

## Major Challenge: Provide First-Rate Cancer Care, Prevention, Outreach to Native Communities

American Indians and Alaska Natives often face overwhelming obstacles in receiving medical care and routine screening procedures for cancer – obstacles that are almost unimaginable to most Americans living in urban areas. These Native populations typically live in very remote areas, sometimes 50 to 100 miles from hospitals and doctors. The distances are complicated by the fact that many Native families do not have cars. The medical care facilities they rely on are typically understaffed and underfunded, with sparse resources that are stretched to the limit.

There also is a widespread lack of awareness of cancer risks, like smoking and obesity, and a general misunderstanding about cancer, according to Judith Salmon Kaur, M.D., an American Indian oncologist who has dedicated herself to confronting the challenge of improving cancer care, awareness, and prevention among Native populations.

Kaur became aware of these challenges while in private practice in Bismarck, ND, where American Indians are the state's largest minority. While practicing medicine and teaching for the University of North Dakota, she also helped conduct research that showed, contrary to earlier findings and assumptions, cancer rates among Native Americans and Alaska Natives are often high and are rising significantly.

Kaur attended school in Chicago, the daughter of a Choctaw-Cherokee Indian father. "Where I grew up in Chicago, it was an American Indian melting

Dr. Judith S. Kaur is medical director of the Native American Programs at the Mayo Clinic in Minnesota. An American Indian herself, she is dedicated to building community-based cancer control programs for Native Americans and Alaska Natives.

*(Photo: Mayo Alumni)*



pot. There were Navajo, Cherokees, Choctaw, and Ojibwa Indians." She says. They were there because of the Bureau of Indian Affairs' past decision to try to overcome rural poverty by uprooting Indians and sending them to the city." (Current census data show that more than half of all Native Americans and Alaska Natives now live in urban settings. Many also migrate between cities and their reservations.)

In school, Kaur was an outstanding student who loved to read, and she had an early interest in science. She was encouraged to pursue her science interest – but as a teacher, not as a scientist or a doctor. "Back then, females were advised to become science teachers," she explains. She graduated from college at 19 and earned a master's degree two years later as she set off on a career as a science teacher and school counselor.

"My first goal was teaching because I'd had

teachers as role models, and I loved to teach,” says Kaur.

She married and had a daughter. When her daughter was two years old, she considered a major career course change, to medicine. “At age 30, people said that I was too old to become a doctor.” But she persisted and was accepted into the University of North Dakota’s INMED (Indians into Medicine) Program. After earning a medical degree with honors from the University of Colorado, she completed a fellowship in hematology and oncology and developed an interest in cancer research. Today she is one of only two American Indian medical oncologists in the country.

In 1984, she opened her own practice devoted to cancer care in Bismarck and began her efforts to improve care for American Indians with cancer. Later, she became an associate professor of oncology at Mayo Clinic College of Medicine and accepted a fellowship at Mayo to conduct cancer prevention and control activities with Indian tribes. She says that at Mayo she is happy to practice under “three shields” – as a researcher, patient care provider, and educator.

It was at Mayo that Kaur obtained the funding to launch the Native WEB and related programs devoted to improving access to cancer care, preventive screening, and outreach programs to native populations.

The Native WEB programs (see "3 Programs Benefit Native Americans," right) headed by Kaur now extend to Native American and Alaska Native populations in 25 states.

In 1998, Kaur was invited by NCI’s then-Director, Richard Klausner, M.D., to serve on the NCI Special Populations Working Group. The panel’s recommendations led to Congressional funding for the NCI’s Center to Reduce Cancer Health Disparities (CRCHD) and its Special Populations Networks (SPN).

In 2000, Kaur applied for and won funding for an SPN project serving American Indians and

### 3 Programs Benefit Native Americans

Dr. Judith Salmon Kaur is the medical director of the Native American Programs at the Mayo Clinic Comprehensive Cancer Center, Rochester, MN. These programs: Native WEB, Native CIRCLE, and Spirit of EAGLES are part of the Population Sciences portfolio of the cancer center.

**Native WEB** provides a 5-day on-site training program for nurses serving Native American and Alaska Native women to increase the number of women receiving screenings for breast cancer and cervical cancer. WEB also has an education outreach program for community health staffers with training in topics such as teaching breast self-exams, developing education outreach ideas, and organizing health fairs.

**Native CIRCLE** (Cancer Information Resource Center and Learning Exchange) develops and provides culturally appropriate cancer education materials for lay people, allied health professionals, and clinicians working in Native communities. Over half of the American Indian tribes in the United States have received and used these materials.

