

African Americans: Health Disparities Overview

Health disparities are believed to be the result of the complex interaction among genetic variations, environmental factors, and specific health behaviors. (US DHHS, 2000).

Report on Unequal Treatment

In 2003, the Institute of Medicine of the National Academies issued *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, which reported that minorities are less likely than whites to receive health services, including clinically necessary procedures, even when controlling for insurance status, patient income, and other access-related factors. Cultural bias can affect clinical decision-making. The authors found evidence that stereotyping, biases, and uncertainty on the part of health care providers can contribute to unequal treatment. (Smedley et al., 2003).

“African Americans have a story to tell that is unmistakably their own. Their history is unique, based on their rich cultural heritage, not all of which was lost in their transplantation to America or on the plantations. Despite insults to their humanity; psychological disorientation; and the social, cultural, and environmental displacement experienced during their early years in America and after, African Americans have managed to defy the forms of enslavement (both physical and psychological) and have attested in every media and form to their resiliency as a people and to the tenacity of their cultural heritage. Although African Americans have always been a part of American society, their world, with its distinctive expressions, has run parallel and sometimes even counter to the mainstream American culture. Social existence for African Americans has been problematic since their earliest days on American soil. Members of this racial, ethnic, and cultural group have experienced the deepest levels of social disequilibrium and nonacceptance.” (Butler, 1994). Given these injustices, African Americans continue to have a disproportionately high burden of disease, disability, and death

The content of this document is organized into the following sections:

Access each of the 9 sections by clicking on the bookmarks or on the links below.

[Demographics](#)

[Health Status](#)

[Traditional Health Beliefs and Practices](#)

[Risk Factors and Challenges](#)

[Strengths and Protective Factors](#)

[Diet](#)

[Adherence Factors](#)

[Complementary and Alternative Medicine](#)

[References and Resources](#)

Demographics

Size and Diversity of Population

- In 2002, there were 36.6 million non-Hispanic blacks in the US and 1.7 million Hispanic blacks. African Americans make up about 12.3% of the US population. (US Census Bureau, 2003).
- **The African-American community is just as diverse as other ethnic and racial populations** and includes immigrants from Nigeria, Ethiopia, South Africa, the West Indies, and other parts of the Caribbean. (ICC, 2001). The majority of African Americans are descendents of slaves, mostly transported from West Africa.

Location

- **About 30% of African Americans live in four states, each of which has an African-American population of 2 million or more: California, Florida, Georgia, and Texas.** More than half of African Americans live in 12 states: Alabama, Illinois, Louisiana, Maryland, Michigan, Mississippi, New Jersey, North Carolina, Ohio, Pennsylvania, South Carolina, and Virginia. Together, these 16 states are home to more than 80% of African Americans. (US Census Bureau, 2000b).
- **Almost half of African Americans live in so-called high-poverty areas, or areas where more than 20% of families live in poverty.** In comparison, only 7% of whites and 16% of Asian Americans and Pacific Islanders live in these high-poverty areas, which also have inordinately high rates of unemployment, crime, substance abuse, and other social problems. (ACS, 2003; NCI, 2003a).

Income and Education

Inequalities in income and education underlie many health disparities in the US. Income and education are intrinsically related and often serve as proxy measures for each other. **In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education.** Disparities in income and education levels are associated with differences in the occurrence of death and illness, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors. (US DHHS, 2000).

Education

- **In 2002, 87.6% of African Americans between the ages of 25 and 29 had high school diplomas, and 18% held bachelor's degrees or higher.** In this same age group, 93% of whites were high school graduates, and 36% had bachelor's degrees or higher. (US Census Bureau, 2002a).

Socioeconomic Status and Health Status

Socioeconomic status (SES) is a reliable predictor of health status throughout the world.

Generally, high SES is associated with better health status, and low SES is associated with poorer health status. In the US, people of lower SES have fewer opportunities to adopt healthy eating and exercise patterns, and they have less access to adequate, regular health care. People of lower SES are more likely than their wealthier counterparts to concentrate on day-to-day survival and experience feelings of hopelessness, powerlessness, and social isolation. **These disparities in economic resources may negatively influence health beliefs and behaviors.** Even when SES changes for a person of color, the effects may not lessen. (US DHHS, 2003b).

Income and Socioeconomic Status

- The **wealth gap** between whites and blacks in the US is much larger than the gap in income. Wealth is a measure of what one owns, including a house, a car, a business, and so forth. In addition to income, the acquisition of wealth is affected by inheritance, the ability to get a mortgage, and access to capital for businesses, all of which require social and political power. The gap in wealth is more indicative of racial disparities than is the income gap. (Menchik and Jianakoplos, 1997).

Employment

- A study that assessed the potential discriminatory treatment of job applicants found that **opportunity denial** (defined as the denial of an opportunity to obtain an application, obtain an interview, or receive an offer of employment) occurred 20% of the time in black–white audits and 31% of the time in Hispanic–Anglo audits across all study sites. (Smedley et al., 2003).

Gender

- **African-American women have historically been treated as subordinates in US society**, which may contribute to lifestyles and behaviors that are associated with poorer health status compared with that of white women. (NCI, 2003a).
- **African-American women automatically belong to two (and sometimes more) low-status and low-power groups:** they are African American and they are women. (Hall, 1994).
- Black men often have difficulty finding socially acceptable employment that incorporates them into the mainstream US workforce. This leads to **disempowerment of African-American men**, more female-headed households, and nontraditional gender roles. Some researchers believe that this results in more violence and unhealthy behaviors in some African-American communities. (Hall, 1994). Many black men have difficulty securing a job because of racial discrimination.

