USUCHD August 2008 Abstracts

Abstracts Included:

1. **Neighborhood Environment and Adherence to a Walking Intervention in African American Women.**

Abstract

This secondary analysis examined relationships between the environment and adherence to a walking intervention among 252 urban and suburban, midlife African American women. Participants received an enhanced or minimal behavioral intervention. Walking adherence was measured as the percentage of prescribed walks completed. Objective measures of the women's neighborhoods included walkability (land use mix, street intersection density, housing unit density, public transit stop density), aesthetics (physical deterioration, industrial land use), availability of outdoor (recreational open space) and indoor (recreation centers, shopping malls) walking facilities/spaces, and safety (violent crime incidents). Ordinary least squares regression estimated relationships. The presence of one and especially both types of indoor walking facilities were associated with greater adherence. No associations were found between adherence and other environmental variables. The effect of the enhanced intervention on adherence did not differ by environmental characteristics. Aspects of the environment may influence African American women who want to be more active.

Source
Health education and behavior, {Health-Educ-Behav}, 31 July 2008 (epub: 31 7 2008), ISSN: 1090-1981.
Author (s) Zenk-Shannon - N, Wilbur – Joellen, Wang - Edward, McDevitt - Judith, Oh – April, Block - Richard, McNeil - Sue, Sava – Nina.
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2. **Discrimination, Distrust, and Racial/Ethnic Disparities in Antiretroviral Therapy Adherence Among a National Sample of HIV- Infected Patients.**

OBJECTIVE: Although discriminatory health care experiences and health care provider distrust have been shown to be associated with health care disparities, little is known about their contribution to racial /ethnic disparities in antiretroviral therapy adherence. We therefore sought to assess the extent to which discriminatory health care experiences and health care provider distrust influence treatment- related attitudes, beliefs, and self-reported adherence in a national sample of HIV-infected patients. STUDY DESIGN: This secondary analysis used data from the HIV Cost and Services Utilization Study. We used structural equation modeling to identify pathways from minority status to adherence through discrimination, distrust, and treatment-related attitudes and beliefs. PARTICIPANTS: The sample was the 1886 participants who completed the baseline and 2 follow-up interviews and were prescribed antiretroviral therapy at the second follow-up interview (54% white, 28% black, 14% Hispanic, and 3% others). RESULTS: Minorities were less likely to report perfect adherence than whites (40% vs. 50%, P </= 0.001). Over one third (40%) of all participants reporting ever having discriminatory health care experiences since having HIV, and 24% did not completely or almost completely trust their health care providers. The effect of minority status on adherence persisted in the full model. More discrimination predicted greater distrust, weaker treatment benefit beliefs, and, in turn, poorer adherence. Distrust affected adherence by increasing treatment-related psychological distress and weakening treatment benefit beliefs. CONCLUSIONS: The relationship between minority status and adherence was not fully explained by patient-level factors. Future studies should consider conceptualizing minority status as a contextual factor rather than predictor.
Publication year

2008.

Source
Journal of acquired immune deficiency syndromes 1999, {J – Acquir – Immune-Defic-Syndr}, 23 Jul 2008 (epub: 23 7 2008), ISSN: 1525 – 4135
Authors (s) Thrasher-Angela-D, Earp-Jo-Anne-L, Golin-Carol-E, Zimmer-Catherine-R.
Author affiliation
From the *Center for Social Disparities on Health, School of Medicine, University of California, San Francisco, CA; dagger Department of Health Behavior & Health Education, School of Public Health; and double dagger Odum Institute for Research in Social Science, University of North Carolina at Chapel Hill, Chapel Hill, NC.