**Spirit of EAGLES (SOE)** is devoted to building an infrastructure to support cancer control in American Indian and Alaska Native communities. It also is increasing awareness of and access to clinical trials. SOE provides funding to community-based cancer projects that serve American Indians by focusing on cancer research, prevention, screening, treatment and supportive care issues. SOE is funded by the NCI’s Center to Reduce Cancer Health Disparities (CRCHD) and is part of the CRCHD’s Special Populations Networks (SPN).

Alaska Natives, called the Spirit of EAGLES (SOE). “We have sponsored 38 grants in small communities across the country, from small tribes to large tribes that have addressed cancer on the community level in ways that it had never been addressed before. Many Native communities that had never dealt with cancer issues before are now very motivated to try to look at



Dr. Kaur grew up in an "American Indian melting pot" in Chicago.

(Photo: Mayo Alumni)

what they can do for their own people for cancer prevention and early cancer detection," she explains.

The grants have helped communities to stimulate cancer survivor groups and provide a positive force for change in their communities, such as developing community-based and culturally

appropriate means to increase awareness of the cancer-causing risks of smoking and chewing tobacco. "We ask all of them to identify one thing they think they can do to improve either the care of cancer patients in their community or to raise awareness of how people could maintain their health and avoid cancer," she says. "The creativity of their ideas is amazing."

In addition, the tribes are encouraged to seek additional funding from other sources to expand their locally oriented cancer awareness programs. So far, the tribes have raised an estimated \$2 million in outside funding.

Another major thrust of the programs is to recruit and motivate Native American students to enter the field of medicine and research. Through the Spirit of EAGLE, the Fred Hutchinson Cancer Research Center in Seattle and the Northwest Portland Area Indian Health Board launched a pilot program that brought Native American and Alaska Native high school students to the medical center to learn more about careers in science and medicine. The workshops have drawn students from throughout Oregon and Washington.

Some 45 Native American high school students and five tribal elders participated in the workshops in Seattle in 2003. "It was a wonderful experience to serve as a teacher and role model for these local Native students," says Rose James, Ph.D., workshop organizer and member of the Lummi tribe. The

students enjoyed hands-on lab activities such as learning to use the micropipette, a lab instrument.

Kaur relishes the role of mentor to young people and the recruitment of students into medicine. "Near and dear to me as a former teacher is the excitement of getting students from high school, college, medical school turned on about medicine and considering going to a cancer-related field," she says. She is quite aware that she is a role model and inspiration to minorities, constantly responding to queries from eager students.

Many of the locally developed SOE outreach programs recognize the existence and importance of traditional health in tribal settings, she says. "Western medicine often does not address the spiritual aspects of healing, but traditional healers always include the spiritual dimension," explains Kaur. Because cancer is seen as a "white man's disease," traditional healers do not feel threatened by Western medicine and often collaborate with Western medicine practitioners at Indian Health Service (IHS) or tribally owned facilities.

"Assimilation has not been healthy for Indians," says Kaur. "Many of the traditional ways



In a Seattle research laboratory, student Cody George of the Lummi tribe learns basic lab skills in a summer program to encourage Native American teens to pursue careers in medicine and science.

(Photo: Spirit of EAGLES. Pacific Region Newsletter)

were healthier. Traditionally, Indians were more active, ate more fish, more berries, more nuts. They had more spirituality to keep them away from drugs and alcohol. Sweat lodges and various ceremonies were geared to keeping people physically, emotionally, and spiritually healthy. So, in many ways, the traditional ways are a cancer-prevention approach.”

Buoyed by the advances made under the SPN,

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## “Assimilation has not been healthy for Indians...”

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Kaur is also quite aware of the many remaining challenges, such as bringing access to clinical trials to Alaska Natives, who, despite facing tremendous geographical problems, have made strides in improving their breast cancer and cervical cancer screening programs.

Kaur is currently conducting breast cancer research funded by the NCI, is about to publish findings suggesting that rates of breast cancer among American Indian and Alaska Native women will be increasing significantly in this generation.