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

Religion

- **African Americans are more likely than whites to report that they have prayed to God** during the past seven days: 92% of African Americans, versus 82% of white adults nationwide. (Barna Research Online, 2002).
- **African Americans are significantly more likely than whites to have read from the Bible** in the past seven days, other than at church. (61% versus 42%). (Barna Research Online, 2002).
- **Fifty-three percent of African Americans attend church** on a given Sunday, which is slightly higher than the rate of church attendance among whites (43%). (Barna Research Online, 2002).
- Fifteen years ago, 36% of African Americans and 23% of whites described themselves as born again or evangelical Protestants. Today, fully **50% of African Americans** describe themselves as such, compared with 28% of whites. (Pew Research Center, 2004).
- The Nation of Islam was founded in the 1930s by an African American named Wali Farad Muhammad. It emphasizes the need among African Americans for strong families and economic empowerment. **Although some statements made by the Nation of Islam have generated significant criticism, it has had a positive influence on the health and well-being of segments of the African-American population in the US.** (MSH, 2004)

More information about African American culture can be found in the [Provider's Guide to Quality & Culture](#) Web site

Health Status

Leading Causes of Mortality and Morbidity

- **The three leading causes of mortality in the African-American population are the same as those for whites:** heart disease, cancer, and cerebrovascular disease. (CDC, 2001a).
- **African-American women have a high prevalence of obesity, diabetes, and hypertension.** Other factors contributing to the overall poorer health and lower life expectancy of African-American women include smoking, unhealthy diet, lack of physical activity, occupational influences, stress, and barriers to preventive health care. (NCI, 2003a).
- **AIDS is now the leading cause of death for African Americans between the ages of 25 and 44.** (Henry J. Kaiser Family Foundation, 2001).
- **Middle-aged and older African Americans are far more likely to die from coronary heart disease, stroke, or lung cancer** than are people of the same age in other racial and ethnic minority groups. (CDC, 1998a).
- **Cardiovascular mortality rates in African Americans aged 35 to 64 are more than twice those in whites.** Hypertension has been identified as the single most significant cause of death, independent of socioeconomic status. It has the greatest impact on the racial disparity between African Americans and whites in potential life-years lost. (NIH, 2003).
- Compared with other racial and ethnic groups, **African Americans are more often obese, have higher rates of hypertension and related complications, have higher rates of HIV/AIDS, are more likely to suffer complications of diabetes such as leg amputation and renal failure, and are more likely to be diagnosed at later stages of cancer**—leading to higher case-fatality rates. (CDC, 2002a, 2003; ICC, 2001; American Diabetes Association, 2004; NIH 2003).
- **The incidence of glucose-6-phosphate dehydrogenase deficiency is much higher among the black American population,** with a heterozygote frequency (carrier state with one normal gene and one abnormal gene) of 24%. Approximately 10% to 14% of the black American male population is affected. (HealthScout, 2004).
- In the US, sickle cell trait and disease occur almost exclusively in persons of African descent. **About 8% of African Americans have sickle cell trait** (sickle cell gene from one parent), and about 0.2% have sickle cell disease (sickle cell gene from both parents). (Medline Plus, 2004).

Traditional Health Beliefs and Practices

- Some African Americans may believe that **health and illness are controlled by God and by the devil**. (Diversity Resources, 2000).
- Because religion plays such a central role in many African Americans' lives, **illness—especially in children—may be attributed to parents' transgressions**, requiring healing through prayer. (Diversity Resources, 2000).

No Stereotyping!

Health beliefs and practices vary widely within the African-American community. Newly arrived immigrants and refugees from Africa may have very different belief systems from African Americans who have been in the US for generations or from immigrants from the Caribbean. As in all racial and ethnic groups, African-American belief systems and practices also vary among individuals, based on educational levels and personal histories.

- Some African Americans may subscribe to magical explanations of health and illness, including **beliefs about the zodiac, numerology, and hexes**. (Diversity Resources, 2000).
- **Patients may use different words to describe illnesses**. For example, diabetes may be referred to as “sugar” or “sugar diabetes.” Pain may be referred to as “miseries,” and “low blood” may be used to describe anemia. The terms “high blood,” “high blood pressure,” and “hypertension” can be used interchangeably. (UWMC, 2001).
- Many Haitians practice **Voodoo**. Voodoo is a religion, a system of justice, a medical practice, and a genre of music and dance. It is practiced as seriously as Christians, Jews, and Muslims practice their religions. (Voudoun culture, 2004; Corbett, 1998).

Recommendation

It is generally not useful to try to change the way a patient thinks, including beliefs about supernatural causes of health and illness. It is more important to design a diagnostic and treatment plan that does not conflict with the patient's belief system. Culturally competent providers ask the patient if the plan is consistent with his or her beliefs.

- A study published in *Oncology Nursing Forum* demonstrated that African-American women with a BRCA1 mutation (indicating a greater risk of developing breast cancer) were **less likely to be screened for breast cancer if they had a strong belief in God**. (Kinney, 2002). In contrast, other studies have demonstrated a positive association between church attendance and utilization of preventive health care. (Felix Aaron et al., 2003).

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

- **Many black Americans have “cancer fatalism”**—a sense that cancer will happen if it is “supposed” to happen, and that there is little that can be done to prevent or treat the disease. (Wolff et al., 2003).
- According to the Patient and Family Education Committee of African American Culture Clue, **the decision to seek medical attention is often composed of three stages:**
 - 1) Wait and see: a stage of self-treatment using prayer and home-based or “folk” remedies.
 - 2) Discuss treatment with key people: this network of key people includes the family, community, or church.
 - 3) Seek medical care: going outside the home and kinship network and consulting Western or traditional health care providers. (UWMC, 2001).

