furniture and equipment. In addition, it houses lab processing and pharmacy areas, a nurses station, two exams rooms designed to accommodate pediatric and adult mix-populations, a handicap-accessible bathroom, and a reception area/conference room equipped with a television and VCR for teaching purposes. Because the mobile health unit brings health care services directly to the community, "system barriers" such as long

waits are eliminated. Traditionally, health care services are usually provided by physicians within an office or clinic setting. The NMHC and the Jag Mobile are non-traditional approaches to delivering health care directly into communities.

Health Services

The NMHC and the Jag Mobile are approved by the Louisiana State Board of Nursing as clinical facility training sites for nursing students. In addition, the NMHC is a state approved Medicaid provider of KIDMED Medical Screening services (the Early Periodic Screening Diagnosis and Treatment Program—EPSDT in Louisiana is called KIDMED). The purpose of the KIDMED program is to provide low-income children with comprehensive health care. This includes medical, vision, hearing, and dental screening services. Medicaid eligible children and youth under age 21 are eligible for KIDMED services.

This disease preventive, well-child care model provides nursing students with hands-on experience in performing clinical assessment skills and offers comprehensive well-child services to the public. This model also helps to eliminate “system barriers” by providing health care services to a population that rarely has health insurance coverage and cannot afford “out of pocket” expenses. The emphasis of this program is on health promotion, disease prevention and early detection of health problems.

In addition to providing well-child services through its KIDMED program, the mobile health clinic collaborates with a host of community agencies and health care providers. Over 500 children enrolled in area Head Start centers receive these services through partnerships with the Head Start program.

Additional partnerships allow the mobile health unit to extend health promotion and disease prevention services to vulnerable populations including homeless individuals and families, battered women, Hispanic and Vietnamese refugees, and senior citizens. The Jag Mobile visits shelters, drop-in centers and soup kitchens for the homeless, public housing developments, churches, and community centers. Health education is provided to participants to enhance individual and family awareness of health promotion and disease prevention strategies, while increasing self-care capabilities. Areas of teaching include nutrition, dental health, aging, immunizations, safety, and self-breast examination. To date, the Jag Mobile has provided primary health care services to over 1,500 rural and inner city citizens. Table 4 outlines services provided by both the stationary clinic and the mobile unit.

Outreach Strategy. The SUSON clinics were intended to attract customers from four market categories. These are KIDMED, Medicaid eligible adults, Medicare clients and self-paying customers. To attract clients, SUSON performed the following activities to eliminate the fears of potential clients and other “personal barriers.”

- operated an advertising campaign in the catchment areas including print and broadcast media;

**Table 4. Services Offered by SUSON's Nurse-Based
Stationary Clinic and Jag Mobile**

Services for the Elderly and other Adults

- Annual Physical Examinations
 - Screening and Diagnostic Testing
 - Preventive Health Education
 - Prenatal and Post-partum Care
 - Immunizations
 - Preventive Health Care
 - Laboratory Tests
 - Medically Necessary Diagnosis and Treatment
 - Family Planning Services
-

Services for Children

- Medical Screenings
 - Comprehensive Developmental Screenings
 - Developmental Assessments
 - Comprehensive, Unclothed Physical Exams and Assessments
 - Age Appropriate Immunizations
 - Laboratory Tests:
 - Neonatal Screening*
 - Iron Deficiency Anemia Screening*
 - Urine Screening*
 - Lead Poisoning Screening*
 - Health Education
 - Preventive Health Care
 - Vision, Hearing, Dental Screening
 - Medically Necessary Diagnosis and Treatment
 - Well Child Care
 - Title V Supplemental Food Program Required Screening
 - WIC Required Screening
 - Head Start Required Screening
-

- targeted churches and other community-based organizations;
- designed the logo on the Mobile unit which was highly visible and contains information for contacting the stationary health unit for enrollment and appointments;
- trained the Agriculture Extension Agents as health outreach workers; and
- designed and disseminated pamphlets and brochures in area hospital emergency rooms.

The NMHC and mobile health unit are owned and operated by Southern University and are an integral part of the School of Nursing. All income generated has been utilized to finance and/or expand education activities and services for stu-

dents, and to further the mission of the Southern University and SUSON by eliminating system, provider, and personal barriers,

Program Evaluation. The purpose of this project is to improve the health status of the target populations by providing primary health care. Obviously, the project cannot raise the health status of all individuals in the target area, but those individuals who are cared for in the NMHC and the mobile health unit should demonstrate a higher-level health status. Thus, an anticipated outcome of the project is that individuals who are provided with health services through the NMHC and mobile health unit will attain a health status commensurate with the health status of citizens in the rest of the United States. Data collection and analysis are ongoing, and reports of the impact of the clinics on the health status of clients may be reported in future publications.

Conclusion

The vision of SUSON is to provide health services to vulnerable populations residing in medically underserved communities. Partnerships with outside agencies and organizations has been crucial in accomplishing this goal. A community-based collaborative approach has been an effective and efficient means of providing low cost health services. Eliminating barriers to meeting health care needs proved to be a successful framework for making health care accessible to medically underserved rural and inner-city populations.

As reported, evaluation of the program is ongoing, but it has been recognized that to meet the health care needs of the most vulnerable populations, it is crucial to effectively and efficiently remove barriers to health care. Using a non-traditional approach, such as a Nurse Managed Health Clinic and a Mobile Health Unit to deliver health care directly into communities, is "prevention" in the broadest sense.

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African American Males Building Community

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Abstract

This article suggests that African American males would benefit from culturally sensitive dialogues on topics related to disease prevention, holistic health care, black manhood development and other topics related to the quality of their lives. The proposed method is designed to generate democratic participatory dialogues through the use of community forums and study circle groups that will challenge African American males to consider different points of view, explore disagreements, find common ground, and work together to solve common problems. The health initiative project includes the following activities: screening and self assessment, holistic health education and training and public forums for deliberation of critical issues, and the opportunity to create new knowledge through generative learning about the critical health and life style issues.

Introduction

The modern world suffers a kind of spiritual poverty and a lack of community. Young people in general are feared for their wild and dangerous energy, which is really energy longing for initiation.
—(Some', 1994)

Initiation rites in traditional African societies were a public recognition that the individual is now passing from childhood to adulthood. As long as a person has not gone through initiation, he is regarded as a child; therefore, he is not given full responsibility at home and in the community. Once the initiation has taken place, he is ready to enjoy full privileges and shoulder various responsibilities, both in his immediate family and in the larger community or nation (Mbiti, 1970 and 1975). The above-mentioned quotation applies directly to the plight of African American males in American society. African American males have traditionally experienced systematic oppression and have been reduced to a childlike status within American society from slavery to the current lost of citizenship due to the rapid rates of incarceration.

This article focuses on the holistic health care needs of African American men, boys and their families. The proposed methods and approaches are innovative and consider the cultural context and worldview of African American males. This approach to the development of African American males considers the multidimensional aspects of their holistic health care needs and recognizes that those needs are influenced by multiple frameworks which include biological,

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developmental processes, families, neighborhoods, schools, culture, ethnicity and race, and history.

The proposed method seeks to generate democratic participatory dialogues through the use of community forums and study circle groups that challenge African American males to consider different points of view, explore disagreement, find common ground, and work together to solve common problems and to collectively address their holistic health care needs. In advocating for a sustained health care initiative, the article is supported by three culturally specific assumptions that are critical to understanding the cultural context and worldview of African American males. These culturally specific assumptions are building community, kinship and spirituality.

In traditional African cultures *community building* is the spirit, the guiding light of the tribe, whereby people come together in order to fulfill a specific purpose, to help others fulfill their purpose, and to take care of one another. The goal of the community is to ensure that each member of the community is heard and is properly giving the gifts that they have brought to this world. Without this giving, the community dies, and without the community, the individual is left without a place where they can contribute. The community is that grounding place where people come and share their gifts and receive from others (Some', 1997).

The concept of *kinship* is the willingness to publicly assume responsibility in acting out the phrase "love thy neighbor as thyself." It is the public acknowledgment that we are family in our community, nations, and world, and that we act accordingly. The facilitation of connections among groups of African American males provides them with the opportunity to work together on internal and external (environmental) issues, bond together, support one another, and to engage in a quality of sharing as men and is an attempt to create sustained community dialogue.

Spirituality addresses the ways in which the African ancestors conceptualized the universe and their relationship to it, and subsequently governed their relationship to each other (Hill, 1992). The demonstration of spirituality provides the opportunity for African American males to gain spiritual leadership skills by engaging in self reflection; to observe enough of oneself so as to allow their work inside to be a positive reflection of their work outside of self. The idea is that a spiritual journey within oneself is self-awareness, which is an authentic gift.

These concepts of community building, kinship and spirituality are areas that are critically important to understanding the cultural context of the African American men, boys and their families.

The African American Male in Contemporary Society

African American males in contemporary society are confronted with many challenges that shape their physical, psychological, and social development. Evidence from both popular and social science literature over the last decade suggest that black men in the U. S. constitute a population at risk (Cordes, 1985; Dent, 1989; Gibbs, 1988; Johnson & Watson, 1990; Jones, 1986; McCall, 1994; Monroe,

1987; Parham & McDavis, 1987; Randolph, 1990; Siholz, 1990; Weathers, 1993; Wright, 1992).

Most social and economic indicators for black men depict individuals whose development and quality of life are in serious jeopardy. In 1990, for example, the National Urban League released a report on the status of the African American men (Johnson & Watson, 1990). This report offers a disturbing portrait of black male life. It states that black males have a shorter life span than any other population group in America, due to a disproportionate vulnerability to disease and homicide. In every age group, black men are significantly more likely to be victims of violent crime than are white men or women of either race. Among youths ages 14 to 17, the black male victimization rate is 65.9 per 100,000 in the population; the white male rate is 8.5 (U.S. Bureau of Justice Statistics 1986).

The National Urban League's report on the status of black males clearly indicates that black males in the context of American society are victims of institutional racism and internalized oppression. Institutional racism is perpetuated by those policies, priorities and accepted normative patterns within the society that are designed to subjugate, oppress and force dependence of black males to the larger society. This institutional racism is then manifest in the social acceptable sanctioning of unequal goals, unequal status, and unequal goods and services (Lipsky, 1978). The Urban League report goes on to note that the internalized negative self-image of many black males and the negative attitudes of authority figures toward black males fosters violence and drug abuse. This is a prime example of the manifestations of internalized oppression, which is the conscious and unconscious acceptance by the oppressed of the oppressor's point of view regarding standards of what is right, good, just and beautiful (Lipsky, 1978). In addition, the report indicates that black males encounter negative stereotypes about their manhood. These stereotypes include notions of social castration, insecurity in their male identity, and a negative self-concept. Many of these stereotypes stem from a failure to understand masculinity in an African American social and cultural context (Staples, 1978). These stereotypes stem from the manifestation of internalized oppression, whether it's in the form of social injustice or domestic control.

Internalized oppression disconnects black males from themselves, their families and community. The plight of the African American male is indicative of the need for holistic health prevention and intervention strategies that will reduce physical diseases, feelings of helplessness, hopelessness, depression and alienation (Grueling & DeBlassie, 1980). These behaviors, resulting from internalized oppression and institutional racism, have locked African American males in U.S. society into the victims' role, thus trapping them into oppression.

One indication of this socially imposed role-assumption is the number of African American males in contact with the criminal justice system. For the first time in U.S. history, there are more than 1.1 million prisoners in state and federal prison, and 508,084 are African American males (The Bureau of Justice Bulletin, 1994). According to an October 1998 report by the Sentencing Project, a Wash-

ington, D.C.-based legal research and services organization, in a dozen states, 30 to 40 percent of the next generation of black men will permanently lose the right to vote if current trends continue. In nine states, one in four black men can never vote again because they have been convicted of a felony. Hilary Shelton, director of the Washington Bureau of the National Association for the Advancement of Colored People (NAACP) underscores this point, "This loss of voting rights nationwide not only highlights the eroding political power base of Blacks, but calls into question the notion of democracy in America."

Despite the harrowing facts, it is important to keep in mind that a large majority of African American males are not breaking the law, but are engaged in the everyday activities of trying to make a way for themselves and their families. It should be pointed out that the number of black males (16 years or older) who are incarcerated represents 4.8 percent of all black males. This percentage is disproportional and unacceptably high since black men constitute more than 50 percent of the male prison population. At the same time, however, this percentage also reflects the fact that well more than 95 percent of black males (16 years and older) are not in prison; a statistic largely ignored in the public discourse.

The impact of oppression on African American males can also be seen through examining indicators of health and well-being. Between 1985 and 1991 the difference in life expectancy widened between black and white males: in 1991 white male life expectancies was 72.9 and black males were 64.6. Homicide rates in 1991 for African American males were 72.5 per 100,000, nearly eight times higher than for white males. Homicide is the second leading cause of death among black children. It is the leading cause of death among black youth 15 to 24, and the second leading cause of death among black males aged 25 to 44.

Of the more than 1.8 million African American families in poverty, 73 percent are headed by females. A key statistic in examining African American family life is the qualitative difference in income between married couples with children less than 18 and similarly situated female-headed household. The black married couple median income is \$35,162. The black female-headed households with children less than 18 is \$9,534 compared to \$41,686 for white married couples with children less than 18 and \$15,011 for white female-headed households with children less than 18 (Source, U.S. Census, 1992). This large income disparity points to both high rates of teenage pregnancy and to the increasingly lower rates of marriage among African American males. In turn, marriage rates among African American males are fundamentally influenced by their income levels. The higher the level of income, the more likely are African American males to marry and establish stable, two-parent families. Family life must be seen as a central component in fostering the well-being of the African American community.

The pattern of unemployment for both African American males and females contrasted with that of their white counterparts is disheartening. In the period 1990–1994 the black male unemployment rate (9.1) is more than twice that of white males (unemployment rate 4.7). Although discrimination is a likely factor, educa-

tional attainment is also a significant factor. The unemployment rates for African American males between the ages of 16 to 24 are alarmingly high (35 to 40 percent).

While it is true that poverty and unemployment are disproportionately high among African American males, it is also important to note some of the positive achievements black males are making in economic terms. For instance, of the 6.9 million black males (16 and older) in the labor force, 11.3 percent are in managerial and professional positions. While black males typically do not have earnings equal to their white counterparts, black males with bachelor degrees or better do have respectable median incomes. There are hundreds of thousands of African American males who are forming stable, two-parent families and are playing a major role in nurturing African American young males to become responsible and productive members of their communities.

African American Men in the State of Ohio

African American males not only suffer from the impact of social and economic disparities, but also from increased risk associated with disease and insufficient health care. Utilizing the state of Ohio's African American male population as a proxy for the health concerns of the U.S. African American male population, it is clear that some preventative action must be taken to improve serious health disparities. The overwhelming conclusion of the following indicators is that greater research is needed to determine why males and Blacks in Ohio—and possibly the U.S.—are suffering higher mortality than females and whites. Intervention programs for black males need to be designed and funded to reduce these disparities. (Ventura, Peters, Martin, Maurer, 1997).

From 1992 to 1996 the rates of mortality from all causes were highest for black males (947 per 100,000) followed by white males (621 per 100,000) black females (557 per 100,000) and white females (382 per 100,000). The ratio of the rates is used to determine the increased or decreased risk of mortality for one group compared to another. In Ohio the overall risk of mortality is 70 percent higher for black males than it is for black females, and 63 percent higher for white males compared to white females. At the national level in 1996 the mortality rates from all causes were: the ratios for males to females by race (1.72 black male/black female, and 1.64 white male/white female) were similar to those for Ohio. The ratios between Blacks and whites (1.54 black female/white female and 1.63 black males/white males) at the national level in 1996 were slightly larger than in Ohio.

Cardiovascular Disease. Black males were 53 percent more likely to die of cardiovascular disease than black females; and were 32 percent more likely to die of cardiovascular disease than white males. Coronary heart disease showed even higher discrepancies for males. Black males had a 65 percent greater risk of mortality than black females.

Malignant Neoplasm (Cancer). Black males were 66 percent more likely to die of cancer than were black females, and were 48 percent more likely to die of

cancer than white males. Lung cancer showed a larger gender discrepancy, with black males more than two and half times as likely to die of lung cancer as black females. Racial disparities for lung cancer also existed with black males 48 percent more likely to die than white males. Black males were two times more likely to die of prostate cancer as whites.

Diabetes. Black males were only slightly more likely to die of diabetes (1.040) than were black females. Black males were 80 percent more likely to die of diabetes than were white males.

Chronic Obstructive Pulmonary Disease (COPD). COPD was the one disease where whites were more likely to die than Blacks. The excess risk for white males was 5 percent compared to black males.

Chronic Liver Disease and Cirrhosis. Both black males and black females were more likely to die of chronic liver diseases and cirrhosis than their white counterparts; black males were 2.41 times more likely to die of chronic liver and cirrhosis than were black females.