She sees her work as “a constant struggle, but also very rewarding. There are a lot of needs. But if we don’t do these things, the next generation will pay the price.” ↻

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## Helping Science to Mold Policy to End Health Disparities

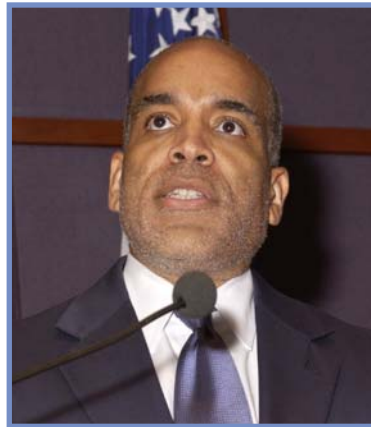
Raynard S. Kington, M.D., Ph.D., believes it is imperative that the United States act decisively to harness the full arsenal of science to reduce health disparities in the United States.

As deputy director of the National Institutes of Health (NIH), and as an African-American physician, a medical researcher, a scholar of social and economic impacts on society and a health policy expert, he fully supports pursuing that goal. This includes ensuring that the health care system does not continue to allow the differences in treatment that appear to be related

to race or ethnicity.

He’s a leader with a record of taking on challenging assignments, such as conducting a series of studies into the role of socioeconomic status in explaining differences in health across populations, the determinants of medical care services utilization, and the health status and health behaviors of Hispanic and black immigrant populations.

For more than 100 years, researchers have noted significant differences in health status across different racial and ethnic groups in the U.S. More recently, numerous well-designed studies have shown that patients may be treated differently by doctors and hospitals based on their race or ethnic background, notes Kington. Those differences in treatment



NIH’s Raynard Kington says health care disparities are “an enormous, complex public health problem. . .”

(Photo: Bill Branson)

probably play a role in the disparities in health outcomes that are so well-described. These differences have been particularly noticeable for some patients with cancer, Kington points out.

“It is an enormous, complex public health problem. It has varying causes and is multi-factorial,” says Kington. “Some causes are related to the type of health care we give; some are related to socio-economic factors; some are related to biologic factors, although rarely does biology alone produce stark differences. There are overlaps that include genetic factors, occupational factors, and environmental factors. We are just now beginning to move from simply describing the differences to really understanding the various causal pathways, and beginning to develop interventions to end these differences.

“It won’t be easy. It won’t be fast. It is going to be difficult,” he concludes.

Kington grew up in Baltimore, the son of an

African-American doctor. He earned his M.D. in 1982 at the University of Michigan. He completed his residency at the Michael Reese Medical Center in Chicago and a fellowship at the University of Pennsylvania, where he was a Robert Wood Johnson Clinical Scholar and also completed his masters in business administration, as well as a Ph.D. in health policy and economics. From 1990-97, he served on the faculty at UCLA while also a senior scientist at the RAND Corp., a think tank in Santa Monica.

“After I came to RAND, I began to get more interested in socioeconomics and race and how they impact health and health care, particularly aging in the African-American community,” says Kington, who went to the Centers for Disease Control and Prevention (CDC) in 1997 to spend three years studying the demographic differences in health status. But his interests extended beyond medicine. He spent

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**“...rarely does biology alone produce stark differences.”**

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two summers during college as an intern on Capitol Hill, where he first became interested in “public policy, the bigger picture.”

In September 2000, he was named the NIH associate director for behavioral and social sciences research and, for most of 2002, he also served as acting director for the National Institute on Alcohol Abuse and Alcoholism.

In his current position, Kington helps oversee all 27 institutes and centers at the NIH, setting policy in a wide range of research fields – everything from alcohol abuse to cardiology, cancer, and complementary and alternative therapies.

A top priority for Kington is health care disparities. How can the nation mobilize its resources to best act to reduce health care disparities?

“We must take care not to get lost in the immensity and the complexity of the problem. It

is not just about racism, not just about income inequality, not just about providing equal access to care. I am all for addressing all those things. But we must realize that it is a complex, multi-faceted pathway that leads to disparities. It has taken us a long time to just define the problem. We, as an agency, must focus now on the value of science here. This is a public health problem, a scientific problem. We must address it with rigorous scientific processes to learn *why* we have these differences.

“Here at the National Institutes of Health, our role is to fund research that addresses this issue. How can we answer important questions about and find ways to eliminate these health and health care differences?” Kington says. “We’ve tried hard to work with sister agencies within the Department of Health and Human Services – the CDC, HRSA (Health Resources and Services Administration), AHRQ (Agency for Healthcare Research and Quality) and the IHS and others. We are getting better at coordinating the various activities across the Federal Government.”

[In February, Senate Majority Leader Bill Frist, M.D. (R-TN) introduced a bill, S.2091, to address minority health disparities. Entitled “Closing the Health Care Gap Act of 2004,” the bill, co-sponsored by seven other senators, would expand access to quality health care, help increase the diversity of health professionals, promote more aggressive health professional education intended to reduce barriers to care, enhance research to identify sources of racial, ethnic, and geographic disparities and assess promising intervention strategies.]