Risk Factors and Challenges

Racism and Social Injustice

- In its 2002 publication “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” the Institute of Medicine reported that **racial and ethnic minorities tend to receive lower-quality health care than nonminorities do**, even when patients’ insurance status and income are controlled for. The study committee found evidence that stereotyping, biases, and uncertainty on the part of health care providers all contribute to unequal treatment. (Smedley et al., 2003).
- Vulnerable and marginalized groups in society experience an undue proportion of health problems. **Many health disparities are rooted in fundamental inequalities in the social structure, which are inextricably related to racism and other forms of discrimination.** Research has shown that inequalities in the health status and health care of ethnic and racial groups are evident, and racism is the most disturbing explanation for these inequalities. (WHO, 2001).
- **There is an association between perceived racial discrimination and high blood pressure, birth weight, and sick days.** In a recent study from the United Kingdom, victims of discrimination were more likely to have respiratory illness, high blood pressure, anxiety, depression, and psychosis. Racism’s adverse effect on health may be linked to stress responses. (McKenzie, 2003).

Distrust of Medical System

- **Because of a history of racism, African-American culture has developed its own view and judgment of the larger American society.** Cultural guidelines about interacting with members and institutions of this larger society, including those that are health related, often emphasize caution, mistrust, and avoidance. (NCI, 2003a).
- **Some African Americans distrust the medical community because of historical racial injustices, such as the Tuskegee syphilis study,** in which medically proven treatment was intentionally withheld from African-American men so that researchers could study untreated syphilis. (Wolff et al., 2003).

Recommendation

As a provider, you must deal with racism on an individual level and within the system. Respect the positive features of this population’s community and culture, and address its understandable wariness when you suggest changes in the lifestyles or health care practices of African Americans. (NCI, 2003a).

Environmental and Occupational Hazards

- **Residents in urban settings have an increased risk of exposure to toxic waste; air pollution; crime and violence;** and older, poorly maintained buildings with inadequate heating, lead paint, and cockroach allergens. Researchers believe that exposure to violence

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

may increase feelings of alienation, powerlessness, and hopelessness. **Individuals who live under these conditions may see limited benefits in adopting health-promoting behavioral changes.** (US DHHS, 2003b).

Recommendation

Inform patients about preventive measures to decrease exposure to lead paint toxins. Refer patients to local and federal agencies that may assist in controlling hazardous materials in the workplace or home. (Kaiser Permanente, 2001). If lead paint cannot be removed from homes, children should wash their hands frequently to remove dust. Similarly, any object that goes into a child's mouth should be washed frequently. Peeling paint on windowsills can be covered with electrical tape. Damp-mopping floors is preferable to vacuuming, because the vacuum cleaner can stir up lead paint dust. Children should be instructed not to play outside near exterior walls with lead paint.

- Attempts to isolate environmental cancer risks have focused on urban pollution, especially motor vehicle exhaust and proximity to heavy industry or hazardous waste dumps. **African Americans are more likely than nonminorities to live in residential areas where concentrations of environmental and urban pollution are high.** (NCI, 2003a).
- Carcinogenic agents in the workplace include certain metals, solvents, dyes, organic and inorganic dusts, pesticides, and herbicides; in some industries, radiation exposure is also a cancer risk. **Exposure to these cancer risks is associated primarily with hazardous industries and blue-collar jobs, which historically have gone to African Americans.** (NCI, 2003a).

Health Insurance Coverage and Access to Quality Care

- **In 2002, 17.2% of African Americans did not have health insurance**, compared with 30.6% of Hispanics/Latinos and 10.8% of whites. (NCHS, 2003).
- Quality care comes from a doctor who knows the individual patient, but not everyone has a regular doctor. **In 2002, about 15% of African Americans did not have a usual place to go for medical care**, compared with less than 10% of whites and about 23% of Hispanics/Latinos. (NCI, 2003b; NCHS, 2003).
- **In 2002, a greater percentage of African Americans were unable to obtain needed medical care due to financial barriers (6.5%)** than were whites (4.4%) or Hispanics/Latinos (5.3%). (NCHS, 2003).
- **African Americans have a lower average number of physician contacts than whites do, in spite of their greater morbidity.** A 1986 national survey on the use of health services showed a significant deficit in access to health care among African Americans compared with white Americans, **and this gap occurred at all income levels.** (NCI, 2003a).

Transportation Difficulties

- **Like other population groups living in rural areas, African Americans may lack transportation to treatment facilities.** What is available may be too expensive or limited by

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

weather factors. If public transportation options are available, the patient may be too sick to use them or to walk to pickup points. (NCI, 2003b).

- **Transportation is also an issue for inner-city residents who do not own cars or cannot afford bus or subway fares.** In addition, some urban cancer patients are too sick to make a trip that covers only a few miles but involves multiple bus transfers and considerable walking. (NIH, 2001).

Suggestion

Discuss transportation issues with your African-American patients. Work together to develop strategies for minimizing or overcoming transportation challenges. Refer your patients to local options, such as church or other community volunteer transportation programs, if they are available.

Obesity

- In 2002, the **age-adjusted prevalence of obesity (body mass index greater than 30) among African-American adults was 40.4% for women and 29.7% for men.** (NCHS, 2003). Obesity prevalence among African-American adults increased from 19.3% in 1991 to 31.1% in 2001—rates that were consistently higher than those for any other racial or ethnic group. (CDC, 2003).
- **Being overweight affects African-American women and men across all socioeconomic levels,** although minority women with lower incomes appear to have the greatest likelihood of being obese. (American Obesity Association, 2002).

To view a video about caring for an obese African American adolescent go to:

<http://erc.msh.org/mainpage.cfm?file=4.1.0.htm&module=provider&language=English>

- In 1999–2000, **African-American adolescents aged 12 to 19 were more likely to be overweight (24%) than were white adolescents (13%).** Among pre-school-aged children, however, African Americans were less likely than children from other ethnic groups to be overweight. (CDC, 2002b).

Read more about common [African American diets](#)

Smoking

- Data from the 1997 National Health Interview Survey (NHIS) showed that, **overall, smoking prevalence among African-American adults was 26%,** compared with 27% for whites. Thirty percent of African-American men smoked, compared with 29% of white men. For African-American women, the smoking rate was 22%, compared with 26% for white women. (CDC, 1998a).