Nephritis, Nephritic Syndrome. Both black males and black females were more likely to die of nephritis, nephrotic syndrome, and nephrosis than white males and females. Black males were 14 percent more likely to die of this disease than black females.

Human Immunodeficiency Virus (HIV). Black males had a fourfold increase when compared to white males. Black females had over an eightfold increase when compared to white females.

Accidents and Adverse Events (Unintentional Injuries). Black males were 2.78 times more likely to die of all unintentional injuries than black females. Black males were 1.23 times more likely to die of all unintentional injuries than white males.

Intentional Injuries (Suicide and Homicide). Black males were almost six times more likely to commit suicide than black females. Black males and females were less likely to commit suicide than white females and males.

The Study Circle Movement: Historical Context

Historically study circles, more appropriately "home study circles," were sponsored in the United States as early as the 1870s by the Chautauqua Literary and Scientific Circle in New York. This popular program of four-year correspondence study, organized group reading and discussion for adults who had no training beyond high school. Many participants were women who were denied access to higher education. During the latter half of the nineteenth century the National Swedish Federation of Adult Education Associations (SFHL) was anxious to conduct their own adult education on basic economic and political questions and were searching for a convenient, non-threatening, highly participatory democratic format. Oscar Olsson, a leader in Sweden's temperance movement, developed the study circle as a means of popular adult education.

The study circles arose in the bleak conditions facing late nineteenth-century

Sweden: a poor, underdeveloped nation unable to support its growing population and burdened with large-scale social and economic inequalities, rural poverty, high rates of illiteracy and threats of social unrest. The study circle, therefore, was a natural vehicle for the popular movements to advance their causes among the people, to create educational opportunities for adults who had limited access to formal education.

The study also taught members how to participate democratically in a community or organization, bringing to the surface new local leadership from circle members. What was learned in the study circle subsequently carried over into political life, as most of the popular movements eventually became active in political affairs. The study circle concept, has moved into a broad adult education movement in Sweden over the last century, and has begun to make inroads into organizational and community life in the U.S.

Despite some intensive adult education efforts in the mid-1970s through the New York State Study Circle Consortium, study circles remained a foreign practice until the mid-1980s when the Kettering Foundation's National Issues Forums (NIF) adopted study circles to accompany their efforts for deliberative democracy through public forums in local communities across the United States. In 1989, through the Study Circles Resource Center (SCRC), the idea received an enormous boost. Some 13,000 organizations and individuals comprise the SCRC database of interested parties.

Yet even in Sweden, with 320,00 study circles and 2.9 million adult participants every year, most of the evidence on study circle effectiveness is anecdotal. Bouton and Garth's study, *Learning in Groups* (1983) looked at collaborative-cooperative learning, concluding that collaborative learning works best with dependent learners and when participants have time to work through materials. They observed that group formats like study circles can help to instill democratic values, stimulate interest in a subject, and enrich students' ability to act collectively. But the study, like most studies on groups versus lecture learning, concentrates on the knowledge gained, not on enhanced capacity to participate, to offer one's views, to tolerate diversity, or to come out with a collective will to act.

Study circles are a resourceful approach to address the holistic health care needs of African American males and have the capacity to be culturally sensitive to appropriately serve the holistic health care needs of African American males and their families. Participants can be recruited directly from the community to participate in this process, utilizing churches, clubs, community organizations, the criminal justice system, media, word of mouth, local governments, community leadership, youth groups, elder groups, schools, higher education institutions and any other identified means within the community that will prove to be effective recruitment methods to increase participation.

The purpose of the study circle process and the use of community forums are to engage African American males in culturally sensitive dialogues on topics related to disease prevention, holistic health care, black manhood development

and other issues related to their "quality of their life." These dialogues will also generate democratic participatory conversations which will challenge African American males to consider different points of view, explore disagreements, find common ground, and work together to solve common problems.

The activities for this study circle health care initiative process focuses on African American men, boys and their families, and include such activities as health screening, health care self assessments, holistic health education and training, and public forums that address the quality of life issues for African American males and issues related to black manhood development and community action.

Definition of Key Terms and Concepts

Study Circle. The study circle is a simple process for small-group deliberation. There are just a few defining characteristics: A study circle comprises 8 to 12 people who meet regularly over a period of weeks or months to address a critical public issue in a democratic and collaborative way. A Study circle is facilitated by an impartial person who is there not to act as an expert on the issue, but to serve the group by keeping the discussion focused helping the group consider a variety of views, and asking difficult questions. A study circle permits a group to look at an issue from many points of view. Facilitators of study circles and discussion materials give everyone "a home in the conversation," and help the group explore areas of common ground. A study circle progresses from a session on personal experience ("how does the issue affect me?") to sessions providing a broader perspective ("what are others saying about the issue?") to a session on action ("what can we do about the issue here?") (Study Circle Resource Center, 1998).

Forums. Is based on the National Issues Forums (NIF) format which brings people together to talk about complex issues. These forums are held in communities nationally and internationally. Each forum focuses on one important problem, and as people share their thoughts and feelings, they talk about various choices, actions and go over the arguments for and against each choice. In forums each person must think as an individual, but also as part of a community. What makes forums unique is the choice work, meaning the work of the forum is to understand the choices involved in the complex issue. Each choice leads to different actions and each action has certain costs that must be weighed, both the good and the bad points of each. This is the meaning of "working through" an issue that occurs during the forum. Forums help people see issues from different points of view. The goal is to figure out what people have in common. The forum's deliberative process is the basis for formulating public policy in a democratic manner.

An African American Male Study Circle Health Care Initiative

The purpose of utilizing the study circle and community forums methodologies to address the holistic health care needs of African American males is to engage them in culturally sensitive dialogues on topics related to the total life quality. The discipline of group learning starts with "dialogue," the capacity of members of a

group to suspend assumptions and enter into genuine "thinking together." Group dialogue facilitates the free-flow of meaning through a group process, allowing the group to discover insights not attainable by individuals (Senge, 1990). The practice of dialogue has been a traditional cultural practice between Africans and Native Americans, but it has been almost completely lost to modern society. Today, the principals and practices of dialogue are being rediscovered and put into a contemporary context (Senge, 1990).

The Study Circle and Community Forum Process: A Model for African American Males

The following is intended as a basic framework for utilizing the study circle process with African American males as a health initiative. Communities should seek to employ any and all aspects of this model in an attempt to begin a dialogue to improve health status.

1. **To provide preventive health and screening services for African American men, boys and their families.**

Participants will be given two self assessments to complete: "Heart Disease Risk Quiz" and the "Stress Test," both instruments will provide participants with immediate feedback on their level of self-health care. Consultation services from a health care professional will be available for all participants who complete the assessments. All health service consultations will be documented.

Participants will be given health services such as: blood pressure and cholesterol screening and participants will receive immediate results from the screening and consultation from a health care professional. All health services administered will be documented for research purposes.

2. **To provide "culturally sensitive" holistic health education and training for African American men, boys and their families.**

The focus of this holistic health education should be couched in the context of community building, as a paradigm for promoting healthy living and improved quality of life. Community building necessitates the freedom to express differing points of view and ideas (Carnegie Foundation for the Advancement of Teaching, 1992).

All participants will attend the "culturally sensitive" holistic health education workshops that will focus on six diseases: cancer, cardiovascular diseases (stroke and hypertension), diabetes, infant mortality, substance abuse, violence and homicide. How these diseases and conditions manifest will be discussed, along with preventive education. Each participant will be given written materials that will further explain each of the diseases.

Additional workshops will focus on: Understanding the definition of holistic health, wellness, vitamin education, and other preventive techniques such as:

meditation, breathing, creative visualization, thought stopping, exercise, diet and stress management education will be covered. Each participant will be given written materials that will further explain each area covered in the workshops. A pre and post test will be administered to all workshop participants along with a workshop evaluation that will also be completed by all workshop attendees.

3. Engage African American men, boys and their families in community forums focused on issues related to African American males. Such forum topics might include the following:

- Learn how to deliberate and interact civilly.
- Gain insight and skills on how dialogue builds sustained community involvement, human capacity and how dialogue has the potential to transform the relationships in a community and thereby alter the political climate.
- Learn the rigor of choice work and that there is no easy answers for complex issues and problems and that choices have pros and cons and trades offs.
- Realize one's own knowledge is not complete until one understands why others feel the way they do about a choice or issue.
- Develop an argument in favor of a richer form of democracy as essential for progress in the African American community.

4. Involve African American males in study circles that deal with issues centered on black manhood development in the context of an oppressive society.

- Active listening, active member participation, creative conflict negotiation, evaluation and mentoring.
- Learning how dialogue moves people beyond blame and scapegoating and leads to more participatory, inclusive culture, which is a path to addressing the deep crisis of African Americans.
- Learning how to work together with others toward agreed-upon ends, finding "common ground" in their relationships and ideas.
- Engaging in equality and democracy among study circle participants with all members acting at one time both teachers and students, with reliance on dialogue rather than on lectures.
- Developing an interest for further study and community action after the study circle ends.
- Engaging in "Journal Writing" on their personal reflections, this activity will be conducted, before, during and after the study circle process. These Journals will be collected for research and evaluation purposes and confidentiality of the participants will be honored.

5. **Encourage African American males to host and facilitate study circles within their own communities centered on black manhood development.**

Each participant will learn the following study circle leadership skills:

- Set a relaxed and open tone.
- Establish clear ground rules.
- Stay aware of and assist the group process.
- Help the group grapple with the content.
- Use questions to help make the discussions more productive.
- Reserve adequate time for closing the discussion.
- Understand the difference between discussion, debate and deliberation.

6. **Provide the opportunity for African American males to learn how to build human capacity.**

Through the practice of the art of democracy, African American males learn the skills that are necessary to solve complex problems and build effective, democratic communities.

Participants will begin to understand the concept of "polis," which is a comprehensive idea that calls for the establishment and teaching of the values, manners, morals, and etiquette that are needed for structuring public life in communities.

Understand the concept of "reclamation," which is the act of African American men, boys and their families making the commitment to go back and bring forth the values and ideals of their African ancestors (Wilcox, 1998). The traditional values are:

- Respect for elder members of the community
- Respect for authority
- Encouraging each other to do and be the best
- Pride in one another's accomplishments
- Mutual aid
- The value of education
- The value of work
- The value of struggle and perseverance in the face of overwhelming odds
- Faith in the ability to succeed
- The value of the spiritual over the material
- Faith in a supreme being

Both qualitative and quantitative data will be gathered to measure cognitive and behavior change, along with the depth of meaning of the process. Data will be

generated via the pre and post forum ballads, workshops and training evaluations, health screening survey results, demographics of participants, and study circle journal data. The research and evaluation will value multiple perspectives and acknowledge multicultural competencies (Arredondo, Oporek, Brown, Jones, Locke, Sanchez & Stadler, 1996) and involve a representative sample of people who participate in the process. Research and evaluation outcome data will be used to inform the practice, and as an ongoing function of the management and leadership of the study circle and community forum process.

Formulation of Democracy: Public Policy Implications

In *Leadership in Black America*, Manning Marable (1998) pointed out that the central political dilemma that has confronted black America for several centuries now is whether and how the principles and practices of liberal democracy can be extended and guaranteed to Black people. He indicated that this question actually centers around two concepts: freedom and equality. Both were effectively denied to African Americans within the U.S. Constitution as well as within the institution of slavery. Marable (1998) stated:

During the Reconstruction, the promise of freedom finally existed. Black men won the right to vote and became active in public affairs. Black Reconstruction established schools and social and economic programs that benefited both racial groups. Nevertheless, it would take another century, filled with suffering and struggle, to achieve the basic freedoms and democratic rights that most white Americans took granted. And then, after that Second Reconstruction, black people still questioned whether their newly won political rights could lead to greater socioeconomic parity.

The central question derived from Marable's (1998) analysis is, can African Americans' devise a plan to utilize their collective resources, more effectively to address the structural crises that plague the African American community? He further asked the question:

Is it possible to persuade a significant segment of the white population that the black community's historical struggle to enrich and expand the meaning of democracy, the egalitarian quest for social justice, was also in its interests?

These and other unresolved complex questions have been the terrain upon which nearly all black leaders and social movements have sought practical solutions. Marable (1998) called for a full redefinition of America's democratic project if black Americans are able to move away from the charismatic, authoritarian leadership style of paternalistic organizations toward the goal of "group-centered leaders" and grassroots empowerment. In essence, instead of leadership from above, democracy from below more toward the concept of "leader fullness," which calls for communities to come together and engage in a "genuine thinking together" to solve complex systemic issues.

In a time when national leaders of all political points of view are talking about civic renewal and civility in our public life, many communities and citizens are creating community-wide study circle programs to invigorate and enliven public life at the local, regional and state levels (Study Circle Resource Center, 1998). These programs create an opportunity for ordinary people to make an impact on public problems and political decision-making, an essential element of democratic citizenship. By helping people first become active participants in their neighborhoods and communities, these programs strengthen democracy on a national scale. Study circles help citizens gain "ownership" of issues, and effectively contribute to a community capable of solving its problems. Through these structured dialogues, citizens better understand others' perspectives and concerns, discover common ground, and enhance their ability to work together as individuals, as members of small groups, and voters and members of large organizations in the community.

Conclusion

Democracy is essential for creating a new national dialogue about the issues confronted by African American males, leading to a new civic culture that improves the way all Americans think about citizenship, and the role racism and other forms of oppression effects our society. The core theme that permeates throughout this article is civic deliberative dialogue, which stresses that capacity and understanding are built through "deliberative dialogue" which overcomes isolation mistrust and civic disconnection. These methods move civic engagement toward the restoration of social life in communities. The work of providing for the holistic preventive health care needs of African American men, boys and their families, suggests the creation of multi-focused, multi-purpose approaches to these complex health issues. The work generated by study circles and community forums can be accomplished by the cooperative activities of civic, social, religious, professional, business, governmental and philanthropic organizations.

The deliberative dialogue that is generated via study circles and community forums is the beginning of an approach to repair society's breaches and restore civility to American communities. (National Task Force on African American Men and Boys, 1996). Individuals and organizations can use these civic building methods to transform communities and begin to create the long-term community structures for sustained intervention into the holistic health care needs of African American men, boys and their families.

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The Utilization of Health Services among Haitian Elderly: An Ethnogeriatric Study

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Abstract

This paper examines the factors related to the use of health services among a subset of the elderly community — the Haitian elderly. Specifically the article focuses on social, structural and cultural forces that impede complete access and maximum utilization of health services among Haitian elderly in the U.S. Barriers found in the authors' study include race of health care provider, deficiencies in use of English language, and lack of transportation. In addition, the author found impediments to service in the cultural beliefs of Haitian elderly and the negative perceptions of public health provision and preferences for private care despite a lack of resources. The article further identifies current public health needs and potential avenues for future research such as the Medicare implications related to the growing diversity of health needs within black elderly communities.

Introduction

Much of the current health care debate focuses on the overutilization of the resources of the federally sponsored Medicare program and the reallocation of resources that will yield maximum coverage and benefit to this nation's elderly population. Additionally, the debate focuses on the growth of the general population, as well as the rapid expansion of the elderly population, which is partially attributed to decreasing fertility rates, increasing life expectancy rates and migration patterns. (Restrepo, 1994). This paper examines the factors related to the use of health services among a subset of the elderly community—the Haitian elderly—and highlights some of the dimensions to be considered as a part of the ongoing debate.

Although the salience of issues concerning the elderly is unquestionable, there is a dearth of information and discussion, however, about the "ethnocultural" factors that affect the health status and assimilation of the elderly population of minority groups generally, and the Haitian elderly particularly, into U. S. society and culture. The belief that the acculturation of the Haitian elderly entails the abandonment of old, traditional practices and the adoption of new "American" practices is dangerously simplistic. The study of *ethnogeriatric* looks at the overlapping effects of the aging process, health status, and ethnocultural characteris-

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tics (U.S. Dept. of Health and Human Services, 1990). This Article attempts to discuss the experience of the Haitian elderly from a *ethnogeriatrics* perspective.

Consider that there are roughly 42 million uninsured Americans, that there has been an increase in immigration from nonEuropean, undeveloped nations, like the Republic of Haiti, and that the process of migration inevitably involves varying degrees of economic, social, and environmental dislocation. All of these affect the health and well-being of immigrants, and thus it is imperative that we consider some of the factors that may contribute to the burdening of the health care system's ability to deliver adequate services. Because of the complexities of the acculturating experience within the U.S., many immigrant groups have differed in their ability to blend into the American mosaic which has been influenced by their length of residence, socioeconomic status as well as the ability to speak the English language (Friedman, 1995). Some of these issues have catalyzed the role that social service agencies have played as advocates, facilitators or collaborators in the formation of neighborhood linkages. This article examines the many variables (i.e. economic, financial, and political forces) that could explain this reality and the utilization, or *under*-utilization, of health services among the Haitian elderly population. This article specifically focuses, however, on structural, social and cultural forces that impede complete access and maximum utilization of health services among the Haitian elderly in the U.S. and identifies public health needs and potential avenues for future research. Admittedly, many of these sociocultural barriers include basic differences such as language and communication; however, some are as multifaceted as values, customs, belief systems, education and personal history (Chapman, 1995). These sociocultural barriers can lead to strained patient-provider relationships, inefficient use of health care services, and negative health outcomes, while exacting a significant cost on this nation's and particular locale's health care delivery systems (Chapman, 1995).