The NIH Roadmap initiative announced last year, designed to speed up medical research, has several key components that will help address health disparities research, especially the measure addressing clinical research, says Kington (see article “Careful Planning Guides Center’s Strategies,” in the Fall 2003 edition of *Equal Access* – Vol. 1, Issue 2).

He notes that continuing research on cancer can prove to be a good model for research into health disparities.

“It is appropriate that the NCI has a resource (the Center to Reduce Cancer Health Disparities) to pull together the many research streams of knowledge and to develop and test some interventions to eliminate these disparities,” he says. ❖

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## Evidence Mounts Linking Obesity and Cancer; NCI Now Looking at “Energy Balance”

For some time researchers have noted that obesity appears to be a risk factor involved in several forms of cancer. But now, mounting evidence has thrust the link between obesity and cancer into the limelight. The National Cancer Institute (NCI) has launched a number of research and public awareness initiatives.

With nearly two-thirds of the U.S. population now considered overweight or obese, convincing evidence suggests that excess body



There is convincing evidence that excess body weight is a risk factor for many cancers.

weight is a risk factor for many cancers. However, body weight most likely interacts with several closely related health behaviors such as physical activity and eating habits, as well as other cancer-related risk factors influencing a person’s ability to prevent or survive cancer.

Cancer researchers have begun to use the term “energy balance” to describe the complex interaction among diet, physical activity, and genetics on growth and body weight over an individual’s lifetime and how those factors may influence cancer risk. Racial and ethnic factors, as well as socioeconomic issues, also appear to affect

the balance of risk.

For example, being overweight and being an inactive “couch potato” may both be risk factors for many cancers. While some research suggests that an overweight person who exercises regularly may be less at risk compared to a less active overweight person, evidence for some cancers suggests that physical activity is protective only among people who do not become overweight. This is a very active area of research.

Consider these recent research findings:

- Men who are obese are more likely to die of prostate cancer than men who are not overweight, according to a study in *Cancer Epidemiology, Biomarkers & Prevention* 2001; 10(10): 345-353.

- A recent study of African-American women found that a high BMI (body mass index, see **What Is Obesity** article, page 7) was significantly associated with an advanced stage of breast cancer at diagnosis, reported the *Journal of Women’s Health & Gender-Based Medicine* 2002; 11:527-536.

- In a study of 4.5 million patients hospitalized at Veterans Affairs hospitals over a 27-year period, researchers found an increased risk for nearly 20 different cancers in those men who were obese. The obese veterans were found to be at increased risk of cancers of the colon and kidney (as previously reported), but also at an increased risk for less common cancers, such as male breast, lower esophagus, gallbladder, thyroid, extrahepatic bile duct, connective tissue cancers, as well as malignant melanoma, multiple myeloma, chronic lymphocytic leukemia, and acute myeloid leukemia. NCI researchers published the data in *Cancer Causes and Control* 2004 Feb.; 15(1):35-44.

For many years researchers have found a consistent relationship between obesity and

a number of diseases, including diabetes, heart disease, high blood pressure, stroke, and some cancers. In 2002, following release of several major national and international reviews establishing the linkage of obesity and physical activity to many major cancers, NCI named a panel to identify priorities for researching the intersection of obesity, physical activity, diet and obesity, and cancer. Following input from scientists, the NCI summarized these research priorities in the 2005 NCI Bypass Budget. This research initiative, “Optimizing Energy Balance to Reduce the Cancer Burden,” set three major goals:

- to better understand the causes of adverse patterns of weight, physical activity, and diet.
- to define how these health factors contribute to cancer.
- to apply this knowledge to prevent and control cancer.

In one of its first major initiatives, NCI expects to encourage researchers’ applications for transdisciplinary centers on energetics and cancers. These centers, based at universities, will bring together researchers from many scientific disciplines to cooperatively seek progress toward reducing cancer incidence, morbidity, and death associated with obesity, low levels of physical activity, and poor diet.

NCI is now working collaboratively with other Federal and private organizations to develop an energy balance intervention dissemination initiative to actively promote understanding of evidence-based interventions for obesity. As a first step, NCI is working to set up a special Web site for information.