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

- **Between 1965 and 2001, adult cigarette smoking declined more rapidly among African Americans than among whites, especially among African-American men with at least a high school education.** (CDC, 1998b). As a result, the **prevalence of smoking among African-American adults is now similar to that among white adults.** Increased prevention and control initiatives targeted specifically at African Americans during the 1990s might explain part of this decline. (CDC, 2004a).
- **Levels of serum cotinine (metabolized nicotine) are higher among African-American smokers than among white or Mexican-American smokers for the same number of cigarettes.** (CDC, 1998a).
- **Among African-American participants in programs serving primarily poor women, smoking rates range from 42% to 49%.** (NCI, 2003a).

Pertinent Facts

NHIS data indicate that **fewer African-American women than white women are heavy smokers.** The mean number of cigarettes smoked per day for African-American women was 11, compared with 16 for white women. **However, African-American women have higher blood levels of cotinine than white women who smoke a comparable quantity of cigarettes.** These data may explain why African-American women have greater difficulty quitting, even though 74.9% say that they want to stop smoking. (NCI, 2003a).

- An Ohio study reported that **90% of African-American female smokers reported smoking mentholated cigarettes, which allow greater smoke inhalation** and may offset the benefits of reduced cigarette consumption. (NCI, 2003a).
- Approximately three-quarters of African-American smokers prefer mentholated cigarettes, versus only one-quarter of white smokers. **Menthol may facilitate the absorption of harmful cigarette smoke constituents.** (OSU, 1999).

Recommendation

Encourage your patients to stop smoking, and provide them with information about smoking cessation programs. Work together toward a risk-reduction plan that gradually decreases their cigarette intake. Inform your patients that mentholated cigarettes may be particularly harmful.

- **Among African-American youth, 8.2% of males and 5.9% of females smoke. Smoking rates are higher among whites:** 17.2% of girls and 14.9% of boys. (CDC, 2004a).

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

- **African Americans find it harder to quit smoking.** More than 70% of current African-American adult smokers have said that they want to quit smoking completely, and they are more likely than white smokers to have stopped smoking for at least one day during the previous year. However, the prevalence of cessation is higher among whites than among African Americans. (CDC, 1998a).
- A one-year study found that **three major African-American publications—*Ebony*, *Jet*, and *Essence*—received proportionately higher profits from cigarette advertisements** than did other magazines. (CDC, 1998a).
- The **tobacco industry attempts to maintain a positive image and public support among African Americans** by supporting cultural events and making contributions to minority institutions of higher education, elected officials, civic and community organizations, and scholarship programs. (CDC, 1998a).

Alcohol Use

- **In 2002, a lower percentage of African-American adults had excessive alcohol consumption (6.6%)** compared with Hispanics/Latinos (10.1%) and whites (10.5%). (NCHS, 2003).
- **General-population surveys of alcohol consumption in African-American adults classify most women as abstainers (45% to 60%) or “infrequent” to “less frequent” drinkers (34% to 36%), with relatively low rates of heavy drinking (2% to 8%).** With increasing age, abstention rates increase, to the point that the majority of African-American women older than 40 do not consume alcohol. (Collins and McNair, 2003).

Physical Activity

- **Less than 25% of African-American women meet the current recommendation of at least 30 minutes of moderate-intensity physical activity at least five days a week,** and between 33% and 42% are inactive. (NCI, 2003a).

Recommendation

Encourage your patients to increase their physical activity through simple lifestyle changes: walking rather than taking the bus, parking the car farther away from the store, taking the stairs rather than the elevator, marching in place while watching TV.

- **In 2002, 25.4% of African-American adults engaged in regular leisure-time physical activity,** compared with 22.7% of Hispanics/Latinos and 34.9% of whites. (NCHS, 2003).

More information about risk factors and challenges can be found at

<http://erc.msh.org/mainpage.cfm?file=5.4.1g.htm&module=provider&language=English>

Strengths and Protective Factors

- **African Americans have a strong cultural orientation and sense of racial pride.** Elders pass on their culture and cultural pride by telling children about African-American history, discussing racism in the family, and showing a preference to be identified as African American. (MSH, 2004).
- **Over time, African Americans have developed and maintained a unique culture that has helped them make sense of and cope with their situation.** This subculture encompasses community and kinship networks, family structure, and beliefs and practices related to health and illness, as well as the special role of women across these elements. (NCI, 2003a).
- **African Americans have a tradition of involving the “whole village” or whole family in raising children.** (MSH, 2004).
- **African Americans are a highly expressive people.** Because of their sense of oneness with life and harmony with nature, they respond naturally and spontaneously to experiences. This sense of balance characterizes their physical movements as well as their interpersonal understandings and interactions. (Butler, 1994).
- **Historically, the extended family and the church provided their members with emotional security and a sense of identity, belonging, and dignity that were denied African Americans in their interactions with the larger community.** However, at present, few reliable data are available on how or whether these traditional cultural and social forms of organization have survived or adapted to today's circumstances. (NCI, 2003a).
- **Surveys of alcohol use among African Americans point to the positive relationship between religious participation and abstinence from alcohol, for both women and men.** (Collins and McNair, 2003).

More information about strengths and protective factors can be found at
<http://erc.msh.org/mainpage.cfm?file=5.4.1d.htm&module=provider&language=English>

Diet

- The **traditional African-American diet** includes sausage, chicken, many kinds of fish, greens (mixtures of chard, collard greens, kale, mustard greens, spinach, and turnip greens), black-eyed peas, okra, grits, peas, tomatoes, squash, cornbread, and sweet potato pie. (Ohio State University Extension, 2004b).
- **Lactose intolerance** is more common among African Americans, resulting in fewer dairy products in the diet. **Frying** is more popular than boiling or baking. (Ohio State University Extension, 2004b).
- A study of the average daily diets of urban midlife African-American women found that although 90% of the participants were avoiding or planning to avoid high-fat foods, 77% were consuming diets that provided more than 30% of calories from fat. Ethnocultural association was the only variable that was consistently positively related to dietary fat intake. Thus, **education about diet should be based on the patient's culture and traditions.** (Daroszewski, 2004).