Background

U.S. Aging and Diversity Trends

The demographic changes projected for the U.S. over the next fifty years have important implications for the use of health services and the need for culturally sensitive care (Barker, 1992). Two key population changes are the aging and the increasing cultural diversity of the population because the cohort age 65 and older in general, and elderly ethnic minorities in particular are considered to be among the fastest growing groups in the country. Between 1990 and 2050, the elderly population is expected to more than double to 80 million (U.S. Bureau of the Census, 1990). In addition to increasing in number, the elderly population is expected to become more racially and ethnically diverse, reflecting the trend of the general U.S. population. According to the 1990 U.S. Census, 19.8 million people or 7.9 percent of the U.S. population were foreign born, with undocumented immigrants comprising about 1 percent of the total U.S. population, or 13 percent of the foreign born population (Chicago Coalition for Immigrant and Refugee Protection,

1995). By 2050, it is projected that Blacks will comprise 14 percent of the aging population, up from 8 percent in 1980, while all racial/ethnic minorities will comprise 30 percent of the older population as the trend toward more rapid growth of older minority populations continues into the 21st century. Older Blacks and Latino populations will more than triple and quadruple, respectively, between 1990 and 2050 (U.S. Bureau of the Census, 1990). In 1990, 10 percent of the 31.1 million people age 65 and older were from racial or ethnic minority groups, 2.5 million of whom were Black; 500,000 were Asian or Pacific Islanders; 100,000 were Native American, Eskimo, or Aleut; and 1.1 million were Latino (U.S. Bureau of the Census, 1990). It has been projected that by 2025, 15 percent of the older population will be ethnic minorities; and by 2050, this number will rise to 20 percent.

The aging and diversity trends magnify previously hidden issues related to the provision of culturally sensitive health services to the elderly, many of whom may have limited ability to communicate in English (Wray, 1992). Thirty six million elderly people reported that they did not speak English in their homes, and 1 million of them reportedly lived in households where no one older than age 14 spoke English very well or at all (U.S. Bureau of the Census, 1990.) This trend suggests the importance of health services delivery systems developing greater sensitivity to social and cultural diversity and communication issues among older patients. Strategies should target this population and the growing complexity of its needs with particular emphasis on the nature of chronic illnesses associated with increasing age in minority populations, the resources needed for the use of longterm care facilities, and language barriers to effective health care.

Minority Health

Key indicators of the health, social and economic status of the U.S. aged population vary considerably by racial and ethnic groups and have become important dimensions in health research comparing different populations. For example, mortality risks in the African American population are considerably higher than in the white population for both genders. Gibson (1994) found that the disparity in health status for African Americans was greater for younger groups than in older groups of the population. Gibson's research also revealed that mortality rates are higher for African Americans, compared to their white counterparts, until age 75 when it becomes lower, a phenomenon known as the "Crossover Effect." African American males are at greatest risk of dying from cancer while most elderly deaths in the general population could be attributed to either heart disease, cancer, or stroke (U.S. Bureau of the Census, 1995).

Most health research targets the health status of Whites, Blacks and Latinos and very little attention is given to variations within the minority groups. The Ethnic Elderly Needs Assessment Survey (EENAS) was conducted in Chicago in 1988 to address the lack of data on various ethnic groups (Yu, Fugita, Prohaska & Liu, 1988). The Pacific/Asian American Mental Health Research Center was the primary contractor for the survey that was funded by a contract from the City of

Chicago Department on Aging and Disability. The survey considered the different factors that impacted the knowledge and use of health services among 11 groups in Chicago elderly, and categorized them into three groupings:

- | | |
|---------------------|-----------------------------------------------------------------------------------|
| I. European | Greeks, Lithuanians, Polish |
| II. Latino/Hispanic | Mexicans, Puerto Ricans |
| III. Asian | Chinese, Filipino, Korean, Vietnamese,
Cambodian & Ethnic Chinese (Indo China) |

While the survey did not include immigrants of African descent (either native Africans or Caribbean islanders), some findings are suggestive of potentially relevant public health issues concerning immigrant groups, specifically Haitian-American immigrants. These findings include:

- Cultural variation within a language such as Spanish which limits the effectiveness of printed bilingual materials;
- Significant variations in prevalence of depression/cultural acceptance of mental illness between the Asian ethnic groups;
- Significant dependence upon informal social support networks for some groups but not others; and
- Underutilization of dental care across all ethnic groups.

The survey recognized the need for the development of an entity that could address some of the pertinent issues concerning ethnic elderly.

Barriers /Access to Health Services

An analysis of the existing literature reveals the identification of four dimensions of access to services: availability, affordability, accessibility and acceptability (i.e., familiarity, language, and cultural experience) (Nyman, 1992; Petchers, 1988). The degree to which these various dimensions impact an individual's ability to access and to utilize health services depends upon the relevance of each dimension to a particular circumstance. Certain systemic barriers have been shown to affect groups regardless of socioeconomic status, ability to speak English or duration of residence in the U.S. Leclere (1994) found that the duration of residence strongly influences use of health care services and that legal status has shown to be a critical intervening variable in the relationship between duration of residence and the use of health care services. Chavez et al. (1992) and Rumbaut et al. (1988) determined that illegal immigrants, regardless of place of origin, language acquisition, and duration of residence, were much less likely to use formal health care services with the exception of the hospital emergency room. Leclere (1994) further found that the use of health care was constrained by lack of knowledge, limited resources, limited access to care, and cultural differences in perceptions of illness and help-seeking behavior. In addition, she reported that, "net of SES characteristics, access to health insurance, and differences in morbidity, recent immigrants are much less likely than both the native-born and those immigrants of longer duration to receive timely health care." Immigrants also have lim-

ited access to publicly funded programs such as Medicaid, Medicare and WIC, which improve access to primary care (Dellios, 1995). Recent immigrants are more likely to be impoverished and face substantial economic barriers to medical care. Wilk (1986) found that, "Haitian private physicians were viewed by refugees as much more desirable than those available at public clinics, not only for cultural commonalties but because of the belief that services that cost money must be better than those that do not. . . ." and posits that, the "[l]anguage barrier causes Haitians to avoid health care agencies where there are no Haitian staff [members] or even Creole-speaking nonHaitians." Similarly, preliminary feedback from this research revealed that Haitians prefer to interact with other Haitian health care providers.

With this in mind, Flores (1995) found that a major limitation of current community intervention studies is that they lack a conceptual/theoretical framework. Marikides, Liang and Jackson (1990) identified a variety of conceptual and methodological issues to be considered as they relate to the study of minority elderly. Johnson and Wolinsky (1994) found that differences in health status among older adults vary according to race and gender and that these dimensions should be considered in measuring levels of disability. Several well-known theoretical models have filled the gap in conceptual clarity present in many health intervention campaigns. The behavioral model of health service utilization framed by Aday and Andersen in the early 1970s is probably the most widely used theoretical framework and breaks down the use of health services into predisposing, enabling and need characteristics of the individual (Mui, 1994; Yeatts, 1992; Wolinsky, 1991; Urrutia-Rojas, 1991). Predisposing factors include ascribed as well as acquired demographic criteria (e.g. race, gender, level of education, religion, etc.) which make individuals susceptible to service use, whereas enabling factors, which include income, transportation, and family support, are those variables that help individuals to obtain existing services (Yeatts, 1992). The need variable refers to the individual's perceived need for health services. Some of the characteristics addressed in the survey considered at socioeconomic and cultural factors related to the use of health services and certain observations were made based upon the Andersen/Aday model of health behavior.

The Haitian Experience

Historical Perspective / Immigration

The country of Haiti, which is about the size of the state of Maryland, has over seven million inhabitants and has experienced a great deal of unrest since gaining its independence in 1804. There were seven presidents between 1908 and 1915, U.S. occupation between 1915 and 1934, and also between 1994 and 1996, and the Duvalier regime, which consisted of father and son (Papa and Baby Doc), lasted 29 years before falling in a coup d'etat in 1986. In the midst of this political chaos, there have been documented human rights violations, a struggling economy and great social class disparities which perpetuate a neocolonial status

quo (Morse, 1988). Jean Bertrand Aristide, Haiti's first democratically elected president in December 1990, was ousted from power in November 1991 following a military coup. In October 1994, however, he returned to power with the assistance of the U.S. government (Beckman, 1993; Duffy, 1994; Smolowe, 1994).

The migration patterns in the Caribbean have been influenced by a host of social, economic and political factors that have created an influx of immigrants to the U.S. These trends have contributed to the 2.7 million legal immigrants from all of the Caribbean countries gaining admission to the U.S. and Canada since the mid-1960s. Between 1950 and 1990, Haiti and Jamaica each sent roughly 1 million immigrants to the U.S. During the same period, Puerto Rico sent 800,000 immigrants to the U.S., and Cuba and the Dominican Republic each sent 700,000 immigrants (Guengant, 1993). Haitians have been immigrating to the U.S. since the late 1950s with the majority of immigrants arriving during the late 1970s and the early 1980s. As a consequence of their mass exodus from the island, Haitians have found themselves in a very tenuous position: they were not well received in foreign lands nor were they free to return to their native land without repercussions. There were reports of deported Haitians who were seen as traitors for having immigrated and, upon their forced return to the island, were beaten and mutilated by those left behind (Sontag, 1994).

It is estimated that there are approximately 100,000 legal Haitian immigrants in the U.S., and there is evidence of two distinct waves of immigrants. The first occurred around 1953, and the second in 1979. The first wave was comprised of 55 percent women and 45 percent men, with the majority ranging in age from 10 and 39 years and mostly from upper and middle class families. The second wave of Haitian immigrants, commonly referred to as the "boat people," occurred between 1978 and 1981 and included Cubans from the Mariel Boatlift in April through October 1980 (Harwood, 1981). This cohort was 70 percent male and young, ranging in age between 20 and 29 years old (Sontag, 1994). Haitians have mostly settled in New York City, Miami, Chicago, Boston, Washington and Philadelphia. According to the U.S. Census Bureau, there are 289,521 people of Haitian descent residing in this country (U.S. Bureau of Census, 1993), but these figures are considered minimally reliable, due to the traditional undercount of congested, poor and Black communities. Each year thousands of Haitians attempt to enter the United States, but only a small fraction, approximately 5 percent, are actually determined to be political refugees and thus allowed to stay.

In Chicago, the 1990 Census reported that there were 13,659 individuals that marked French or French Creole as the language spoken at home but these may include immigrants from other French-speaking countries in the Caribbean such as Martinique and Guadeloupe and native Africans from Francophone nations (U.S. Bureau of Census of Population and Housing, 1990). Again, the fact remains that it is very difficult to estimate the number of immigrants in Chicago, especially because the Census categories are very broad in identifying specific sub-populations and the relative immigrant numbers are so small (U.S. Bureau of the

Census, Ethnic and Hispanic Branch, 1990). Estimates have ranged from 30,000 to 50,000. Earlier immigrants held professional, technical or managerial positions. The majority of new arrivals have worked at unskilled jobs in the service industry and as domestic servants (Sontag, 1994). Because of the nature of many of these jobs, there may be some inherent barriers to adequate health care services such as the lack of available health insurance, transportation and unhealthy work environments.

Following the outbreak of the AIDS epidemic during the early 1980s, Haitians were identified as the main carriers of the Human Immunodeficiency Virus (HIV) because their population contained a high rate of HIV (Martin, 1995; Farmer, 1991). Researchers have not documented the incidence of AIDS in the Haitian community in the U.S. because those numbers have been merged with the statistics of other Black American groups (Martin, 1995). Yet, Haitians were considered a risk factor related to the transmission of the HIV and were classified as one of the *four Hs* (heroin addicts, homosexuals, hemophiliacs, and Haitians) by the Centers for Disease Control & Prevention (CDC) (Farmer, 1991). Since the Immigration Act of 1990, mandatory HIV testing with indefinite detention without treatment in HIV-positive detention camps has indiscriminately singled out Haitians from other immigrants (i.e., Cubans, Vietnamese, Chinese (Annas, 1993)). From these practices emerged negative stereotypes and sentiments towards refugees blamed for usurping American jobs and spreading HIV. There have been cases of discrimination where individuals have lost their jobs and were denied citizenship or deemed to be "unemployable" by virtue of their alleged infectious nature. This phenomenon of the 1980's created the perception that Haitians are social pariahs with a somewhat unique history and acculturating experiences.

Haitians, in fact, range in phenotypic characteristics and exhibit cultural and ethnic differences indicative of their historical and economic development. Consequently, the elderly members of this immigrant Black group face a sort of "triple jeopardy" as a nonEnglish speaking minority population (i.e. Black, nonEnglish-speaking, elderly). Although the "double jeopardy" hypothesis refers to minority aging phenomena, these particular circumstances are magnified in the Haitians population and, consequently, impact their use of health and social services (Belgrave, 1993). Foner (1987) observes, "As a population of foreign immigrants who, are phenotypically black, Haitians occupy an ambiguous position (in American society). . . . They are a minority within a minority." This particular scenario may have greater health implications in that certain risk factors (hypertension, obesity, stress, etc.), which are more prevalent within the African American community, may be harder to diagnose due to language, cultural and socioeconomic constraints. How true is this concept of a *triple jeopardy* as it applies to this Black sub-population? What are some of the acculturative experiences that Haitians, especially the elderly may face? This article now turns to a further explanation of the continuum of experiences and looks at possible public health implications.

Haitian Health Status

The current health status of the Haitian population has been somewhat difficult to assess due to many of the aforementioned factors (migration, poverty unrest, health illness behavior, etc.), yet some progress has been made in recent years. In a survey on Mortality, Morbidity, and Utilization of Services (EMMUSII) conducted by the *Institut Haitien de L'Enfance*, in 1994–95, researchers assessed the current health status of mothers and children in rural and urban settings in Haiti. The population is young with an exploding fertility rate, which is a common feature of third world countries. There were 23,904 interviewed in 4,818 households, and the following findings were made:

- High rates of illiteracy: 10 percent among boys between ages 15 and 19, 15 percent among girls between ages 15 and 19; 66 percent among men above 65, 84 percent among women above 65.
- Infant mortality rate: 74 / 1000.
- Life expectancy: 55 years (males) and 56 years (females).
- Annual income = 300 U.S. dollars as of 1994.
- Indoor Plumbing: 31 percent of population has access to portable water located within a 15 minute walk from home.
- Leading Diseases and infections: malaria, tuberculosis, HIV/AIDS, malnutrition; children are greatly impacted by diarrhea, malnutrition, respiratory problems (asthma).
- Electricity: $\frac{1}{3}$ of households have electricity; 40 percent of households use radio as means of receiving information; 17 percent have a television; 8 percent have refrigerators; only 3 percent of households have cars as means of transportation.

Survey results also reveal that overall distance from health facilities and the lack of transportation are significant barriers to obtaining health services for a large portion of the population. Some of the conditions identified by the research may contribute to the increasing prevalence of chronic diseases especially if they are not accurately detected through various screenings and other interventions. The health risk factors experienced earlier in life in Haiti are the antecedents to chronic diseases in Haitian elderly in the U.S. later in life. In a 1996 study of Haitian Americans, Holcomb (1996) found that the most common health conditions affecting Haitians and Haitian Americans include sexually transmitted diseases, cancer, and tuberculosis and states that, "Because Haitian Americans have not been appropriately delineated from other African Americans in health statistics, it is difficult to determine what prevailing conditions are prevalent among this group." Wilk (1986) found that Haitian refugees, especially adults, suffered primarily from problems related to gastrointestinal complications, tuberculosis and related chest pain, and venereal diseases which were more prevalent in Haitian men than women indicative of the fact that Haitian males have multiple sexual partners whereas Haitian women are expected to remain faithful to one man (Cosgray, 1995). The major cancers reported in Haiti are cervical, hepatic, stom-

ach and intestine, and Karposi's sarcoma (Mitacek, St. Vallieres, & Polednak, 1986). Incidents of liver, stomach and intestinal cancer were highest among Haitian males.

Cultural Beliefs and Acculturation

Different ethnic groups have adopted a variety of cultural beliefs over time and the ethnic elderly are likely to retain their culturally influenced health beliefs according to a study conducted by Congress and Lyons (1992). The researchers further found that a variety of approaches may be used by Blacks such as home remedies, sorcery and witchcraft, or strictly prayer and rituals. Although most Haitians (about 80 percent) identify themselves as practicing Catholics, a sizeable number do engage in voodoo practices but may not openly admit to such religion (Holcomb, 1996; Gustafson, 1989). A lack of cultural understanding of these practices only increases the chances of a misdiagnosis and incorrect treatment on the part of clinicians. The health beliefs and practices of their native countries may especially influence Caribbean Blacks. The beliefs of some Haitians about the causes of illness, treatment and prevention differ markedly from American health care practices, and diseases are often attributed to supernatural causes (Wilk, 1986).