More information on NCI’s energy balance initiative, including research plans and progress, is available on the Web at [http://cancer.gov/pdf/nci\\_2005\\_plan](http://cancer.gov/pdf/nci_2005_plan). ↻

## What Is Obesity?

Obesity means many things to many people. Health professionals define “overweight” as an excess amount of body weight that includes muscle, bone, fat, and water. “Obesity” specifically refers to an excess amount of body fat. Some people, such as bodybuilders or other athletes with a lot of muscle, can be overweight without being obese.

Weight-for-height tables show a range of acceptable weights for a person of a given height, but sometimes the tables can be misleading. A very muscular person may appear obese, according to the tables, when he or she is not.

In recent years, body mass index (BMI) has become the medical standard used to determine if a person is overweight or obese. The Centers for Disease Control and Prevention (CDC) has prepared a Web site in which you can type in your height and weight, calculate your BMI, and compare it to a Weight Status Table to determine whether you are *underweight*, *normal*, *overweight*, or *obese*:

<http://www.cdc.gov/nccdphp/dnpa/bmi/calc-bmi.htm>.

Height:	<input type="text"/> feet
and	<input type="text"/> inch(es)
Weight:	<input type="text"/> pounds
(Note: 8 ounces = 0.5 pounds)	
Your BMI: <input type="text"/>	

BMI	Weight Status
Below 18.5	Underweight
18.5 – 24.9	Normal
25.0 – 29.9	Overweight
30.0 and Above	Obese

# American Cancer Society's 2003 Humanitarian Award Presented to Two Longtime CRCHD Grantees

*By Francis X. Mahaney, Jr. Staff Writer*

Amelie G. Ramirez, DPH and Moon S. Chen, Jr., Ph.D., current grantees of the Center to Reduce Cancer Health Disparities Special Populations Networks funding, have been awarded the American Cancer Society's (ACS) 2003 Humanitarian Award.

The ACS presents the award yearly to individuals who have made outstanding accomplishments in human welfare and social reform, impacting cancer prevention and treatment in health disparities.

"Your selection to receive this award is indicative of the high esteem in which your peers and colleagues hold you," said Harmon J. Eyre, M.D., ACS chief medical officer and executive vice president for research and medical affairs at the award presentation in Atlanta Nov. 15, 2003.

"This is truly an honor, and a great deal of the credit goes to the outstanding team effort focusing on addressing the cancer health disparities of Latinos and all medically underserved populations," said Ramirez. "While I'm very proud of what we've accomplished, there is still much to be done, and I look forward to building on our achievements and continuing to make significant progress in this challenging endeavor."

Ramirez is currently a member of the Presidentially appointed National Cancer Advisory Board, an associate professor of medicine, and deputy director of the Chronic Disease Prevention and Control Research Center at Baylor College of Medicine in Houston, Texas. She serves as a clinical associate professor in the department of pediatrics at the University of

Texas Health Science Center at San Antonio. She is the principal investigator of *Redes En Acción*, a major NCI-supported initiative to combat cancer among Latinos through a network of community-based organizations, research institutions, government health agencies and the public.

As a behavioral science and health communications investigator, she directs several research projects involving cancer risk factors, genetics, smoking prevention and cessation, and the effects of breast cancer in Latino families.

Chen is a professor of epidemiology and preventive medicine at the UC Davis School of Medicine and Medical Center and co-chair of the U.S. Department of Health and Human Service's Trans-HHS Cancer Health Disparities Progress Review Group (PRG).

The President of the United States has challenged the Department of Health and Human Services (HHS) to seek novel ways to eliminate health disparities among all Americans. HHS has responded to this challenge, in part, by establishing the Trans-HHS Cancer Health Disparities PRG charged with developing an integrated set of recommendations for implementation by HHS and its agencies.

An internationally renowned investigator regarding the cancer burden of ethnic minority groups, Chen heads an \$8.5-million CRCHD project to eliminate disparities in cancer incidence, awareness and early detection among Asian-American populations. He also heads the UC Davis Cancer Center's Control and Prevention Program. ♡



# Upcoming Conference Schedule

## *National Conferences*

<i>Date</i>	<i>Location</i>	<i>Conference</i>
April 16-18, 2004	Richmond, VA	The Sisters Network, Inc. 6th National Breast Cancer Conference
April 19-20, 2004	Washington, DC	Leadership Summit on Health Disparities
July 31-August 5, 2004	San Diego, CA	102nd Annual Convention and Scientific Assembly of the National Medical Association (NMA)
September 6-12, 2004	Phoenix, AR	6th National Conference Sponsored by the Eagles (Native American)
October 6-10, 2004	Atlanta, GA	Overcoming Health Disparities: Global Experiences from Partnerships Between Communities, Health Services and Health Professional Schools

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