Recommendation

Focus on the way food is prepared, encouraging families to modify the sodium, fat, and sugar content of traditional foods. Simple changes in diet might include broiling rather than frying, substituting herbs for high-sodium seasonings, decreasing the amount of meat, removing the fat and skin from meat, and eating more fresh vegetables and fruits. Eating smaller portions should also be encouraged. It may be useful to ask patients to submit a list of their favorite foods and recipes and then discuss how to modify them. (Ohio State University Extension, 2004b).

- **African-American men aged 30 to 50 eat only 3.5 servings of fruits and vegetables a day**, compared with the 9 servings recommended for men. Black men eat fewer fruits and vegetables than any other population group. (NCI, 2002).

Recommendation

Fresh fruits and vegetables, lean meat, and seafood are often more expensive than less healthy foods. You may want to discuss ways of obtaining quality foods less expensively, such as growing small gardens in community sites, shopping at roadside garden markets, shopping at large supermarkets rather than small corner stores, developing budgeting clubs and food co-ops, and participating in food bank programs. (Ohio State University Extension, 2004b).

- **Sodium intake is high in the African-American diet.** Many African Americans have deficiencies in iron and calcium. (Ohio State University Extension, 2004b).

- **Only 14% of African Americans are aware of recommendations to eat at least five servings of fruits and vegetables a day.** In focus groups, African Americans were less likely than other groups to make a connection between fruit and vegetable consumption and reduced risk for disease, particularly cancer. (NCI, 2002).

Recommendation

In focus groups, African Americans were more likely to believe health messages about diet if they were related to hypertension and diabetes and if they included clear advice about which specific foods to eat to prevent those diseases. (NCI, 2002).

Adherence Factors

- Patients are more likely to ask questions, raise concerns, and adhere to recommended treatments when they feel respected by the provider. **Granting proper respect is important to African Americans**, especially as conveyed by the use of formal titles such as Mr., Mrs., or Ms. or formal references such as Sir or Ma'am. Until you are invited to greet them by their first names, using formal titles sends the message that you are treating your patients as equal partners in their health care decision-making. (UWMC, 2001).
- A growing body of research demonstrates that **patients recall and comprehend less than half of what clinicians explain to them**. Less than half of patients understand written medication instructions, such as directions to take medications on an empty stomach or to take a medication three times a day. (AHRF, 2004).
- As with patients from many racial and ethnic groups, written treatment instructions may not be as affective as **asking detailed questions and discussing patient's fears and feelings**. This may be particularly true of African Americans, who are often more reliant on oral communication. (McNeil, 2002).

Questions to Promote Adherence

- Do you have any questions about what I have explained?
- Do you understand the treatment plan I am recommending?
- Is there anything that would make it difficult to follow my recommendations?
- Is there anything you would like to change?

- Many African Americans rely on the **advice and support of a family elder or matriarch**. Health care professionals should ask their patients about their social support networks to identify advocates for treatment adherence. (McNeil, 2002).

Recommendation

The church plays an important role in the lives of many African Americans. It may therefore be helpful to enlist local clergy in assuring patients that seeking appropriate preventive services and adhering to medical advice is consistent with God's will. Consider holding screening programs at the church.

- **Including family members in consultations is often critical to the care of the patient** and may contribute to the patient's ability to adhere to the recommended treatment. The African-American concept of kinship makes this an effective method of promoting positive health behaviors. (MSH, 2003).

For more information on relating to patients' families go to:

<http://erc.msh.org/mainpage.cfm?file=4.7.0.htm&module=provider&language=English>

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

- **Ensure adherence by “showing” and “telling.”** In one tragic attempt at correct adherence, a father was shown how to administer oral medication to his 9-month-old child with a syringe. At home, the father tried to repeat what he had seen the doctor do, but he neglected to remove the syringe cap. The cap became lodged in the child's trachea, and the child died. This tragedy might have been avoided if the father had been asked to “show” and “tell” the provider how to administer the medication. (AHRQ, 2004).

Commit to Empowering Rather Than to “Fixing” People and Communities

Being “problem free” is not the same as being prepared or empowered to live a purposeful or productive life. Help individuals and communities rebuild their vision of who they are and who they can become. Help them realize their capacity to take control of their lives and the circumstances they confront. Strengthen your clients' sense of connectedness to African heritage and cultural traditions. People who have a sense of purpose or a vision of the future that they do not want to jeopardize are more likely to avoid destructive behaviors. Create a sense of purpose and awareness of possibilities. (MSH, 2004).

Compared with other races, **African Americans' participation rates in clinical trials are low** (ranging from 3% to 20%) because of past episodes of racism in medical research. Providers should respect the patient's distrust, discuss the research in detail with the patient and family, and explain the safeguards that prevent mistreatment in human research. (Adams-Campbell et al., 2004).

More information about adherence can be found in the [Provider's Guide to Quality & Culture](#)

Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) has growing social, economic, and clinical significance in the US. It is important for providers to understand the implications of CAM for their patients: what it is, who uses it, and why. CAM covers a broad range of healing philosophies, approaches, and therapies that the US medical community does not commonly use, accept, or study. (Kaczmarczyk and Burke, 2003).

CAM

The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as:

“a broad range of healing philosophies (schools of thought), approaches, and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine to promote well-being or treat health conditions. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a complementary or an integrative approach.

“Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional, and spiritual aspects.” (Cited in US DHHS, 2003a).