Some articles have addressed intergenerational conflicts and the parenting practices of Haitian mothers with their newborn infants (DeSantis and Ugarriza, 1995; DeSantis, 1989). For example, there develops an unnatural role reversal when children are expected to act as interpreters for their families because of their familiarity with the English language (Holcomb, 1996). DeSantis & Thomas (1992) have found that the structure of the Haitian family is authoritarian and it is the expectation that each member is responsible for his or her own actions. Family rules and roles dictate that elderly persons are to be highly respected and that elderly parents often live with their children in traditional Haitian society. Following immigration to the U.S., roles may change whereby parents and elders become more dependent upon the children to serve as interpreters (Holcomb, 1996; DeSantis, 1993). In addition, the role of the elderly in Haiti was formerly that of a major advisor and counselor. This becomes a very difficult adjustment in a new environment where the elderly no longer are considered the economic or social anchor in the family or the authority on community matters and the loss of this role may have deeper implications not only for the individual but for the entire family. It is important to keep in mind the potential health implications related to the use of health services and recognize that behaviors such as the compliance to medical prescriptions may be constrained by family dynamics as well as health and cultural beliefs. The elderly within the Haitian community may be impacted by a variety of these factors and it therefore becomes imperative that we better understand how these issues may impact upon a broader constituency.

Generating Hypothesis About the Haitian Elderly

As the preceding discussion shows, there is an interesting, yet complex, interaction of ethnicity, race, education, culture, socioeconomic status, and the ability to

speak English. Since little has been published on the Haitian elderly's health behavioral pattern, a logical point of departure for this study was analyzing issues related to the triple jeopardy hypothesis. That concept embraces a majority of the significant interactive variables, and surveys Haitian health providers, who interact with the Haitian elderly on a daily basis. Resultantly, this study explored the Haitian elderly's health behaviors by first identifying key themes centered on broader health access issues, then determining the barriers limiting their access to health services, and finally offering explanations and rational solutions that can facilitate the delivery of services to a vulnerable and often voiceless population.

The Coalition of Limited-English Speaking Elderly (CLESE), a nonprofit organization incorporated in 1989, has a mission to address and accommodate the needs of non or limited Englishspeaking elderly populations in the metropolitan Chicago area. With its membership increasing to more than 30 organizations over the past few years, CLESE has been instrumental in sponsoring and coordinating a variety of community events and neighborhood collaborative efforts like health fairs and programs on illiteracy, depression, language barriers, racial and ethnic discrimination. In March 1996, CLESE cosponsored one such event that targeted Haitians from the Rogers Park and northern Chicago area. Although the program was neither specifically for the Haitian elderly nor on health services, the attendees' greatest interest was health service, as evidenced by a long waiting line at the doctor's table. Many of the Haitian elderly were eager to be attended and examined by a Haitian doctor and the clear implication from their feedback was that they preferred to be seen by someone who could not only communicate but also relate to the context of their health-related issues. As a majority of the elderly attendees waited in line, spoke in their native Haitian Creole language and enjoyed a traditional Haitian lunch, it was apparent that a doctor's ability to relate linguistically and culturally was very important to them. This scene presented a clear cultural preference that could be partially accommodated in Haitian enclaves in Chicago, Miami, New York City and Boston but could have broader and potentially devastating implications for Haitians and other ethnic minorities accessing health services. As researchers have noted, minority older adults prefer to be examined by health care providers with shared cultural backgrounds and that their social networks, such as the family, peers and the community-at-large greatly influence health and illness behaviors (Bell, 1997; Friedman, 1995).

These observations as well as a number of individual encounters and conversations with members of the Haitian community prompted a look into some of the acculturative issues and their impact on the use of health services. To that end, a short openended questionnaire was developed, after consulting with faculty at the University of Illinois at Chicago School of Public Health, members of the clergy, educators, and health providers within the Haitian American community, with the purpose of addressing three main issues related to the Haitian elderly in Chicago: 1) barriers to the use of health services, 2) reasons for the existence of these barriers, and 3) measures which would ameliorate or eliminate the barriers. The sur-

vey was administered to health providers at an annual CLESE community health fair that targeted Haitians on the South side of Chicago. The questions solicited suggestions on the best strategies that could be used to reach the Haitian elderly, the types of facilities most used throughout the Chicago metropolitan areas, and the degree to which Haitian health providers are sought for health services. The questionnaire included thirteen questions, nine of which related to the utilization of health services among the Haitian elderly and four of which pertained to demographic information. The questions pertaining to health services include:

- What do you feel are some of the barriers that Haitians face that may impact upon the use of health services?
- What do you think are some of the reasons for the lack of access to certain services?
- What would you suggest could be done differently in order to address some of these issues?
- What do you think are the best ways to reach the elderly in the Haitian community?
- What have you found to be some of the major health issues faced by the elderly in the Haitian community?
- What would you consider to be the main health facilities used by Haitians in the Chicago land area?
- Do you think that Haitians seek or avoid other Haitian health care providers (in general)?
- Can you estimate the number of Haitians that live in the Chicago land area?

Although these survey questions were, in fact, developed to shed light on the plight of the Haitian elderly community in Chicago, they were crafted with the underlying intention to gain more insight the following four topical queries:

1. Do Haitians have similar health problems compared to the overall Black community in the United States or other immigrant groups?
2. Who are "Haitians" and what are the estimated number of Haitian immigrants in the United States?
3. What are some of the major health problems faced by the Haitian elderly?
4. Can we apply the Andersen/Aday model for the utilization of health care services to the Haitian American Community Association (HACA) in Chicago?

These preliminary questions led to further investigation of the issue through conversations with members of the local Haitian community in Chicago. These conversations covered a range of issues, including 1) estimated number and area of residence of Haitians; 2) family composition; 3) migration patterns as these have influenced level of education and income; 4) healthcare facilities most used by Haitians; 5) impact of language barriers on daytoday activities; 6) main problems of adjustment (culturally, socially); and 7) discrimination.

Administration of the study was standardized: each interview took approximately 10 to 15 minutes; instructions and questions were read to each of the respondents in English; and interviews were conducted in English. The survey was administered to thirteen health professionals rather than the attendees primarily for reasons of convenience. The respondents were mostly medical doctors and registered nurses; one respondent identified herself as a health educator and another as a medical technologist. And, the majority of the respondents identified themselves as Haitian American rather than Haitian, Black or African American.

Results and Preliminary Findings

The respondents cited *language difficulties* and a *lack of available transportation services* as the most common barriers and reasons why the Haitian elderly do not use available health services. The *lack of knowledge* on how to use available resources was also identified as a major barrier within the Haitian community-at-large and especially as this relates to the elderly. The respondents also highlighted that *certain cultural beliefs and health/illness behaviors* (such as a selfconcept of not being sick) may influence how Haitians adhere to particular normative behaviors and may consequently rationalize against the use of available health services. The reasons do vary and yet all emphasize the need for culturally specific interventions that may target this population, in an attempt to bridge the gap that exists between the perceived need for health services and the availability of such service (Appendix B).

Table 1. Factors that Health Providers Felt Restricted Access to Health Services*

Barriers	Key Words	Percent of Total
Language	Language, communication	29.4%
Cultural	Culture, beliefs, superstition, trust, fearbeliefs,	35.3%
Socioeconomic	Money, transportation, insurance, education	32.4%
Other	"Lack of interest"	2.9%

*Respondents cited many variables in answering the questions

Respondents considered language and cultural factors to be the greatest barriers to the use of health services for many Haitians in the Chicago area. These combined factors accounted for 64.7 percent of the responses that were given in order to identify the main barriers to using health services. Again, respondents found that sociocultural dimensions rather than economic factors to be the main barriers, which further validates the call for more culturally specific approaches to addressing this population's health needs.

When asked about the reasons for the restricted access to the use of health services among Haitian individuals and especially the elderly, the following responses were given:

Table 2. Reasons for the Restricted Access to Health Services*

Barriers	Key Words	Percent of Total
Language	Language and communication	11.4%
Cultural	Culture, beliefs, superstition, trust, and fear	20.0%
Socioeconomic	Money, transportation, insurance, education	60.0%
Other	"Lack of interest"	8.6%

*Respondents cited many variables in answering the questions

The respondents cited mostly socioeconomic factors as the reasons for the restricted use of health services. Respondents identified lack of insurance, lack of available transportation and overall lack of knowledge as the determinant factors. When asked what *they* considered to be barriers to health services for Haitians in general, the respondents felt that there were more cultural and language impediments to using health services; the answers ranged from the self-concept of not being sick and a fear of doctors to language and communication difficulties. But when respondents were asked why they felt that these factors restricted the use of health services they commented that the lack of structural and social support such as affordable health insurance, lack of transportation and a knowledge of the available resources, outweighed some of the cultural issues. Findings such as these may allow us to better structure public health outreach efforts and other interventions programs.

The respondents further identified barriers to health services for Haitians and provided suggestions for improving outreach efforts to the community and especially the elderly. When asked about any suggestions in reaching the Haitian elderly in the community the respondents cited strategies to increase the use of radio to promote health education efforts, church announcements at the services conducted in Haitian Creole and word of mouth "*telediòl*" as the best ways to target the elders in the community. Respondents also felt that better efforts for community organizing should be made in the Haitian community. They felt that this would improve the dissemination of information and especially health education materials. Those surveyed cited a litany of diseases that they believed plagued the Haitian elderly population and listed diabetes, hypertension and symptoms of depression as the most common. The implication here is that many of these diseases are reflective of those found within the overall African American community yet more culturally sensitive interventions may be needed in order to reach

those restricted by language and other health beliefs. The respondents also believed that Cook County Hospital, which is the city's largest provider of health services to Medicaid patients, was the most visited facility by the elderly in the community despite the fact that most would prefer to visit a private Haitian physician. The frequent visits to Cook County Hospital may be due to the fact that interpretation services are available in a variety of languages that include Haitian Creole.

Policy Implications

This study was a "pilot investigation" which confirms the plausibility of the *triple jeopardy* hypothesis (minority, non-English speaking, and elderly) as it relates to the Haitian elderly. While some Haitian immigrant issues and their impact upon the use of health services have been identified, and although the findings are far from being conclusive, they give us better insight to better analyze areas of future research. Factors such as low socioeconomic status, illiteracy, lack of transportation and affordable health insurance have been identified as barriers to the use of health services. Cultural factors such as the ability to speak English, the level of comfort with the health care provider and the venues used for health education and promotion have also been identified as barriers but are considered secondary to the broader structural barriers such as poverty and unemployment. This study should help us focus on more practical means by which to reach minority elders, factoring in the cultural nuances that may restrict their use of health services. The Andersen/Aday's model on the use of health services should be used as the framework to examine the predisposing, enabling and need characteristics that determine the use of services. A study which uses this or a similar framework can help in providing a more practical dimension to the policies and interventions designed to target immigrant populations.

As there is a disparity between the enactment and implementation of public health policy for obtaining adequate medical care (Petchers, 1988), this study highlights potential avenues for public health research interventions within the Haitian community such as the use of linguistically/culturally appropriate surveys; the effectiveness of printed bilingual materials and; the impact of increased outreach efforts that better target this population as a whole. More studies, which are culturally specific (especially to the Haitian elderly), may be necessary to adequately capture these nuances. Better health promotion efforts should target Haitian elderly through churches, radio programs (currently conducted in English, French and Haitian Creole), and the translations of materials into cassettes and videotapes. There is a need for more cohesive community support for activities that can bridge the geographic and social gaps which have become synonymous with cohort in the Chicago area.

There currently exist a few Haitian programs that are aired on the cable stations which can disseminate health information to the community at large. Through regular social events, Haitian holiday celebrations, community and

intergenerational projects, the elderly in the community can better withstand the stressors of acculturation. Although additional health providers are needed in area facilities in order to better address this population's needs, the emphasis should be placed upon the public health interventions as well as medical needs of the population. Cultural and language barriers may impede the access to other services besides health-related ones and therefore strategies should be broader in scope rather than simply providing translators at area hospitals and clinics. Future studies could address a variety of issues that were found both in the literature and through this exploratory exercise. Studies could look into the methodology of surveying hard-to-reach or isolated Haitian elderly in Chicago as well as other cities. Other studies could look at the process of conducting a community needs assessment in order to determine the health status of Haitians in the Rogers Park area compared to Haitian residents on the South East Side of Chicago.

Other studies could address the assumed prevalence of depression among the elderly in the community and the effect of radio/church interventions in reaching the Haitian elderly. This suggestion considers the church and radio to be the most practical venues that could be used to target this group in that many elderly attend church services and most Haitians in this cohort are accustomed to listening to the radio in order to gather. This approach also takes into account the different levels of education that exist in the community as a result of the contrasting migration patterns. The community needs assessment would help further identify some of the health needs within the Haitian community and would also allow providers to refine current interventions.

Conclusion

The results and findings of the study highlighted some of the various observations made by health services providers within the local Haitian community. Many of the respondents shared some of the same views related to the barriers faced by members of the Haitian community, which are exacerbated by the elderly. This Article was intended to raise some of the concerns around this invisible cohort of Haitian elderly and to heighten the awareness as it pertains not only to the Haitian elderly but also to communities of color as a whole. In addition, the point here reminds us of the need to pay particular attention the sub-groupings in America and to further recognize the heterogeneity that exists within the black community. As a result of these observations, some preliminary conclusions may be drawn and some policy recommendations can be enumerated that may impact upon the black elderly as this pertains to the overall disparities in health that exists within the U.S. and the rest of the world. Similar exercises could consider policy implications related to the availability of funding for research which focuses on the health status of various subgroups within the black community; sociocultural strategies of acculturation and its impact upon mental health status of black immigrant groups; Medicare implications related to the growing diversity within black elderly communities. By and large, there may not be great differences in health

status among the subgroups but the implications may pertain to the most appropriate strategies to better target the subsets of communities of color.

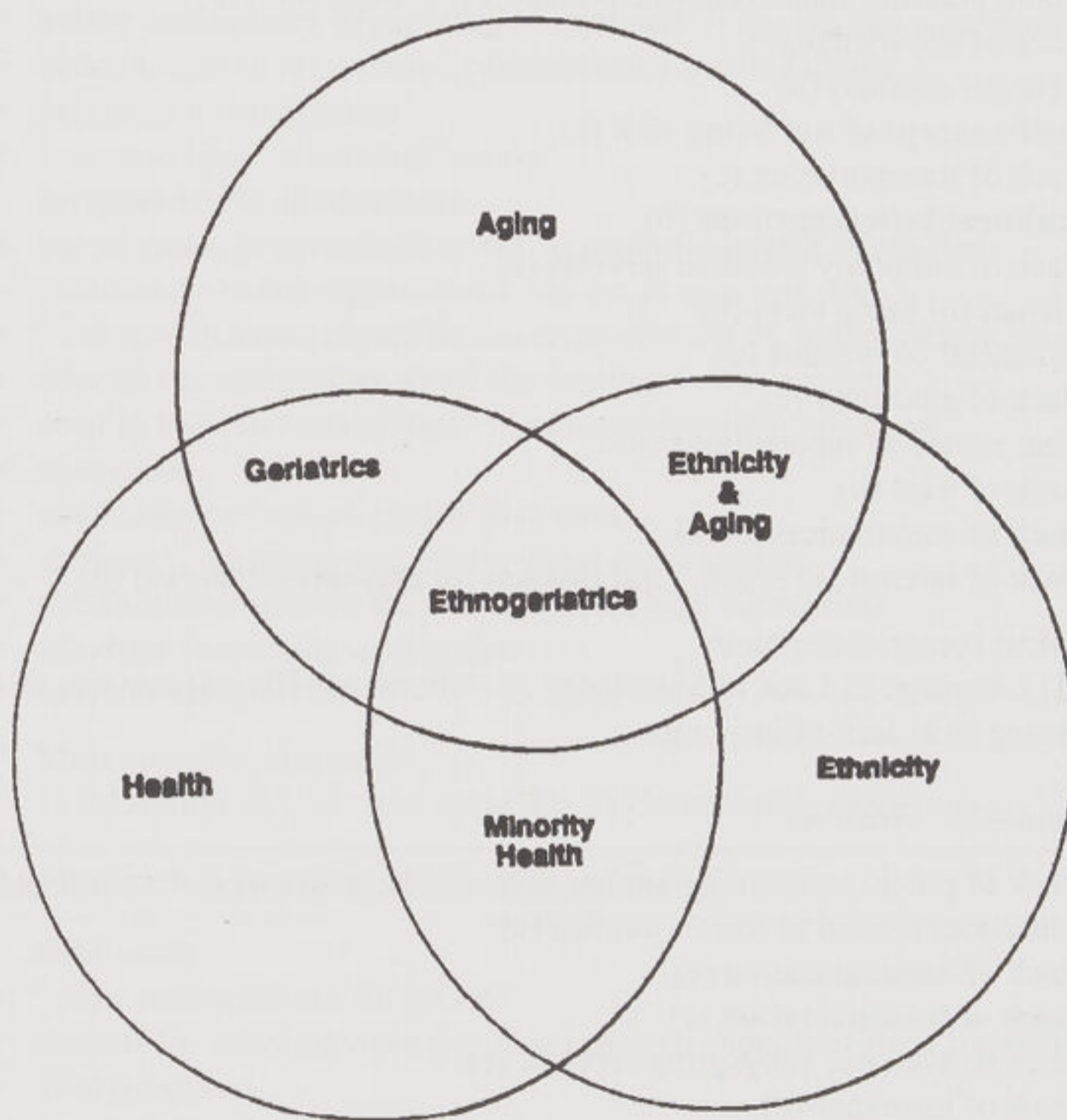
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Appendix A