3. **Differential effect of birthplace and length of residence on body mass index (BMI) by education, gender and race/ethnicity.**

Abstract

Although birthplace and length of residence have been found to be associated with Body Mass Index (BMI)/obesity in the USA, their effects may not be the same across groups defined by education, gender and race/ethnicity. Using cross-sectional population based data from the 2001 California Health Interview Survey, we investigated the associations of birthplace and US length of residence with BMI, and whether the influence of birthplace-US length of residence on BMI varied by education, gender and race/ethnicity. Our sample included 37,350 adults aged 25-64 years. Self-reported weight and height were used to calculate BMI. Birthplace and length of residence were combined into a single variable divided into five levels: US-born, foreign-born living in the United States for more than 15, 10-14, 5-9, and less than 5 years. Controlling for age, gender, marital status, race/ethnicity, education, income, fruit and vegetable consumption, current smoking and alcohol use, we found that: (1) foreign-born adults had lower BMI than US-born adults; (2) among foreign-born adults, longer residence in the United States was associated with higher BMI; and (3) the effect of birthplace-length of US residence on BMI differed by education level, gender and race/ethnicity. Specifically, longer residence in the United States was associated with the greatest percent increases in BMI among the lowest educated groups than higher educated groups, among women (vs. men) and among Hispanics (vs. other racial/ethnic groups). These findings suggest that a protective effect of foreign birthplace on BMI appears to attenuate with length of residence in the United States, and also reveal that BMI/obesity trajectories associated with length of US residence vary by education, gender and race/ethnicity. Immigrant status, independently and in combination with education, gender and race/ethnicity should be considered in future obesity prevention and reduction efforts.

Source
Social science and medicine 1982, {Soc-Sci-Med}, 24 Jul 2008 (epub: 24 7 2008), ISSN: 0277-9536.
Author(s)
Sanchez-Vaznaugh-Emma-V, Kawachi-Ichiro, Subramanian-S-V, N-Sánchez- Brisa, Acevedo-Garcia-Dolores.
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4. Health literacy not race predicts end-of-life care preferences.

Abstract

BACKGROUND: Several studies have reported that African Americans are more likely than whites to prefer aggressive treatments at the end of life. OBJECTIVE: Since the medical information presented to subjects is frequently complex, we hypothesized that apparent differences in end-of-life preferences and decision making may be due to disparities in health literacy. A video of a patient with advanced dementia may overcome communication barriers associated with low health literacy. DESIGN: Before and after oral survey. PARTICIPANTS: Subjects presenting to their primary care doctors. METHODS: Subjects were asked their preferences for end-of-life care after they heard a verbal description of advanced dementia. Subjects then viewed a 2-minute video of a patient with advanced dementia and were asked again about their preferences. For the analysis, preferences were dichotomized into comfort care and aggressive care. Health literacy was measured using the Rapid Estimate of Adult Literacy in Medicine (REALM) and subjects were divided into three literacy categories: low (0-45, sixth grade and below), marginal (46-60, seventh to eighth grade) and adequate (61-66, ninth grade and above). Unadjusted and adjusted logistic regression models were fit using stepwise algorithms to examine factors related to initial preferences before the video. RESULTS: A total of 80 African Americans and 64 whites completed the interview. In unadjusted analyses, African Americans were more likely than whites to have preferences for aggressive care after the verbal description, odds ratio (OR) 4.8 (95% confidence interval (CI) 2.1-10.9). Subjects with low or marginal health literacy were also more likely than subjects with adequate health literacy to have preferences for aggressive care after the verbal description, OR 17.3 (95% CI 6.0-49.9) and OR 11.3 (95% CI 4.2-30.8) respectively. In adjusted analyses, health literacy (low health literacy: OR 7.1, 95% CI 2.1-24.2; marginal health literacy OR 5.1, 95% CI 1.6-16.3) but not race (OR 1.1, 95% CI 0.3-3.2) was an independent predictor of preferences after the verbal description. After watching a video of advanced dementia, there were no significant differences in the distribution of preferences by race or health literacy. CONCLUSIONS: Health literacy and not race was an independent predictor of end-of- life preferences after hearing a verbal description of advanced dementia. In addition, after viewing a video of a patient with advanced dementia there were no longer any differences in the distribution of preferences according to race and health literacy. These findings suggest that clinical practice and research relating to end-of-life preferences may need to focus on a patient education model incorporating the use of decision aids such as video to ensure informed decision-making.

Source
Journal of palliative medicine, {J-Palliat-Med}, Jun 2008, vol. 11, no. 5, p. 754-62, ISSN: 1557-7740.

Author(s)
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5. Culturally appropriate health education for type 2 diabetes mellitus in ethnic minority groups.