- **Until recent times, mainstream medical care was not available to all African Americans, especially in the South.** African-American health professionals were extremely few in number because of discriminatory admissions practices in medical and nursing schools, and few resources were devoted to establishing health care facilities for African Americans. **As a result, there was considerable reliance on home remedies and alternative health care providers**—a practice that remained prevalent among African Americans even while mainstream America was adopting a science-oriented health care system. (NCI, 2003a).

Recommendation

Look for ways to combine folk remedies with Western medicine by encouraging treatment that promotes self-care. Determine when the remedies are beneficial, neutral, or harmful. Incorporate beneficial and neutral remedies into the plan of care. Consider potential drug interactions. (UWMC, 2001).

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

- **Traditional folk medicine may include a belief that the four major causes of natural illness are cold, dirt, improper diet, and improper conduct.** Women are more susceptible to cold than men, especially during menstruation and right after childbirth, when bleeding causes the body to be “open.” Because cold and dampness are thought to impede the flow of blood, women are warned not to wash their hair or do anything that may bring on a chill while bleeding. (Diversity Resources, 2000).

Caution

It is not known how many African Americans practice traditional folk medicine. The number may be very small. Some African Americans may be offended if the provider assumes that they subscribe to this belief system and practice.

- The idea of expelling “dirt” manifests itself in several ways, including an **overuse of laxatives and the use of potentially dangerous chemicals to “clean” the gastrointestinal tract.** Reduction or cessation of menstrual blood flow due to oral contraceptives or pregnancy may be thought to make the uterus “dirty.” (Diversity Resources, 2000).
- **Improper diet may cause “high blood” or “low blood.”** “High blood” is associated with overly rich and reddish foods, such as beets, carrots, grape juice, red wine, red meat, and pork. A diet rich in these foods is believed to send an oversupply of blood to the heart or brain, raising “pressure” and clogging these organs. Treatment includes the consumption of white foods, herbal remedies, and laxatives. “Low blood” is associated with anemia; its symptoms are weakness and fatigue. African Americans who subscribe to these beliefs may confuse these conditions with high or low blood pressure and may have concerns about medication. (Diversity Resources, 2000).
- For many African Americans, a provider’s sincere acknowledgment of and respect for their opinions regarding the cause of their illness will **enhance the doctor-patient relationship.** (UWMC, 2001).

Recommendation

Determine whether there is a match between your explanation of the cause and likely course of the illness and that of your patient. If there is a mismatch, many patients from this culture will rely on their own explanations rather than those of medical professionals. Making even one medically neutral suggestion that fits your patient’s belief system can help build rapport.

References and Resources

Adams-Campbell, L.L., Ahaghotu, C., Gaskins, M., Dawkins, F.W., Smoot, D., Polk, O.D., Gooding, R., and DeWitty, R.L. (2004). Enrollment of African Americans onto clinical treatment trials: Study design barriers. *Journal of Clinical Oncology* 22(4):730–734.

Agency for Healthcare Research and Quality (AHRQ). (2004). Morbidity and mortality rounds on the web. <http://webmm.ahrq.gov/cases.aspx?ic=53>. Cited April 22, 2004.

American Cancer Society (ACS). (2003). *Cancer facts & figures for Hispanics/Latinos 2003–2005*. Atlanta, GA: American Cancer Society. <http://www.cancer.org/downloads/STT/CAFF2003HisPWSecured.pdf>. Cited August 6, 2003.

American Diabetes Association. (2003). The diabetes assistance & resources (DAR) program. <http://www.diabetes.org/main/community/outreach/latinos/dar.jsp>. Cited September 23, 2003.

American Diabetes Association. (2004). Statistics for African Americans. <http://www.diabetes.org/diabetes-statistics/african-americans.jsp>. Cited April 20, 2004.

American Obesity Association. (2002). Obesity in minority populations: Fact sheet. http://www.obesity.org/subs/fastfacts/Obesity_Minority_Pop.shtml. Cited March 17, 2004.

American Stroke Association. (2002). Stroke facts 2003: All Americans. <http://www.americanheart.org/downloadable/heart/1046366409922SFAAFS.pdf>. Cited September 23, 2003.

Barna Research Online. (2002). African Americans. <http://www.barna.org/FlexPage.aspx?Page=Topic&TopicID=1>.

Betancourt, J.R. (2003). *The impact of race/ethnicity, culture, and class on clinical decision making*. Module 4 of Cultural Competence in the Clinical Care of Patients with Diabetes and Cardiovascular Disease. Washington, DC: Health Resources and Services Administration, Bureau of Primary Health Care, and Institute for Healthcare Improvement.

Betancourt, J.R., and Like, R.C. (2000). Editorial: A new framework of care. *Patient Care*, Special Issue, Caring for diverse populations: Breaking down barriers, May 15, pp. 10–12.

Butler, J.P. (1994) Of kindred minds: The ties that bind. In Orlandi M.A. (Ed.). *Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities* (pp. 23–54). DHHS Publication No. SMA 95-3066. Washington, DC: US Department of Health and Human Services.

Centers for Disease Control and Prevention (CDC). (1998a, last reviewed September 2003). African Americans and tobacco. http://www.cdc.gov/tobacco/sgr/scr_1998/sgr-min-fs-afr.htm. Cited March 17, 2004.

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

Centers for Disease Control and Prevention (CDC). (1998b, last reviewed September 2003). At-a-glance. http://www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-aag.htm. Cited August 20, 2003.

Centers for Disease Control and Prevention (CDC). (2001a). Deaths, percent of total deaths and rank order for 113 selected causes of death by race and sex, US 2001. http://www.cdc.gov/nchs/data/dvs/LCWK10_2001.pdf.

Centers for Disease Control and Prevention (CDC). (2001b, last reviewed September 2003). Pattern of tobacco use among women and girls—fact sheet. http://www.cdc.gov/tobacco/sgr/sgr_forwomen/factsheet_tobaccouse.htm. Cited March 17, 2004.