The Combination of Related Fields to Form Ethnogeriatrics

Appendix B

Essay Survey Responses

Question #1 *Barriers . . .*

- **language** (a)
 - **lack of insurance** (c)
 - more pressing socioeconomic problems (i.e. food, rent) (c)
 - lack of knowledge (c)
 - fear (of doctors) (b)
 - **self-concept of not being sick** (b)
 - lack of transportation (c)
 - **cultural beliefs/customs** (b)
 - lack of culturally sensitive services (b)
 - denial (of being sick) (b)
 - financial constraints (c)
 - lack of education (c)
 - fear rooted in superstitions (b)
 - lack of trust (b)
 - lack of communication (a)
 - lack of interest (in seeking information for preventive reasons) (d)
- * Most common responses:
 1) Language 2) Lack of knowledge 3) Cultural beliefs; self-concept of not being sick; lack of insurance

Question #2 *Reasons . . .*

- lack of public assistance (number of available programs is decreasing) (c)
- distances needed to travel (too far) (c)
- lack of communication (a)
- **lack of transportation** (c)
- lack of available babysitting services (c)
- lack of insurance (c)
- **lack of knowledge on how to use the available resources** (c)
- lack of information about health education (c)
- lack of available Haitian health care providers (b)
- fear (b)
- lack of ethnically specific activities which target Haitians (b)
- lack of a cohesive Haitian network ("Haitians don't network") (b)
- lack of education (c)
- "*Not as concerned about health*" (d)
- language barrier (Haitian Creole preferred over French) (a)
- **Cultural issues** (i.e. privacy) Don't want healthcare providers to know their business (b)

- lack of employment (c)
 - economic problems (c)
 - some problems (illnesses) may be psychosomatic (d)
- * Most common responses:
1) Transportation 2) Lack of knowledge 3) Culture issues

Question #3 *Suggestions . . .*

- **better community organizing** (on the part of the Haitian community)
 - better access to information (disseminated by the facilities)
 - provision of interpreters
 - “increase lines of communication”
 - **increase levels of education**
 - **use of radio programs in order to promote health education**
 - community-based organizations can act as catalysts (b)
 - “*community needs should be based on cultural vs. policy perspective*”
 - educate the community about the health services available
 - need to have support of local community hospital, clinic, etc.
 - motivation
 - emphasize prevention (rather than cure)
 - increase job training and employment opportunities
 - decrease immigration barriers in establishing citizenship
 - advertise (especially in churches)
 - have workshops
- * Most common responses:
1) Education 2) Use radio programs 3) Community organizing

Question #4 *Outreach activities (Haitian elderly) . . .*

- field visit
- “show more concern for group”
- support for other services (i.e. fixed income should result in fixed bills)
- food programs
- house-to-house
- **churches** (as opposed to social gatherings such as parties)
- audio-cassettes
- **word of mouth** / “telediòl”
- need “cultural brokers” in order to facilitate process
- priests at church services
- friends (social networks) and social gatherings
- TV
- **radio (Haitian)**
- center for the elderly
- through other aging agencies

- family
- newspaper (community)
- picnics
- * Most common responses:
 - 1) Churches
 - 2) Radio (Haitian)
 - 3) Word of mouth

Question #5 *Major health issues (problems) . . .*

- lack of knowledge on the use of health services
- need to be better culturally understood
- high blood pressure
- **diabetes**
- **depression**
- abuse by children (elderly feel isolated, stranded, dependent; abuse for money)
- vision problems
- social isolation
- health promotion programs that are more culturally specific
- transportation needed (since elderly live with their children & depend on them for rides)
- cancer
- lack of cancer detection programs (screening)
- low SES contributes to decreased likelihood of seeking preventive services
- **hypertension**
- financial / insurance barriers (especially with cuts in welfare provisions)
- lack of education
- osteoporosis
- arthritis
- nutrition (need to learn how to eat properly)
- loneliness
- * Most common responses:
 - 1) Diabetes
 - 2) Hypertension
 - 3) Depression

Question #6 *Health facilities used . . .*

- Uptown clinic
- **other CDOH agencies**
- depends on area of the city where they live
- depends on their socioeconomic status and insurance coverage
- **private physicians**
- *“Many don’t go to the doctor; don’t feel sick”*
- **Cook County Hospital** (“cares for indigent population”)
- clinics (public or private)
- mental health programs (for depression)

- nutrition facilities
- “*They (Haitians) usually wait until they feel sick*” (before going to the doctor)
- “*Staff at Cook County (hospital) make the person feel comfortable and can relate to the person*”
- “*There is (also) a social hang-up against using Cook County (hospital)*”
- HMOs
- hospitals
- “*(Haitians) don’t change doctors easily especially if these are also Haitian (as well)*”
- “*Some may go to the doctor’s home*”
- don’t know
- -emergency room
- “*I think that they avoid it (using health facilities)*”
- no answer
- * Most common responses:
 - 1) Cook County Hospital
 - 2) Private physicians
 - 3) CDOH agencies & clinics
- ** “*Usually wait until very sick . . .*”

Question #7 *Haitian health care providers . . .*

- **would seek other Haitian health care providers** (language, culture)
- “*It’s better if providers look for Haitians rather visa versa*”
- “*People don’t want charity*”
- lack of trust
- “*both are possible*”
- psychosomatic; “*look for concern (attention) from physician*”
- “*cultural affinity*”
- “*Doctor doesn’t respect patient in Haiti; concept of health is different*”
- “*Doctors don’t make it convenient for patients; there are no ER services*”
- “*Real emergencies end (result) as deaths*”
- “**Yes & No . . .**”; (seek) “*some do so because of snobbism . . .*”
(avoid) “*others fear of patient confidentiality not respected*”
- scared of being “*known*”
- lack of education
- “*Haitians avoid (other) Haitian businesses*”
- “*Some avoid because the doctor doesn’t accept their insurance and asks for Money instead*” (feel that there is some abuse of authority and that they are being taken advantage of)
- Avoid Haitian health care providers
- * Most common responses:
 - 1) Seek similar Haitian providers
 - 2) Seek & avoid providers

Question #8 *Estimated numbers (Chicago land) . . .*

- 10,000
- 15,000
- **10–20,000**
- 25–30,000
- 50,000
- 60,000
- **50–60,000**
- **no idea**
- **don't know**

* Most common responses:

1) No idea/don't know 2) 50–60,000 3) 10–20,000

Respondent Profile...

Question #9 *Average age of respondents:* 48.7 years old
(3 respondents "no answer")

Question #10 *Sex/gender:* 9 females, 4 males

Question #11 *Residence:* Even split between Southside and suburbs;
some Northsiders

Question #12 *Occupation:* Medical Doctor (5)
Registered Nurse (4)
Medical Technologist
Nurse Educator
Nurse (?)
Public Health Nurse

Question #13 *Identify themselves as:* Haitian-American (7)
Haitian (4)
Black (2)

AIDS and the Black Community: The Need for Accessible and Adequate Care

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Abstract

This article argues that two decades into the HIV/AIDS epidemic, it is abundantly clear that Blacks are disproportionately affected by HIV/AIDS. The proportion of Blacks with the disease is increasing more quickly than in any other segment of society. What's more, the disease is often severe, goes undiagnosed and untreated until the end stage and becomes rapidly fatal. Behavior, community apathy, inequities in health care practices and politics have all played a part. The authors propose that religious and political leaders must come forward to implement an AIDS prevention and treatment strategy modeled on the successes of the homosexual community, but tailored to the needs and strengths of the black community.

By the Numbers

AIDS has become one of the most alarming health issues facing the African American community. Current epidemiological data suggest that the disease is increasing unabated among Blacks while it is declining and leveling off in the white homosexual community where the initial impact of the epidemic was severe. While Blacks constitute about 13 percent of the population, they are increasingly disproportionately affected by HIV infection and Acquired Immunodeficiency Syndrome (AIDS) (Rosenberg & Bigger, 1988). In the United States among young people 20 to 25 years old, HIV prevalence declined by about 50 percent in white men but has remained stable in black and Hispanic men. Surveillance data suggest that Blacks are 16 times more likely than whites to be diagnosed with HIV/AIDS (Diclemente & Wingood, 1995). HIV prevalence in women aged 20 to 25 years old has risen by about 36 to 45 percent due to an increase in heterosexual transmissions. Fifty-five percent of all women who contract AIDS are black and they are nine times as likely to die from the disease than their white counterparts. Even more disturbing is the higher incidence of the disease among black females than black males.

The initial peak and decline in the incidence of HIV/AIDS in the homosexual community does not appear to be occurring in the black community. The rate of HIV infection continues to climb among black males, female heterosexuals, and drug users (Greenland et al., 1996). Furthermore, HIV infection has been cited as the third-leading cause of end-stage renal disease in Blacks aged 20 and 64. The incidence of HIV-associated kidney disease, nephropathy, has steadily increased each year for the past several years (Winston, Burn & Klotman, 1996). The continuing increase in the absolute number of new HIV cases in Blacks is expected

to result in a 1 to 4 percent increase in HIV-associated renal failure. This trend will continue relentlessly unless new treatment methods are put in place and preventive measures are successfully implemented in all segments of the population.

The incidence of HIV/AIDS in black children up to 14 years old is also increasing. This is a direct result of the disproportional increases in the heterosexual transmission of the disease in females of childbearing age. AIDS has become the leading cause of death in children in this age group (Santelli et al., 1995). The number of black children with AIDS will continue to rise unless the heterosexual transmission of HIV to women of childbearing age is halted through effective preventive measures.

Part of the problem is that many of these women underestimate their risk of contracting HIV. Often, a combination of low self-esteem and psychological depression predisposes women to make risky sexual choices. Likewise, a lack of social cohesiveness and social resources, in addition to a coping mechanism of avoidance, contribute to the problem. Although these characteristics explain the current HIV infection rates among women, some of the causes are external. Many women are unable to exert influence on their partners in sexual decision-making. Some black women living in deprived socio-economic circumstances with little control over their daily lives and are likely to feel powerless over decisions affecting their health and personal well-being. Often, such women are dependent on male partners and engage in unprotected sex. In many instances, the women are not practicing high-risk behavior other than having sexual relationships with men who are often bisexual, sexually promiscuous or drug addicts. Thus the risky behavior of male partners becomes critical in explaining the heterosexual transmission now escalating in the black community (Quinn, 1993).

Barriers to Community Action

The black community has neither faced up to this epidemic nor harnessed its energies to effectively address the impact of the continuing spread of the epidemic. The sense of urgency that spurred the successful campaign waged by the predominately white homosexual community in the early 1980s has not occurred. The inaction in the black community may in part be due to its culture and religious beliefs. The black community has been in denial regarding the homosexual practices in its midst. There is also a generally pervasive religious belief that homosexual is immoral and sinful; some have even considered HIV to be divine punishment for homosexuality (Stokes & Peterson, 1998). As a result, some community members harbor negative attitudes toward homosexuality, which may explain the absence of widespread action in the community at the onset of this disease. In addition, some homosexual and bisexual black men who fear they will be ostracized are in denial and continue to engage in risky sexual behaviors that have perpetuated the increasing infection rate in the black community.

The refusal to accept homosexuality as a legitimate sexual preference and the resulting homophobia has resulted in a lack of organizing and implementation of

effective measures for prevention and treatment. Within the black community, there has been a notable lack of leadership from the traditional sources: religious leaders. This leadership vacuum may continue to impede the progress of any effort to organize effective preventive measures, including the dissemination of HIV/AIDS education to members of the community (Morales & Fullilove, 1992).

The belief among some that AIDS is a genocidal tool targeted at the black community by a society that has oppressed and subjected generations to suffering has become an inadvertent barrier for HIV prevention. The legacy of Tuskegee studies, in which black men with syphilis were left untreated, may explain part of this distrust. The perceived racist experiment led to a lack of faith in public health authorities by many African Americans. Consequently, it is often difficult for white researchers to recruit many Blacks for participation in investigational studies.

The meltdown in the social structure of the urban black community has also contributed to the problem. The disconnection of people from their communities has fostered individuality, impaired social control and dampened economic opportunity. The social disruption has been devastating to some of the black community's youngest members who witness intensified substance abuse problems and indiscriminate sexual activity (Wallace, 1993).

Exacerbating these issues is the decrease in governmental expenditures for municipal services in the inner cities that has contributed to the disintegration of essential social services necessary to support health maintenance. Many have blamed the government's withdrawal of support for the rise of violence, increase in substance abuse and other deviant behaviors as well as the spread of HIV within the black community (Wallace 1990).

The refusal of society to consider drug addiction a medical condition has also created a barrier to implementing effective preventive measures that could ward off the current HIV infection rate. Furthermore, drug addiction, often regarded as a character defect or a moral problem in religious terms, has been a source of shame and denial among some African Americans because of the inability to rid the community of the problem.

Barriers to Equal Medical Treatment

There is a major disparity between whites and minorities in the accessibility of care for HIV/AIDS. This disparity is evidenced by the significant difference in survival time rates between Blacks and whites with the disease. This difference is thought to be directly related to diagnosis and accessibility to highly effective but expensive drug therapy (Moore et al., 1994). More than 50 percent of black HIV-positive patients are not taking any antiretroviral medication compared to 38 percent of Hispanics and 35 percent of whites. Early initiation of drug therapy has clearly been proven to prolong life expectancy as well as improve quality of life. Protease inhibitors, a class of antiretrovirals that has revolutionized both HIV therapy and patient survival rates, are not readily available to black patients. The

problem is in part economics, as these medications can cost thousands of dollars annually. Thirty-three percent of whites and 19 percent of Hispanics are on protease inhibitor therapy, compared to only 12 percent of Blacks. What's more, patients who contracted HIV through homosexuality are twice as likely to be treated than those who contracted it via heterosexual contacts (Stein et al., 1991).

Both the National Institute of Allergy and Infectious Disease and the Centers for Disease Control and Prevention have established guidelines for the use of antiretrovirals and preventative treatments of opportunistic infections. Despite their recommendation that uniform standards of prescription drug therapy be followed regardless of socio-demographic factors or behavior, there is evidence indicating that Blacks are not given drug therapy early enough when such therapies will clearly have positive outcome on HIV disease progression. In addition, there have been reports of racial disparity in the receipt and use of antiretrovirals therapy prior to referral to an HIV clinic. Sixty-three percent of eligible whites receive antiretroviral therapy compared to only 48 percent of eligible Blacks. Preventative treatment for *Pneumocystis carinii* pneumonia (opportunistic lung infection) is recommended for and is received by about 82 percent of eligible whites and 58 percent of eligible Blacks (Chaisson et al., 1992).

The prescribing habits of a caregiver may affect the likelihood of a physician recommending a therapeutic regimen. It has clearly been established that members of minority groups, Blacks in particular, are less likely than whites to be offered available treatment in a variety of medical conditions including: surgical or other treatment for coronary artery disease (Maynard et al., 1986), analgesia for long bone fracture (Todd, Samaroo & Hoffman, 1993), treatment of alcoholism (Moore et al., 1989), erythropoietin for end stage renal disease (Powe et al., 1992), and rehabilitation after mastectomy (Dier et al., 1989). Furthermore, black Americans have historically had an uneasy relationship with Western medicine partly due to suspicion of health authorities. This has often resulted in Blacks, particularly black men, not having a primary care provider and instead utilizing emergency departments. Finally, black Americans, especially those in inner cities or rural areas, may lack access to care due to financial constraints since many of these people are either underemployed or unemployed and thus lack health coverage.

Potential Solutions to Overcome the Barriers

Many barriers clearly have impeded adequate preventive measures and care of infected black patients. This is even more glaring in stark contrast to the preventive measures and health care received by the largely white middle-class homosexual community within the first decade of HIV's onset. The homosexual community was able to obtain this level of success because of its crisis response as well as its ability to rally allies in government, industry and the medical establishment. The gay community was successful in lobbying and raising funds for research. These efforts resulted in the emergence of more efficacious medical therapy that was made available to the largely middle-class white male community.