Abstract

BACKGROUND: Ethnic minority groups in upper-middle and high income countries tend to be socio-economically disadvantaged and to have higher prevalence of type 2 diabetes than the majority population. OBJECTIVES: To assess the effectiveness of culturally appropriate diabetes health education on important outcome measures in type 2 diabetes. SEARCH STRATEGY: We searched the The Cochrane Library, MEDLINE, EMBASE, PsycINFO, CINAHL, ERIC, SIGLE and reference lists of articles. We also contacted authors in the field and handsearched commonly encountered journals. SELECTION CRITERIA: RCTs of culturally appropriate diabetes health education for people over 16 years with type 2 diabetes mellitus from named ethnic minority groups resident in upper-middle or high income countries. DATA COLLECTION AND ANALYSIS: Two authors independently assessed trial quality and extracted data. Where there were disagreements in selection of papers for inclusion, all four authors discussed the studies. We contacted study authors for additional information when data appeared to be missing or needed clarification. MAIN RESULTS: Eleven trials involving 1603 people were included, with ten trials providing suitable data for entry into meta- analysis. Glycaemic control (HbA1c), showed an improvement following culturally appropriate health education at three months (weight mean difference (WMD) - 0.3%, 95% CI -0.6 to -0.01), and at six months (WMD -0.6%, 95% CI -0.9 to -0.4), compared with control groups who received 'usual care'. This effect was not significat at 12 months post intervention (WMD -0.1%, 95% CI -0.4 to 0.2). Knowledge scores also improved in the intervention groups at three months (standardised mean difference (SMD) 0.6, 95% CI 0.4 to 0.7), six months (SMD 0.5, 95% CI 0.3 to 0.7) and twelve months (SMD 0.4, 95% CI 0.1 to 0.6) post intervention. Other outcome measures both clinical (such as lipid levels, and blood pressure) and patient centred (quality of life measures, attitude scores and measures of patient empowerment and self-efficacy) showed no significant improvement compared with control groups. AUTHORS' CONCLUSIONS: Culturally appropriate diabetes health education appears to have short term effects on glycaemic control and knowledge of diabetes and healthy lifestyles. None of the studies were long-term, and so clinically important long-term outcomes could not be studied. No studies included an economic analysis. The heterogeneity of studies made subgroup comparisons difficult to interpret with confidence. There is a need for long-term, standardised multi-centre RCTs that compare different types and intensities of culturally appropriate health education within defined ethnic minority groups.

Source
Cochrane database of systematic reviews (Online), {Cochrane-Database- Syst-Rev}, 2008 (epub), no. 3, p. CD006424, ISSN: 1469-493X.
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6. **How old are African American women when they receive their first mammogram? Results from a church-based study.**

Abstract

African American women in the U.S. have the highest breast cancer mortality though not the highest breast cancer incidence. This high mortality rate has been attributed in part to discrepancies in screening between African American and White women. Although this gap in

mammography utilization is closing, little is known about what has been and is driving the screening practices of African American women, in particular age at first mammogram. This study examined the rates of breast cancer screening in an African American community sample from eight churches in greater Baltimore, Maryland and investigated the association between various factors and age at first mammogram. Participants were 213 women ages 22-89 years. About 77% of women had ever had a mammogram. Over 40% had their first mammogram before age 40. Women who first screened before age 40 had greater odds than women who had never screened of being knowledgeable about screening guidelines, of having received a physician recommendation to screen, and of having three or more female relatives who had been screened. Women who first screened at or after age 40 were more likely to have stronger religious beliefs of health than women who never had screened. These findings suggest the importance of reinforcing factors in screening behavior for African American women and have implications for physician training and public health education about breast cancer screening. A better understanding of African American women's mammography practice including early screening is needed to reduce this population's disproportionate breast cancer mortality risk.

Source
Journal of community health, {J-Community-Health}, Aug 2008, vol. 33, no. 4, p. 183-91, ISSN: 0094-5145.
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Please note: please find attached recent abstracts from articles on health disparities. We will be sending these out monthly in an attempt to keep current with research on health disparities. (If you know someone who would like to be added to our mail list, please have them contact Paul Trotter at paul.trotter@usuhs.mil)