Centers for Disease Control and Prevention (CDC). (2002a). Cases of HIV infection and AIDS in the United States, 2002. *HIV/AIDS Surveillance Report* 14. Atlanta, GA: CDC. <http://www.cdc.gov/hiv/stats/hasr1402.htm>. Cited March 4, 2004.

Centers for Disease Control and Prevention (CDC). (2002b). Obesity still on the rise, new data show. <http://www.cdc.gov/nchs/releases/02news/obesityonrise.htm>. Cited September 15, 2003.

Centers for Disease Control and Prevention (CDC). (2003). Obesity trends: 1991–2001 prevalence of obesity among US adults, by characteristics. http://cdc.gov/nccdphp/dnpa/obesity/trend/prev_char.htm. Cited September 15, 2003.

Centers for Disease Control and Prevention (CDC). (2004a). Prevalence of cigarette use among 14 racial/ethnic populations—United States, 1999–2001. *MMWR Morbidity and Mortality Weekly Report* 53(3):49–52. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5303a2.htm>

Centers for Disease Control and Prevention (CDC). (2004b). Tobacco industry marketing: Fact sheet. http://www.cdc.gov/tobacco/factsheets/Tobacco_Industry_Marketing_Factsheet.htm. Cited March 16, 2004.

Collins, R.L., and McNair, L.D. (2003). *Minority women and alcohol use*. Bethesda, MD: National Institute of Alcohol Abuse and Alcoholism. <http://www.niaaa.nih.gov/publications/arh26-4/251-256.htm>. Cited August 7, 2003.

Corbett, B. (1998). Introduction to Voodoo in Haiti. <http://www.webster.edu/~corbetre/haiti/voodoo/overview.htm>.

Daroszewski, E.B. (2004). Dietary fat consumption, readiness to change, and ethnocultural association in midlife African American women. *Journal of Community Health Nursing* 21(2):63–75.

Diversity Resources, Inc. (2000). Culture-sensitive health care: African American. In Salimbene, S. *What language does your patient hurt in? A practical guide to culturally competent care*. Amherst, MA: Diversity Resources, Inc. <http://www.diversityresources.com/rc21d/african.html>.

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

Eberhardt, M.S., Ingram, D.D., Makuc, D.M., et al. (2001). *Urban and rural health chartbook. Health, United States*. Hyattsville, MD: National Center for Health Statistics.
<http://www.cdc.gov/nchs/data/hus/hus01.pdf>. Cited September 15, 2003.

Felix Aaron, K., Levine, D., and Burstin, H.R. (2003). African American church participation and health care practices. *Journal of General Internal Medicine* (November). 18(11):908-13.

Hall, R. (1994). Manuscript consensus and African American Women: Complicity at its finest. *Women's and Gender Studies Newsletter*, Trenton State College.
<http://wgst.intrasun.tcnj.edu/newsletter/archives/march1994.html>.

HealthScout. (2004). Glucose-6-phosphate dehydrogenase deficiency.
<http://www.healthscout.com/ency/article/000528.htm>. Cited April 20, 2004.

Henry J. Kaiser Family Foundation. (2001). African Americans' views of the HIV/AIDS epidemic at 20 years: Findings from a national survey.
<http://www.kff.org/hiv/aids/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13866>. Cited March 4, 2004.

Hoffman, C., and Pohl, M. (2000). *Health insurance coverage in America: 1999 data update*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Intercultural Cancer Council (ICC). (2001). African Americans & cancer.
<http://iccnetwork.org/cancerfacts/cfs1.htm>. Cited March 17, 2004.

Kaczmarczyk, J.M., and Burke, A. (2003). *Complementary and alternative medicine issues in serving diverse populations*. Module 7 of Cultural Competence in the Clinical Care of Patients with Diabetes and Cardiovascular Disease. Washington, DC: Health Resources and Services Administration, Bureau of Primary Health Care, and Institute for Healthcare Improvement.

Kinney, A.Y. (2002). Screening behaviors among African American women at high risk for breast cancer: Do beliefs about God matter? *Oncology Nursing Forum* 29:835-43.

Kittler, P.G., and Sucher, K.P. (1998). *Food and culture in America: A nutrition handbook*, 2nd ed. Belmont, CA: Wadsworth Publishing Company, a Division of International Thompson Publishing.

Management Sciences for Health (MSH). (2004). The Provider's Guide to Quality & Culture.
<http://erc.msh.org/quality&culture>. Cited August 5, 2004

McKenzie, K. (2003). Racism and health. *British Medical Journal* 326:65–66.

McNeil, J. (Ed.). (2002). *BE SAFE: NMAETC cultural competency model*. Washington, DC: Howard University, National Minority AIDS Education and Training Center.

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

Medline Plus. (2004). Sickle cell anemia.

<http://www.nlm.nih.gov/medlineplus/ency/article/000527.htm#Causes,%20incidence,%20and%20Orisk%20factors>. Cited April 20, 2004.

Menchik, P., and Jianakoplos, N. (1997). Black–white wealth inequality: Is inheritance the reason? *Economic Inquiry* 35:428–442.

Murtha, S., Allen, C., and Welch, M. (2002). *Toward culturally competent care: A toolbox for teaching communication strategies*. San Francisco: University of California–San Francisco, Center for the Health Professions.

National Cancer Institute (NCI). (2002). How diet affects African American men's health. 5 a Day for Better Health Program, September.

National Cancer Institute (NCI). (2003a). Cancer in African American women: Monograph chapter. http://cancercontrol.cancer.gov/womenofcolor/pdfs/african_american-chapter.pdf. Cited March 15, 2004.

National Cancer Institute (NCI). (2003b). Examples of unequal treatment and unequal access to care. http://crchd.nci.nih.gov/chd/disparities_examples.html. Cited September 24, 2003.