This model of crisis response and coalition building is one that the black community can adapt to fit its HIV/AIDS needs. There is ample evidence indicating that HIV intervention programs helped lower rates of HIV infection in the homosexual community. It makes sense to adapt those programs into the black community (Kelly et al., 1996; Kegeles, Hays & Coates, 1996). Existing tools such as sterile needle exchange, condom distribution to drug users and drug treatment should be implemented. Successful programs that call for learning through interaction with others, can also save time and money, especially in the current climate of fiscal constraints. Intervention strategies which worked for gay and bisexual men include the following: small group counseling and safe sexual skills training, peer outreach, counseling and testing, 24-hour hot lines, media campaigns and intensive community mobilization (Kelley et al., 1992; Kegeles, Hays, & Coates, 1996; Blower & McLean, 1994). One such program implemented in several medium-sized towns trained popular residents to deliver AIDS risk and reduction messages to friends and acquaintances in local gay bars. A variety of social outreach and group activities such as picnics, dances and athletic events were also used to promote safe sex among young gay men. As a result, the rates of unprotected sex declined by 9 percent in these communities.

The black community is in many respects different and unique when compared to the homosexual community. However, there are similar characteristics in the social, political and emotional environments that will enable the black community to benefit from strategies similar to those used in the gay community. Both groups perceive themselves to be disenfranchised from the larger society, a feeling that has historically spurred political organization. The elements of successful programs in the homosexual community to be adopted by Blacks include those heavily reliant on communal involvement, one-on-one interventions, use of peers, local program delivery in a familiar and non-threatening environment and empowering participants to change their behavior. For example, in Chicago, street outreach intervention with intravenous drug users through peer educators helped reduce transmission of the virus (Weibel et al., 1993).

Implementation of HIV intervention strategies in the black community must involve both spiritual and service organizations. These programs should recruit and teach local peer educators, specifically those from groups at high risk for HIV infection such as women with multiple sex partners, intravenous drug users and teenagers. The church, which has long remained a major anchor in the community, and other spiritual leaders must play a proactive role in any implementation effort. To succeed, programs must be culturally sensitive, addressing the strengths of the community such as family, community and ethnic pride. Programs that support and protect family, children and community will be embraced rather than those that simply focus on protecting the lone individual.

There is legitimate concern that implementing the above strategies may fall short in replicating the kind of success witnessed in the homosexual community because of a lack of funds and researchers focused on in the black community.

There is hope that President Clinton's AIDS initiative in the minority community will shine the limelight on the plight of Blacks and other minority groups. Maintaining continual funding of HIV programs in the black community will ultimately play a major role in long-term success of any such programs. Thus, there is a need to create partnerships with the medical, private and governmental sectors to address the plight of black Americans. There is a crucial need to implement programs to educate, screen and refer patients for appropriate care. Black patients deserve to receive and benefit from life-extending therapies resulting from medical research which is funded largely by public monies.

The black community needs to disavow itself of the illusion that HIV is a disease of homosexual white men. The epidemic is rapidly spreading and disproportionately affecting black females with very little attention being devoted to it. The time is now for community leaders—religious and political—to design culturally sensitive preventive programs and establish cooperative alliances with other communities and governmental entities to aid the effort to curb and decrease HIV infection and AIDS related morbidity and mortality.

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Violence and the African American Community: A Public Health Concern

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Abstract

This article focuses on the epidemic of violence in America and its impact on the health of African Americans. By applying the comprehensive public health framework, it is possible to analyze violence and its causes to design and implement actions to arrest its alarming trend within the African American community. For policy leaders the goal is to learn the importance of including strategies to address the social constructs of racism and underlying socioeconomic factors when developing programs for violence prevention. Including the public health perspective will complement current enforcement only strategies to fight crime and violence and in many cases yield better overall outcomes.

Introduction

Violence is not an inevitable consequence of social existence for all members of our society. Therefore, African Americans should not be at greater risk to experience violence than anyone else. But, homicide, suicide and interpersonal violence—threatened or actual physical force against an individual likely to cause harm or death—represent an ongoing crisis for the African American community (Mercy, Rosenberg, Powell, Broome; Roper, 1993). Today, violence and its consequences remain listed among the top ten threats to the health and well-being of African Americans (Stolberg, 1998; U.S. Dept. of Health and Human Services, 1998). In America, violence continues to leave a legacy of devastation in inner cities and among the poor. Populations living under these circumstances are disproportionately African American, immigrant, and people of color. Therefore, members of these groups are more likely to be exposed to, suffer and even survive the ravages of violence.

In public health, a greater than expected occurrence or spread of disease causing increased morbidity and mortality define an epidemic. Violence in America is a regional example of a global public health epidemic. Worldwide, the greatest amount of civil war and violence occurs in emerging nations with the least economic development. Mortality counted as death due to intentional injuries—war, homicide, suicide—and their morbidities are highest in socially depressed and

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impoverished regions of the world. (Wilkinson, 1992). Violence, under these circumstances, meets the criteria to be named a public health problem. When these measurements are applied to America's poor urban neighborhoods, morbidity and mortality secondary to violence are significantly more prevalent. Because members of the African American community are disproportionately affected by America's violence, for us it should be considered an epidemic, just like polio, small pox, or the measles.

Therefore, just like for polio, small pox, and the measles, taking a public health approach may eradicate violence. With these epidemics, prevention by immunization was found the most effective intervention, only after examining the problems created by the disease from multiple angles. The evolution of disease in each case was carefully studied, while at each step along the way as much information as possible was collected. Previous research and testing streamlined the implementation of immunization policies.

Using public health to characterize the magnitude and scope of violence, while reviewing its epidemiology, makes it possible to implement stronger anti-violence strategies. The continuous collection and analysis of data while intervening keeps the approach to reducing violence progressive. Interdisciplinary collaboration is required to accurately quantitate violence and achieve successful outcomes. By constantly including new information, incremental reductions in violence are possible. Unlike the focus of the criminal justice system on reactive and punitive approaches to violence, public health emphasizes the need to combine resources for intervening early and proactively. The public health approach adds critical pieces to the overall picture of health and well-being while searching for the most effective solution to violence. Integrating public health practices among individuals, groups and organizations within a community structure is relevant to eliminating the disparities in health outcomes of African Americans.

Why is Violence an Epidemic for African Americans?

On an average day in America, 70 people die due to violent assaults and at least another 18,000 survive the injuries of interpersonal and intentional violence. Almost daily, 3000 Americans attempt suicide and 87 people succeed (U.S. Dept. of Health and Human Services, 1997). In 1997, on average, an individual was murdered every 29 minutes and one violent crime was committed every 19 seconds (US-DJ, 1998). The costs and losses due interpersonal violence are high. Violence takes an immediate as well as long term toll on individuals and their quality of life. It also negatively impacts the cost of health care in America. Violence is responsible for 30 percent of the 10,000 new spinal cord injuries each year in America. The average costs of caring for each new spinal cord injury patient approaches \$200,000 during the first year and then costs \$25,000 each year thereafter (National Spinal Cord Injury Statistical Center, 1997). When all types of gun related injuries are considered, the average in hospital cost of caring for each shooting victim equals \$32,000 (Kizer, Vassar, Harry, Layton, 1995). This amount

contributes to the estimated \$5 billion in yearly costs for medical care for violence in America, but does not reflect the estimated \$170 billion Americans spend each year repairing shattered lives (Farrell, 1997). Most of the costs for emergency care and hospital expenses for victims of violence and crime are redistributed to society as higher taxes and health care costs. Violence particularly drains the health care resources of public and charity hospitals in large metropolitan cities. It is these hospitals which usually provide care for the majority of America's poor and uninsured African Americans. For these people, the social and economic costs and consequences of violence are one more reminder of the devastating overall disparity in health they face (Wintemute, Wright, 1992; Cornwall III, Jacobs, Walker, Jacobs, Porter, Fleming, 1995).

In 1997 despite these terrifying statistics on violence in America, violent crime declined to a 30-year low (CNN, 1999). Yet, certain segments of the American population are not celebrating the benefits of less violence in our society. Instead, people younger than 25 and African Americans are still dying and being killed at alarming rates. They also seem to be experiencing violent injuries more frequently. For these youths, and African Americans, statistics describing homicide, suicide and other tragic consequences of interpersonal injuries and violence are rising rapidly.

Firearm related deaths by youth aged 18 to 24 increased from roughly 5,000 in 1980 to greater than 7,500 in 1997 (US-DJ, 1998). Approximately 3000 teens each year are committing suicide using a gun (American Academy of Child and Adolescent Psychiatry, 1995). A young person aged 15 to 34 is at significant risk of dying or losing his or her quality of life because of violence. Every day 10 American children younger than 19 are killed or commit suicide in incidents involving handguns. For every youth killed by a gun and ending up in a morgue, somewhere in America approximately four other youths are hospitalized with non-fatal gun injuries. Gun injuries to teenagers younger than 17 have increased 300 percent in major urban areas since 1986. The amount of death and disability due to guns yields the equivalent to a jumbo jetliner crash of young people once every month (Sickmund, Snyder, Poe-Yamagata, 1997).

The statistics for African Americans are equally frightening. African American women and men are at greater risk of experiencing violence than their white counterparts. In 1997, African Americans suffered homicides seven times more frequently than whites and were eight times more likely to be named as the assailant in a murder. American violence and intentional injury are truly interpersonal because at least half of the time (48 percent), the victim knew his/ her attacker. These crime statistics show that for African Americans the incidence of Black-on-Black homicide was 94 percent. (CNN, 1998; US-DJ, 1998). The number of African American victims paralyzed by intentional injury has also steadily increased. Spinal cord injuries incurred through violence accounted for almost one half of the number of new cases among African Americans (Franklin, 1997). African American men between the ages of 25 and 44 visited the emergency room

for treatment after interpersonal violence assaults four times more than white males (US-DJ, 1998). Suicide for young black males has been steadily increasing; rising 114 percent between 1980 and 1995. It is now the third leading cause of death for 10 to 19-year-olds. For younger African Americans aged 10 to 14 years old, suicide rates increased 233 percent, compared to a 120 percent increase for white youths. For young African American men, between the ages of 15 to 19, the rate of suicide is up 146 percent and climbing (MMWR Weekly, 1998). Guns, again, were the most common agent of death.

If all Americans were being killed, injured, or dying at the same rate as young African American males, over 460,000 people would be lost every year, and greater than 2.2 million people would feel the impact of violence on their quality of life (National Center for Health Statistics, 1994). A tragedy of this magnitude would normally galvanize public outcry for an immediate investigation and end to such an epidemic. Preventing violence would become a priority on the American agenda. A multitude of resources would be targeted to study and design anti-violence interventions until something happened. The case of highway safety in America is but one example of the public health and safety measures taken when the perception of an American epidemic exists. In recent history, people struggled for decades to make America's highways safer by dramatically decreasing traffic fatalities. Coordinating and combining strategies for engineering, education, and enforcement were key. Public health practitioners helped to study and implement better traffic safety programs and to broaden the prevention focus beyond driver error. Proper use of child restraints and car seats, air bags, anti-drinking campaigns, decreased speed limits, and better highway design all contributed to decreasing the highway fatality rate from 5.5 people per 100 million in 1966 to 1.7 people per 100 million in 1996. Thus, in 1996, at least 90,000 additional lives were saved compared to deaths expected at the 1966 traffic fatality rate (U.S. Dept. of Transportation, 1998).

Unfortunately, since violence is perceived to be a problem for segments of the American population historically marginalized, underrepresented in positions of public decision making and often blamed for causing the problem, America's response to violence is, at best, reactionary and at most, incremental (Hawkins, 1993). Most attempts to break the cycle of violence focus on punishing the perpetrator, offender or assailant instead of asking why and what could have been done to avert these outcomes. The interest in pursuing the root causes of violence and applying prevention more often resembles a tree falling in the forest. This inertia in violence prevention is devastating for African Americans and other non-white communities that may have lower socioeconomic status and already lag behind the rest of America in other indices of health and well-being.

Violence is Another Health Disparity for African Americans

Poor children, and children with minimally educated parents are less likely to have a regular doctor or provider for receiving health care. Consequently, these fami-

lies will rely more on emergency rooms and public hospitals as their primary source for care. Children living in poverty tend to be of lower birth weights and have higher infant mortality rates. They also run a greater risk of suffering excessive exposure to environmental lead that may cause developmental delays and slow learning (US- DHHS, 1998). African Americans have a lower overall life expectancy compared to white Americans, (70.2 years vs. 76.8 years). Their morbidity and mortality rates for breast cancer, prostate cancer, AIDS, stroke and heart disease are higher. Violence is merely another indicator along a spectrum of health inequalities that illustrates the widening gap in health care for America's poor and ethnic minorities.

When it comes to health care in the U.S., it is no secret that African Americans compose a significant number of those left behind. As a whole, African Americans are poorer and sicker (U.S. Dept. of Health and Human Services, 1998; Rosenbaum, Serrano, Magar; Stern, 1998). While inequity in health insurance coverage, and access to care have contributed greatly to differences in health outcomes, and are well documented barriers to care, other factors such as lack of culturally competent care and continued discriminatory practices perpetuate the problem (Smith, 1998). A recent study revealed that African Americans received lesser quality care than white patients did when presenting to physicians complaining of symptoms of a heart attack. This difference in treatment persisted despite comparable levels of education and income (Schulman et al., 1999). Other studies have shown that non-white cancer patients were medicated less frequently and less often for pain (Bernabei et al., 1998). Although an African American is 7.5 times more likely to be seen in the emergency room for a drug overdose treatment, this patient is 3.5 times more likely to die compared to a white. (Marks, 1999). And, African American diabetic patients were more likely to receive an amputation rather than a vascular bypass by surgeons for the limb-threatening changes of their disease compared to white patients (Brothers, Robison, Sutherland, Elliott, 1997; Ashry, Lavery, Armstrong, Lavery, van Houtum, 1997).

Violence and crime among African Americans and Hispanic Americans is more commonly discussed as a cultural flaw resulting from an inherent difference in values, attitudes and beliefs from white America than as a health concern (Spigner, 1998). Acknowledging socioeconomic inequality is secondary, as poor people are assumed to have an unhealthy reliance on federal aid. As a result, cultural dysfunction and criminal behavior are emphasized as race-linked traits and indicators of interpersonal violence instead of emphasizing the need to alter economic, educational, and employment disparities (Hawkins, 1993). While approximately 40 percent of African American youths under the age of 18 live in poverty—a percentage that has changed little during the past twenty years—only 16.3 percent of white youths suffer from the same conditions (Bureau of the Census, 1997). African American teenagers have an unemployment rate of 29.2 percent compared to 11.8 percent for white teenagers, and African American males drop out of 10th through twelfth grades at a higher rate (7.9 percent as compared to 5.4

percent) (U.S. Bureau of Labor Statistics, February 1999; Bureau of the Census, 1996). Failing to examine the lower income, education, and unemployment as co-factors in the etiology of violence ignores the concerns for the underlying stability, health, and well-being of any neighborhood.

Sadly, stereotypes and misperceptions about violence and African Americans are reinforced for the general public by the media and have come to symbolize the problems of urban America. Negative images depicting African Americans as predatory and lawless legitimizes racist views that African Americans are prone to violence. A recent study of violence in MTV music videos depicted African American males as assailants on white females 70 percent of the time (Rich, Woods, Goodman, Emans, DuRant, 1998). Content analysis of print news found that stories on violence in Los Angeles disproportionately covered youth and African Americans incidents of violence. These stories were over-represented compared to their proportion of actual crime (Dorfman, Woodruff, Chavez, Wallack, 1997). Such messages continue to capitalize on the fear that America is under siege by pathological, young and poor people from the inner city.

The Challenges to Preventing Violence

The social constructs of racism are superimposed on the problems of poverty, unemployment, poor education and poor health. Ignoring these inequalities makes it easier to perceive violence as an innate problem and perpetuate stereotypes about African Americans. Under these circumstances, the challenge of preventing violence by changing cultural norms seems unrealistic because the changes would not occur immediately or even over several generations. The punitive solutions of law enforcement and incarceration appear more appealing and expedient to developers of public policy than carefully drafted plans for prevention.

Questions such as how guns so easily enter communities of color and disadvantaged neighborhoods are rarely asked, answered or explored. A gun was used by youth ages 10 to 19 to commit suicide 66 percent of the time (MMWR Weekly, 1998). The fact that 50 percent of 10th and 11th grade high school boys at 53 different schools across the America in the survey by National Institute of Justice believed that they than can obtain guns with relative ease, and that almost 3 out of every 10 young men have access to a gun, should be cause for immediate concern (CNN, 1998; DuRant RH, Krowchuk, Kreiter , Sinal; & Woods, 1999). These facts further illustrate that the potential for gun violence and suicide is not merely a problem unique to the urban poor in America.

The higher density of liquor outlets in poor neighborhoods, and the increased tobacco and alcohol billboard advertising in these same areas is not recognized as contributing to the problem of violence when 90 percent of victims or murderers were shown to have used alcohol or other drugs prior to the homicide. Youths who used guns for suicide were five times more likely to have been drinking. Despite the strong casual relationship that tobacco, drugs, guns, malt liquor and other alcohol products have to violence and crime, opposing the selective marketing of

these products to African American youths is not usually thought of as violence prevention. While research supports that addiction, increased cancer rates and other illnesses directly correlate to excessive use or abuse of these substances, their link to violence is often overlooked and understudied.

Better Strategies for Violence Prevention in African American Communities

Despite having successful models for some types of prevention, public health is often relegated to a minor role behind the criminal justice system. Instead, public health should play a leadership role to reduce violence and by extension crime. Understanding the violence a community faces involves considering more than crime, race, immigration, poverty, education and employment (Kennedy, 1998). Public health models promote building social cohesion and trust among residents of a community and their surrounding environment. The quantity of social cohesion is shown to correlate with the variations in violence between neighborhoods (Sampson, Raudenbush, Earls, 1997). This comprehensive problem-solving approach to violence prevention represents a refreshing paradigm shift from current crime prevention models (Kong, 1997; Kawachi, Kennedy, 1997). Public health will more likely recognize and offer corrective and reconciliatory efforts to eradicate racism and biases in managing problems of different populations since these steps are seen as essential for eliminating health disparities among all non-white populations.

Despite current public policy, which suggests the contrary, more policing and larger prisons will not solve the problem of violence in America. Thus, it behooves communities to think creatively to promote alternatives to violence (Zimring, Hawkins, 1997). Law enforcement and criminal justice interventions are only one dimension of the strategies for ending violence in the African American community. Given the legacy of overt racism and the increasing incidence of police brutality within the justice system, it seems logical that interventions to reduce violence are met with skepticism and suspicion in African American communities. A recent poll reveals that 43 percent of New York City residents feel there is widespread police brutality against minorities and less than 25 percent of New Yorkers believe that the police treat whites and African Americans objectively equal. While one-third of African Americans surveyed shared that they had been in situations where they feared the police, this was true for only 11 percent of white residents. Fifty-seven percent of African Americans indicated that they felt less safe when the New York City police were present. (Di Iulio, 1997; Barry & Connelly, 1999). The challenges of establishing a sense of ownership, changing community norms and building family and community wealth are key components to reducing violence. Encouraging law enforcement to collaborate with health departments, schools, businesses and faith communities may go farther than current practices toward police agencies rebuilding trust among institutions of African Americans and other disadvantaged populations.

Public policies that disrupt the juvenile gun markets, restrict youth access to

alcohol, drugs, and tobacco and create comprehensive approaches to support youths, their caregivers and support networks prior to an individual becoming caught up in the criminal justice system will prevent and interrupt the cycle of violence. Policy leaders should advocate for more consistent communication between public agencies to accurately characterize the epidemiology of community violence. It is possible to combine police and justice department data with hospital and public health injury and fatality statistics to identify individuals at risk for recidivism. By including as many groups and individuals as possible to reflect the demographics and physical characteristics of the community in gathering and analyzing this information, the cycle of violence is seen from different viewpoints. The benefits of multiple perspectives of where, when, and how to intervene are more easily recognized.

Research to demonstrate the cost effectiveness of improved health and quality of life through violence prevention should be an ongoing priority. Detailed violence prevention plans outlining best practices should be a requirement for a community and its leadership. Inexpensive integrated mapping and surveillance systems are now available to identify not only areas of violent crimes, homicides, and suicides, but also to highlight neighborhood locations desperately needing economic development. Communities traumatized by urban blight, abandoned buildings, dangerous pedestrian intersections, and an oversupply of liquor outlets near schoolyards do not have to remain the norm. This is especially true if the magnitude of the problem can be quantified. If a neighborhood identifies excessive gun and drug trafficking and high gun injury rates as a problem, the community will now have information in hand to advocate for stronger policies to match stronger enforcement. Such policies can take the form of mandating firearm surveillance registries, banning junk guns, and requiring trigger locks and other gun consumer safety modifications. Limiting the number of guns purchased every thirty days or every year, or prohibiting gun shows may cut down on excessive interstate shipping and illegal gun trafficking. An alternate approach could be enacting more public nuisance laws for personal and property damages resulting from gun-related incidents. All of these strategies have yielded interval victories to slow the flow guns into the wrong hands (CNN, 1999). Applying models for sharing information will allow communities to prioritize their problems, recognize the value in collaborating to improve its overall health, and empower citizens to alter norms in ways that have a lasting impact on reducing violence.

Linking initiatives for violence prevention to efforts to improve health outcomes and eliminate other disparities in the health of African Americans is an uncomplicated yet effective mechanism for reducing violence. An example of this, is combining anti-violence instruction with services to provide mental health, maternal and prenatal care, and parenting skills for new fathers. Peer to peer counseling projects for youth, combining issues such as conflict resolution, safe sex, and self-esteem with violence prevention claim success (Krug, Dahlberg, Rosenberg & Hammond, 1998). Reaching pregnant women in clinics and emergency

rooms makes sense since studies show that during pregnancy a woman may be at greater risk to become a victim of domestic violence (Benton, Henderson, Organ Jr, 1997). Seventy-six percent of women who are seen in health care settings by physicians and other practitioners will share their fears about domestic violence only if asked (Caralis & Musialowski, 1997; Hayden, Barton & Hayden, 1997). However, many providers do not, because the questions are unpopular and often answers make health care providers uncomfortable. Integrating violence prevention education to increase awareness of resources for referring victims and perpetrators of violence throughout all dimensions of health, social and educational systems would lower anxiety levels and make discussions of violence prevention more socially acceptable (Dearwater et al., 1998; Oriel & Fleming, 1998; Alpert & Tonkin, 1998).

In some cases, conventional violence prevention programs may fail to meet the needs of communities of color by overlooking cultural components. Current programs should specifically evaluate their capacity to address racial biases. Customizing interventions may be key to overcoming obstacles faced in conventional violence prevention programs and curricula. Remaining aware of how a population's cultural traditions influence their interactions and responses under the stress of having limited economic resources can go a long way toward reducing tensions that can escalate to full-scale violence. Learning what common values members of different racial and ethnic groups equate with healthy living will make it easier to identify shared goals and foster trust, mutual confidence, and respect.

Mentoring and engaging youth through faith organizations is a meaningful strategy often overlooked. However, it can play a distinct educational role in communities of color. In many neighborhoods, churches, temples and mosques still serve as the center of social and political life. These organizations are continually reaching out and trying to attract younger members. Today, churches frequently sponsor health fairs. It is common for pastors and ministers to preach on the need to get mammograms and be screened for prostate cancer.

Since tattooing is frequently done by non-white youths to indicate gang affiliation, unconventional programs such as tattoo removal programs for youths that were former gang members offer another example of a public health solution. Such programs combine mentoring, job training and culturally competent life skills sessions with technology to surgically erase tattoos originally intended to be permanent. Youth participants must select a mentor, return to school, and complete fifty hours of community service before they are allowed to undergo treatment. These programs allow collaboration between probation departments, juvenile halls, hospitals, public health departments and local businesses and introduce unlimited opportunities to intervene with youth to interrupt the cycle of violence. Tattoo removal programs were designed in response to youths citing visible tattoos as barriers to their quitting gangs and leaving a violent lifestyle. These young adults also felt their future was hindered by a lack of mentors and positive role models and limited job prospects. Highly visible and identifying tattoos also

made them more likely targets of retaliation from rival and fellow gang members (Benton & Alvarado, 1999).

Preliminary data from the first 34 candidates of Project New Start Oakland, California shows that 97 percent of the youths feel that removing gang-related tattoos improves their self-esteem and will help them get better jobs. It also revealed that many of the youths were under age when they received tattoos and that one-third of the youths used drugs or alcohol immediately before the procedure. The dropout rate for the program during its first 2 years was 3 percent. Currently, the waiting list is over 200 people.

Conclusion

By viewing violence and crime prevention through the lens of public health, it will be possible for us to make greater progress toward ending violence. Public health as a discipline in our society has the capacity to be all-inclusive when it comes to promoting health and well-being. The historical track record of public health and its current missions to eliminate racial and ethnic disparities in health, can justify trying non-traditional interventions. Once violence is recognized as an epidemic within the African American community, the public health approach can bring a greater armamentarium for problem-solving to the battlefield. These features make it the most logical choice to tackle the multifactorial causes of violence as it connects to other health threats for African Americans.

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Improving Access to Dental Care: The Case of the North Carolina Medicaid Dental Program

Betty King Sutton
North Carolina Medicaid Dental Program

In the U.S. Medicaid is the dominant payer of dental bills, spending \$1.8 billion in 1996; the Indian Health Service is a distant second at \$65 million a year. Other public payers include the Departments of Defense and Veterans Affairs, maternal and child health, and state and local welfare programs (ADA NEWS, 1998). Thus while there are several public insurers in the marketplace, indigent population across the country are largely dependent on Medicare for dental care coverage.

It is vital to include health care provision to the country's poor populations in any valid and organized restructuring of the national health care delivery system. This premise holds true particularly for indigent African American and other minorities. According to a variety of health status indicators, these groups lag behind the total population. As reported in "The Progress Report For: Black Americans" (U.S. Department of Health and Human Services, 1994-98), black Americans fall short with respect to infant mortality rate, life expectancy rate, teen pregnancy, homicides, and more. And while U.S. Surgeon General David Satcher indicated that the dental health indicators gap was narrowing between black Americans and whites, a great deal of effort still needs to be made. As a recent study of the National Institute of Health reports, dental care remains a serious problem for a concentrated number of our country's poor children. The report found that 80 percent of dental cavities occur in only 25 percent of children. Dental decay can affect any child but the bulk of it is found in children of low income and minority status (Burton & Edelstein, 1998). Moreover, children and adults with the highest rates of dental decay are also least likely to have access to dental care. It is precisely for these reasons that our efforts to improve dental care provision should be immediately targeted to this segment of the population.

As we consider the future of dental care access for indigent populations, three questions must be considered:

- Who should be covered?
- What services should be furnished?
- How should the costs of that care be managed and shared?

The answers to these questions must come from all parties involved (i.e., the patient, the doctor and the financier of the care). Identifying the appropriate pop-

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ulations to serve and the necessary levels and services of care is not easy. And, determining how such programs are financed is even more difficult. Yet, absent a concerted effort on the part of all key stakeholders, access to dental care and the continuance of dental illness and disease will remain problems for the most needy segments of our society. The complexity of the problem requires a significant investment by politicians, policy makers and practitioners at all levels of government. The state of North Carolina has recently taken action to address the complex issue of access to dental care with comprehensive, solution-oriented action.

In North Carolina, a Dental Task Force was convened by the Division of Medical Assistance (DMA) in July of 1996. The Taskforce was charged with addressing the aforementioned questions, as well as identifying ways of improving its dental programming.

The North Carolina Medicaid Dental Program had its inception in the early 1970s. It currently spends about 44 to 55 million dollars on direct service programming for poor and minority populations. The program is federally mandated for persons up to age 21 but adult services are covered at the state's discretion. The program has been successful at helping the citizens of North Carolina because it provides a comprehensive array of services that takes care of the basic and primary dental needs of all people.

Minority populations stand to benefit from the services of the North Carolina Medicaid Dental Program, as they comprise 57 percent of North Carolina's indigent population. However, the record of Medicaid eligible population indicates that the dental services offered are going unutilized at an alarming rate. As of State Fiscal Year (SFY) 1998, Medicaid eligibles totaled 1,259,860 (Consultec DMA/Drive System). Of those eligible, 18 percent actually received a dental service compared to the approximately 50 percent of the general public who received dental services. The racial breakdowns for receiving services (North Carolina Medicaid-Consultec/Data Drive System) are found in Table 1.

The North Carolina Dental Task Force concluded that several barriers existed in the dental care system which prevented indigent and poor populations from taking advantage of the states services. High on this list of barriers are low Medicaid reimbursements to dentists who provide care, followed by patient non-compliance (missed or broken appointments), and minor claims-filing/paper-work concerns. Other barriers include geographic, language, cultural, attitudinal and doctor/patient behavioral conflicts. One can see that the problem is indeed multifaceted and extends far beyond a simple solution. Moreover, it is likely that similar difficulties are experienced in other states.

In a recent national study conducted by the Office of the Inspector General (U.S. Department of Health and Human Services, 1996), the overwhelming reason for dentists not treating Medicaid patients was low reimbursement by Medicaid. The North Carolina Dental Task Force determined that practice expenses for overhead alone, as reported by the American Dental Association's 1995 Survey of Practices, are 60 to 65 percent of total expenses. With Medicaid rates at 62 percent of expenses or less, Medicaid reimbursements are not sufficient to cover

**Table 1. Receipt of Dental Services by Race
SFY 1998**

Race	Number of Eligibles	Recipients of Dental Services	% of Eligibles Receiving Dental Services
Asian	11,777	1,443	12%
African American	547,803	99,224	18%
Hispanic	44,799	3,396	8%
Indian	22,180	4,766	21%
Other	91,081	12,290	13%
White	542,220	101,468	19%
All	1,259,860	222,587	18%

costs. The North Carolina Dental Task Force further suggested that perhaps the insufficiency of Medicaid reimbursements resulted from the programs failure to recognize the large overhead expenditures of dentists as compared to other medical doctors. For example, physician practice overhead expenses are 37.5 percent or only about one half as much as dentists' overhead expenses according to the 1994 Medical Economics Survey. Despite the inability of the the Medicaid program to meet the expense needs of dentists and thus the access needs of patients, expenditures for the program have declined. The North Carolina Dental Medicaid Program coverage slipped from 3.53 percent of total Medicaid expenditures to 1 percent in 1995. While other state-performed Medicaid program expenditures have also declined as a percentage of Medicaid budget expenditures they have not decreased as dramatically as Dental Program expenditures.

The efforts of the North Carolina Dental Task Force produced a set of recommendations for improving access to dental care for the state indigent and minority populations. The overwhelming recommendation of the Task Force was that a fee increase was central to any attempt to improve access to dental care. The Task Force recommended immediate fee increases and a plan for annual increases to bring fees more in line with other payers. Other companion strategies for consideration included:

- Development of strategies for the recruitment and retention of dentists in both the public and private sector for participation in Medicaid.
- Exploration of community-based approaches with partnerships and coalitions to address population based dental disease prevention, patient education and dental health promotion.
- Development of strategies aimed at improving patient/recipient education.
- Evaluation of alternative financing arrangements (e.g., managed care models).

North Carolina has not taken steps to improve the dental care system in isolation. Throughout the process of analysis and recommendation, leaders within the Medicaid program have participated in activities that offer exposure to the solutions and goals of other state and federal entities. For example the June 1998 National Medicaid Directors meeting was an opportunity for information and resources sharing with others in the field such activities are vital to the improvement of entitlement programs

Following the June conference, states, including North Carolina, made an effort to address the barrier of greatest concern. North Carolina increased fees for 44 dental procedures by 39 percent. While this increase still falls short of the 80 percent of the "Usual, Customary, and Reasonable" procedures, which are regional and national standards, the agency must be commended for taking a step in the right direction.

Medicaid dental programs across the country are gearing up with special outreach plans and efforts to improve access to dental care, especially for children. North Carolina Medicaid has a vigorous dental outreach and public awareness plan. Recognizing that fees increases is but one barrier to remove from access, additional strategies must be employed. Dentists have been chosen as the key targets for the dental outreach and public awareness campaign. An appeal to the moral obligation of dentists to share the responsibilities of caring for poor and minority populations is a central component of this effort. The details of the North Carolina Medicaid dental access, outreach and public awareness plan are as follows:

Goal: To dramatically improve access to basic and primary dental services (comprehensive/preventive/corrective) for all medicaid eligible and medically indigent persons

I. *Objective One:*

Recruit private practitioners to provide care for Medicaid recipients

Strategies for realization of Objective One:

- A. Obtain legislative authorization to increase Medicaid dental fees with annual updates
- B. Start an active dentist recruitment process
- C. Mount an extensive Outreach and PR/Educational Campaign
- D. Provide dental case management services
- E. Educate dental students about the need to provide care to the indigent
- F. streamline the provider enrollment process
- G. Increase the efficiency of the enrollment process for persons eligible for medicaid
- H. Assist dental office personnel

II. *Objective Two:*

Increase the capacity of existing local publicly subsidized dental service facilities and create others as needed

Strategies for realization of Objective Two:

- A. Develop public/private funding consortiums
- B. Increase the local capacity of existing health departments, FQHCS, rural health clinics and other clinics to serve more Medicaid and medically indigent persons
- C. Develop and encourage new publicly subsidized regional dental facilities as local communities dictate

As in North Carolina, Medicaid dental programs could participate in outreach activities, such as instructional and information materials which would be disseminated to all dentists across the state. Activities that acknowledge and support the efforts of dentists who serve minority and poor populations should be considered as tools for improving dentist community responsibility levels.