National Center for Health Statistics (NCHS). (2002). *National Vital Statistics Report* 50(16). www.cdc.gov/nchs/products/pubs/pubd/nvsr.htm. Cited January 8, 2003.

National Center for Health Statistics (NCHS). (2003). Early release of selected estimates based on data from the 2002 National Health Interview Survey.

<http://www.cdc.gov/nchs/about/major/nhis/released200306.htm>. Cited March 17, 2004.

National Institutes of Health (NIH). (2001). *Voices of a broken system: Real people, real problems*. President's Cancer Panel: Report of the chairman 2000–2001. National Cancer Institute. http://156.40.135.142:8080/webisodes/pcpvideo/voices_files/PDFfiles/PCPbook.pdf. Cited September 25, 2003.

National Institutes of Health (NIH). (2003). Interventions to improve hypertension control rates in African Americans. <http://www.grants.nih.gov/grants/guide/rfa-files/RFA-HL-04-007.html>.

Ohio State University. (OSU) (1999) Women Smoking Menthol Cigarettes Have Greater Nicotine Exposure. <http://researchnews.osu.edu/archive/smoking.htm>

Ohio State University Extension. (2004a). Cultural diversity: Eating in America. African American fact sheet. <http://ohioline.osu.edu/hyg-fact/5000/5250.html> Cited April 21, 2004.

Ohio State University Extension. (2004b). Food guide for African Americans. <http://ohioline.osu.edu/ss-fact/0172.html>. Cited April 21, 2004.

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

Pew Hispanic Center. (2002). *Hispanic health: Divergent and changing*. Washington, DC: Pew Hispanic Center. http://www.pewhispanic.org/site/docs/pdf/health_pdf_version.pdf. Cited August 7, 2003.

Pew Research Center. (2004). The 2004 political landscape. <http://people-press.org/reports/display.php3?PageID=757>.

Pleis, F.R., and Coles, R. (2002). Summary health statistics for US adults: National Health Interview Survey, 1998. *Vital Health Statistics* 10(209). Atlanta, GA: National Center for Health Statistics.

Saleeby, D. (Ed.). (1992). *The strengths perspective in social work practice*. Reading, MA: Longman Publishing Group.

Smedley, B.D., Stith, A.Y., and Nelson, A.R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press, Institute of Medicine of the National Academies.

Tucker, M., and Tervalon, R.T. (2003). *The health disparities experience*. Module 1 of Cultural Competence in the Clinical Care of Patients with Diabetes and Cardiovascular Disease. Washington, DC: Health Resources and Services Administration, Bureau of Primary Health Care, and Institute for Healthcare Improvement.

University of Washington Medical Center (UWMC). (2001). Culture clues: Communicating with your African American patient. <http://depts.washington.edu/pfes/cultureclues.html>. Cited May 26, 2004.

US Census Bureau. (2000a). Population profile of the United States: 2000 Internet release. <http://www.census.gov/population/www/pop-profile/profile2000.html>. Cited August 5, 2004.

US Census Bureau. (2000b). United States: Black or African American persons, percent, 2000. <http://quickfacts.census.gov/qfd/maps/thematic/PL1210000.html>. Cited March 15, 2004.

US Census Bureau. (2001). Table 4: Difference in population by race and Hispanic or Latino origin, for the United States: 1990 to 2000. In *Census 2000 PHC-T-1: Population by race and Hispanic or Latino origin for the United States*. Washington, DC: US Census Bureau. www.census.gov/population/cen2000/phc-t1/tab04.pdf. Cited January 8, 2003.

US Census Bureau. (2002a). Educational attainment in the United States: March 2002. <http://www.census.gov/population/www/socdemo/education/ppl-169.html>.

US Census Bureau. (2002b). Health insurance coverage: 2001. <http://www.census.gov/hhes/hlthins/hlthin01/hi01t3.html>. Cited July 21, 2003.

US Census Bureau. (2003). Guidance on the presentation and comparison of race and Hispanic origin data. <http://www.census.gov/population/www/socdemo/compraceho.html>.

The Provider's Guide to Quality and Culture

<http://erc.msh.org/quality&culture>

US Department of Health and Human Services (US DHHS). (2000). *Healthy people 2010: Understanding and improving health*, 2nd ed. Washington, DC: US Government Printing Office. <http://www.bphc.hrsa.gov/quality/HealthyPeople2010.htm>. Cited August 26, 2003.

US Department of Health and Human Services (US DHHS). (2003a). *Complementary and alternative medicine: Issues in serving diverse populations*. Draft curriculum module 5 for Cultural Competence in the Clinical Care Model Project. Washington, DC: Health Resources and Services Administration, Bureau of Primary Health Care.

US Department of Health and Human Services (US DHHS). (2003b). *Demographics and health disparities*. Draft curriculum module 2 for Cultural Competence in the Clinical Care Model Project. Washington, DC: Health Resources and Services Administration, Bureau of Primary Health Care. http://whqlibdoc.who.int/hq/2001/WHO_SDE_HDE_HHR_01.2.pdf. Cited September, 15, 2003.

Voudoun culture. (2004).

<http://www.geocities.com/Athens/Delphi/5319/ayibobo.htm>. Cited April 21, 2004.

Wolff, M., Bates, T., Beck, B., Young, S., Ahmed, S.D., and Maurana, C. (2003). Cancer prevention in underserved African American communities: Barriers and effective strategies—a review of the literature. *Wisconsin Medical Journal* 102(5):36-40.

World Health Organization (WHO). (2001). *Health and freedom from discrimination*. Health & Human Rights Publication Series, no. 2 (August). Geneva: World Health Organization, Department of Health and Development.

Yale University Economic Growth Center. (2002). The role of permanent income and demographics in black/white differences in wealth. Center Discussion Paper No. 850. http://www.econ.yale.edu/growth_pdf/cdp850.pdf. Cited April 23, 2004.