Dental students must be encouraged in dental school to make service to low-income patients an element of their practice following graduation. Acknowledging the increase costs of dental programs and the restrictions that high loan payments make on the career choices of students, loan forgiveness programs would offer a great incentive. It would be helpful if dental school debts could be forgiven upon return to practice in under-served areas, especially so for minorities. This would improve access to care for minorities and other under-served groups. Cultural sensitivity must be taught in dental schools. Internships in a variety of communities that vary racially and culturally should be a part of a dentist's education. Access to care will increase when there is an understanding and acceptance of the diverse dental needs of all people.

On the issue of active recruitment of dentists into Medicaid participation, Medicaid dental programs must consider contracting with professional staff who will visit dental offices directly and encourage participation. Further, the need to develop new publicly subsidized regional dental facilities should be an immediate or long-term goal for programs. Expanding the local capacity of existing facilities such as health departments, rural health clinics and others to serve Medicaid recipients and other indigent citizens should always be a main thrust of outreach efforts.

Policy Implications

If this access crisis is not remedied Medicaid dental programs will be on the brink of extinction and the largest losers will be the indigent or the recipients of services. Only one out of five Medicaid-eligible children currently gets the preventive dental care sought. The elderly must continue to have access to dental services if Medicaid eligible because Medicare doesn't cover dental services. All people need dental care and barriers to access must be removed.

Parties affected must cooperate in solving this access to dental care crisis across the states. Each dentist, as a care provider, must see his or her fair share of indigent patients per year so as to prevent putting the burden on a single provider. Recipients, on the other hand, must take dental appointments seriously and not miss them and must understand that good dental health is a part of total well-being. Medicaid agencies also may start to penalize recipients if appointments are missed by limiting benefits or by some other means yet to be determined. Public Health must target and teach dental disease prevention and health promotion to the indigent, especially those who have not yet been reached.

Medicaid program administrators and benefits managers must assure that dental programs are provider-friendly as well as recipient-friendly, espousing only policies that will facilitate the efficient and effective delivery of dental services to the poor. Appropriate state legislative funding of Medicaid dental programs is essential for success and continuation. Dental schools must teach the future dentists of America the need to feel "morally obligated" to treat a certain number of indigent patients and be publicly accountable for it. Lastly, continued support is needed for Medicaid dental programs from those who are indirectly affected but willing to serve as advocates.

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COMMENTARY

Black Women and Depression: An Interview with Julia Boyd

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Abstract

Julia A. Boyd is a psychotherapist working in clinical practice. She is the author of *Girlfriend to Girlfriend: Everyday Wisdom* and *Affirmations from the Sister Circle*, and *In the Company of My Sisters: Black Women and Self Esteem*, which is a national bestseller. Her new book, entitled *Can I Get A Witness? For Sisters When the Blues is More Than a Song*, explores the crucial links between self-esteem, depression, and women's health in sassy, witty, down-to-earth voices. Her writing has appeared in professional publications as well as in *Essence* magazine. Julia A. Boyd was awarded the African American Women's Achievement Award for 1994. In this interview she discusses the significance of depression in the lives of African American women and the need for public awareness and policy solutions.

Edney: Your three books, "*Can I Get a Witness?*" "*Embracing the Fire,*" and "*In the Company of My Sisters,*" all address the emotional and psychological health of black women. Why did you choose to write about these issues and do you take them from your life's experiences?

Boyd: Yes, in some ways they do reflect my life. I consider myself to be one of many black women out here who are struggling. And so, my thought was if this is impacting me, I wonder how many other sisters it is impacting. Especially, the book on depression, "*Can I Get a Witness?*"

Edney: Describe how you dealt with your depression before you got help?

Boyd: What I found was that I wanted it to be a secret because it wasn't okay to be a black woman and to be hurting. Our legacy is to be strong and to bear whatever is given to us. And the reality was that I was hurting and needed support. I needed someone to witness that I could move through this. That was important to me. And in my practice I was seeing the staff assistant walk through the door hurting in much the same way and scared to death that others would know or see it. I wanted to make it okay to be able to talk about these issues without a stigma of feeling 'less than' in some way.

Hazel Trice Edney is currently completing a Masters of Public Administration at the John F. Kennedy School of Government, Harvard University. Previously, Edney was a reporter for black newspapers in Richmond, Virginia, including the *Richmond Free Press*. She has specialized in covering civil rights, politics and social issues. At the Kennedy School, she is the William S. Wasserman Jr. fellow on the press, politics and public policy.

Edney: Do you feel that these emotional and psychological health issues as they pertain to black women are being addressed enough in the public policy arena?

Boyd: The reality is that it doesn't get addressed by anyone, especially by the sister herself. I keep going back to where Fanny Lou Hammond said 'I'm sick and tired of being sick and tired.' The reality is that the issues that affect us don't get talked about as far as policies or as far as health care goes. It really frightens me because I feel like when those issues are not addressed, we become invisible again. I really believe that unless we ourselves keep these issues in the forefront, they won't be talked about or dealt with on any level.

Edney: Of course you're dealing with these issues by writing your books. Has there been any kind of cohesive effort on the part of other authors who write similar kinds of books to lobby politicians on these issues?

Boyd: I definitely think that hearing from us would make a difference. The only group that I am aware of that has lobbied on our behalf as black women has been the *Black Women's Health Project*, headed by Bylle Avery. That, for me, has been like a beacon in the storm because the first time that I heard Billy Avery speak during a conference here in Seattle, I just couldn't believe it. I was so enamored of her. It was like - yes! Somebody recognizes how important this is. I'm not alone here. And that felt like a gift for me. I'm not a joiner. I don't belong to sororities or clubs or anything else. But I almost hurt myself going to join the *Black Women's Health Project* because I really recognized how important the work was and I knew that in that group, that is where our issues would be addressed.

Edney: How important is the group relationship among women who have similar backgrounds and how much does the group interaction lead to healing of emotional traumas?

Boyd: I think it's a big part. Again, it's about, "*Can I Get a Witness?*" What's really gratifying to me is when I go out on speaking engagements and book tours and so many women will come up to me and say, "It's just like you called my name. When I read your book, it stood out for me that I am not alone and it's so nice to see that I am not alone in dealing with this."

Edney: Professionally, what do you say to encourage these sisters once they have read the book?

Boyd: What I have to tell sisters is that we are strong. But part of being strong is being human. And being human, there are going to be times when we hurt and it's okay to talk about the pain that we've experienced.

Edney: Within the Black community in particular, how is depression perceived by our families and in the community in general?

Boyd: One of the things I pointed out in the book was that we don't talk about depression because the signs and symptoms of depression mimic personal weakness. So, I think it's really difficult. I have to tell sisters over and over again that this is an illness we're talking about. This is not laziness or craziness. This is not

procrastination. This is not weakness. This is an illness. We sometimes even assume that this is what our life is supposed to look like. What I have to say to sisters is that suffering is not a requirement for living a full life.

Edney: But, does your message get across to the black woman? Are we not caretakers?

Boyd: Oh, we are extreme caretakers. Many of us don't talk about it because we do see our roles as primary caretakers. We kind of honor suffering because we assume that we are supposed to suffer because our mothers and our foremothers suffered so much that we are to carry on the legacy. This is a grossly unhealthy practice. But, we don't recognize that they suffered so that we won't have to. Of course, we come upon things that we do have to do on some level, but I shouldn't have to do it in the same way because there are other options out here, especially for taking care of myself.

Edney: But that self-care is difficult if the system of health care in America does not really address emotional well-being as a major health concern. Why does it not?

Boyd: I think it is starting to. I recognize that depression is starting to gain greater attention. But let's face it, according to the health care system, it's only been within the past 25 or 26 years that women have even had health care. When you look at the studies and the treatments, everything has been done on men and on white males in fact. We are not even recognized as a gender, much less as a race. However, that's starting to change. It started to change with the feminist movement. It started to change when we started getting more female doctors in places where we could start talking about these issues and what does affect us as women.

Edney: Other than the influence of the traditional roles, what other social factors are compounding the self-esteem and emotional problems of black women? For example, the high rate of black men going to jail, does that compound our problems?

Boyd: Economics has got to be at the top of the list. The ability to earn an equal dollar has got to be a part of this. I think concerns around our families, our children and yes, what's going on with the black male impacts us because we are very empathetic when it comes to our brothers. Also, I think it is important that we increase our ability to be recognized as an integral part of what goes on in society. It's almost like we've become invisible on some level and if we try to deal with that, it's hard because we're so busy taking care of everyone else.

Edney: If you were to propose one specific piece of legislation that you knew would pass within the next month to address these issues, what would that legislation be?

Boyd: Because I am a health care professional, I would propose that more health care be allotted to all Americans. I would love to see more women's clinics, more dollars go into issues that affect black women. Breast cancer would be at the top

of the list. Also, that more money be spent looking at education. I would like to see more money available for black women entering the health care professions so that they could study health issues that pertain to black females.

Edney: There are now some black men who are specializing in and writing about self-esteem and emotional problems of black women. Can a man really address those issues that come from so deep within the woman and do you recommend this?

Boyd: That's difficult. I've been asked several times why don't I write for black men. I have to write from my own experience and who I am. I am a black woman. It's not that I don't think that males can write our issues, but I realize that we are secretive about a lot of things that pertain to who we are and how we are. It is really hard for a black male to address us on a deeper level. Not being a black male, I don't know the heart. I can think that I know it, but I haven't lived it. I know what they've experienced to some degree, but nobody knows how they feel better than they do. And I think the same holds true for us.

Edney: Why did you become a psychotherapist?

Boyd: I tell people this jokingly, but it's true on some level. I wanted to know when I was going crazy. Because I was hurting so badly around the time of my divorce until it scared me. And I thought, is this what craziness looks like? It was really important for me. One of the reasons I got an MEd as opposed to an MSW was because I knew I wanted to work with communities of color. I knew that there was a lot of stigma in communities of color and that degree would be an important factor in being able to talk to folks. I wanted to be able to, number one, be there as someone that they could talk to and not feel afraid. I wanted to be able to share my experience and let them know that they weren't alone and they could survive this. I don't see us as broken because we don't have to be fixed. What we need is the support to know that we can work through our issues and still feel good about ourselves.

Edney: In what direction is this new focus on the emotional health of black women going to grow?

Boyd: My hope and my dream is that we can give to our daughters and our younger sisters, again what we missed. That is the knowledge that they have the inalienable right to take care of themselves, not just to take care of others. There has to be the written and the spoken word about it. And there has to be the support from government and others that we are not invisible. But, I know that we have issues that are particular to us and they won't get addressed unless we start raising our voices in unison to address them.

Edney: How publicly accessible are books on this subject that are written by black authors, including your own?

Boyd: They are in the libraries and bookstores, but they are often lumped into the African American sections with novels and fictions rather than the health section.

I don't see that being done with white books. When I go into the health section at Barnes and Nobles, Laura is in the health section. She's not over with the novels. I also now see my books in the schools and in school libraries and that makes me feel good.

Edney: Speaking of education, what can be done outside of the public policy arena to address these issues and how can your books facilitate this?

Boyd: I have been so honored to be invited to groups that call themselves "Sister Circles." They are book groups. They are church groups. Some of them are just young sisters getting together. They're reading the book and they're starting to talk about it together. They'll read my books and then they will go on to read other books that deal with similar issues. I get beautiful letters from women who thank me profusely. One woman thought that getting her Ph.D. would solve her problem with inner-emotional turmoil that she had struggled with for some time, but did not know where to look. She said she had taken her burdens to God as she has been taught, but didn't feel like she was getting any response. That often happens. We've been taught to take it to the Lord. When we don't get the relief, we think that God isn't with us. That's not what it's about. This is about, you can do some tangible things—in additional to spiritual growth—to help you move through this. Most of what you pick up and read about us is from the spiritual perspective and I think that's great. But I think we need to address other issues as well. We are more than just spirit. Iyanla Vanzant is a great friend of mine. Iyanla addresses our spirit. I address our mind. We need more voices. We need that balance.

Edney: What is it about depression that makes it easy for health care policy-makers to get around the issue?

Boyd: Depression is very seductive in its subtleties. Many people can still function when they are depressed. And that's why we have to push it as a health care issue because they want to believe that we are lazy when we can't pull it off or hold ourselves together any longer.

Edney: Doesn't society want to believe this too?

Boyd: Oh, definitely, particularly about black women. I think that's why it has taken us so long to get the care that we need. It's because of the stereotypes and myths about who we are. On the one side of the fence, we're the stone black woman. On the other side of the fence, we're shiftless and lazy. We haven't been able to give ourselves the middle ground that we need in order to look at this issue clearly. It has only been within the last maybe seven to ten years that doctors have even screened patients around the issues of depression. Because we are not used to recognizing it in ourselves, they are not used to recognizing it either. Part of my job right now is helping doctors identify depression within women.

Edney: Do you feel that policy makers might also say that these issues are already being addressed through non-profits, such as women's shelters and advocacy programs?

Boyd: Having worked in that arena, I know that there are some things that are happening on a grassroots level. But this is not a grassroots issue. And I get so tired of us having to start from square one that even if it is being addressed, it's not enough. You can't pacify us by saying this is being addressed in shelters or in programs for homeless because that is not all of who we are. We are bigger than that. We are not all in shelters. We are not all homeless. We are not all on welfare. They are more than willing to go into those areas because—again—they want to see us in little boxes. And they don't want to see us as everyday women who walk the street, who go to jobs, who are professionals, who are homemakers, who are mothers, who are teachers. They want to see us in little pockets as if they are taking care of us and that's not real.

Edney: Have black women been particularly susceptible to being given prescription drugs for depression just to sort of put a band-aid on the problem?

Boyd: I don't see medication as a band-aid. I see it as a viable option, as a tool, because for some of us, in some instances, it really does help.

Edney: How does depression manifest itself in ways that may not be readily detected?

Boyd: Many patients come in with flu-like symptoms, but there's no virus there. Or this person has had countless migraine headaches and has been taking narcotics for that. That's where, again, you need that balance. The answer is not just medication. It has to be medication with that balance of therapy. They must know why they're taking the pills and that we're not looking at a lifetime of pills.

Edney: Some women would argue that even with the medication, with the counseling—whether pastoral counseling or from a psychotherapist—that's still only half the problem because the other half of the problem is how they are sometimes treated by the black man in their lives. Some would argue that until he gets his healing and his counseling and until the books are written for him, the women are still in trouble. Do you agree with that?

Boyd: No I don't. While it's important for our brothers to get what they need as far as healing goes, our healing cannot depend on their readiness, their willingness or their access to their own feelings. We are individuals. And while we share the same legacy and the same history, we cannot hold the black male hostage in saying he needs to do his work in order for us to do our work. We have to be responsible for doing our own work, for taking care of ourselves. Or again, we will fall into that myth, that stereotype. It's not like our men are boys. We don't have to take care of them. They are men and they can take care of themselves. Yes, they want our support because we want their support, but our support does not need to cripple them. We too often fall into that stereotype of being more willing to take care of someone else than we are willing to take care of ourselves. That's not exactly stereotype. That's probably more than a little bit of the truth. But our men are not children and we must not treat them as such. They have been seen in that light long enough and they need to be seen and honored as men and that means that they are

able to take care of themselves—again with our support—just as we are able to take care of ourselves.

Edney: How will you get America's public policy makers to really listen concerning these issues when traditionally, they have not listened to us?

Boyd: It can't start or stop with just my voice. There has to be more and more voices. And it needs to be looked at within the context of public policy support for African American health care generally. When I look at who speaks for me in the public arena, it frightens me because I don't know who our leaders are. So that leads me to believe that we all have to be leaders. I think a part of the answer could be electing and supporting more black candidates from a variety of areas and backgrounds so that we can, again, get these issues where they need to be.

Edney: In seeking to get the issues heard, how much help have you gotten from white women?

Boyd: Oh, they have been tremendous. Of course I get the questions about why is this issue different as it pertains to black women. And I say that it is different because of our history, our legacy and the stereotypes that we've dealt with and because we don't talk about the problems. And I say that we are definitely not going to talk about this with you because we need to talk about these issues among ourselves first to start our healing process. But, I've gotten a lot of support from white women around the works and that has been good.

Edney: What would you say to black women who are hurting, who are down and emotionally badgered right now? What is the first step they should take?

Boyd: Please talk to somebody. I can't say it enough. Our silence is not golden. Recognize that you can talk to a therapist, your minister, your best friend. Talk to someone who is going to support you. And support is not monolithic. This is on many different levels. Also, talk to the powers that be. Talk to your doctor, talk to your health care providers, talk to legislators, talk to teachers. We've got to stand up and we've got to speak out. Otherwise, nothing changes.

