ATTITUDES, BELIEFS, AND BEHAVIORS:
An Examination of Health Disparities in Hypertension and Diabetes Among Racial and Ethnic Minorities in Baltimore, Maryland

-An Urban Health Documentary-

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A. Introduction

Project Overview

This project documents the attitudes, beliefs, health behaviors, and lifestyles of racial and ethnic minorities in Baltimore, Maryland. A series of ten meetings and interviews were conducted between March and May 2003, with eighty-seven participants from four racial and ethnic groups (Hispanic, African American, Asian, and Native American) to explore the dimensions of behavior and lifestyle when managing chronic diseases. Participants were engaged in direct discussions about how their specific attitudes and beliefs impact behaviors that can lead to the perpetuation of health disparities in the areas of these two conditions: Diabetes and Hypertension. These conditions were selected as the illness framework for this study because (1) they are within the realm of an individual's locus of control; (2) there are no social stigmas associated with these conditions; (3) there are no related legal or ethical concerns; and (4) there are limited access to care issues for these conditions. The Community-Based Participatory Research (CBPR) model was used to involve community members in the implementation of this project from beginning to end (see Section B). Participants were involved in an investigative process in which they identified and analyzed their life conditions and health behaviors. The project was designed to obtain information from community members in the general population, regardless of socioeconomic or insurance status. The attitudes, beliefs, and behaviors reported are from participants receiving Medicaid or Medicare, as well as those who have private insurance or are uninsured.

Research Goals and Objectives

The primary goal of this project was to investigate the contribution of culturally-specific lifestyle and behavioral factors to the high prevalence rates for two conditions for which there are health disparities among minorities. In order to achieve this goal, community members were given an opportunity to candidly and openly share their experiences, in settings in their own neighborhoods, about living with hypertension and diabetes.

A second goal was to educate participants about minority health disparities and the local prevalence of the two conditions being studied. These goals were accomplished by involving participants in an interactive educational orientation session that included:

- An overview of the health disparities dilemma in the U.S. and in Maryland
- Basic health information about hypertension and diabetes

The specific objective of this project was to chronicle meetings and conversations with interviewees in order to document:

- Community members' thoughts about specific environmental, social, and behavioral issues that are barriers to the attainment of good health
- Participants' perspectives about current messages from the health care system that do or do not help
- Participants' recommendations for effective health care delivery and outreach that are culturally appropriate and relevant

In order to meet these goals and objectives, demographic and lifestyle data was collected from each participant through two surveys and an in-depth group interview (see Appendix).

B. Description of Methodology

Community-Based Participatory Research (CBPR)

This project employed the CBPR method in order to examine the impact of culture and race on attitudes and behaviors relative to health among racial and ethnic minorities in Baltimore, Maryland. This exploration of "citizen knowledge" was done through surveys and open discussions with members of the Hispanic, Asian, African American, and Native American communities. The Baltimore City 2000 Census data was reviewed in order to determine the racial and ethnic groups to be targeted in this study, and meetings were held with the Deputy Mayor, the Baltimore City Council, the Health Commissioner, and local civic leaders in order to gain support for the project and to identify potential gatekeepers from each racial and ethnic group. Once gatekeepers were identified, an Urban Health Coalition, comprised of all the gatekeepers, was formed to serve as an advisory panel for the researchers. Researchers met with the Coalition and with the gatekeepers individually to learn more about their communities and to get suggestions for the best approach to use when meeting with and filming them. The gatekeepers coordinated the meetings between persons from their communities diagnosed with diabetes and/or hypertension and the researchers. The Urban Health Coalition continued to meet periodically throughout the implementation of the project.

Central to this research was the creation of a video that chronicled the conversations and discussions that occurred between the researchers and each of the four racial/ethnic groups. Participants were encouraged to be candid and natural in conveying their issues, concerns, and recommendations relative to their health and the delivery of health care services. Their actual responses to questions and the interactions between them in each of the meetings were captured on film. The integrity of this process rested in providing a voice to the community members to deliver their message in their own way and in their own words. A professional production team was assembled from Maryland Public Television and the New Media Studio at the University of Maryland, Baltimore County. This team guided the development of the video plan, the filming of the recruitment activities and meetings with the interviewees as well as with the Urban Health Coalition, and the actual production of the documentary.

Two meetings were held with each group: a two-hour orientation meeting and a two-hour interviewing session at locations in the community identified by each gatekeeper. At the beginning of the orientation meeting a light meal was served, of foods that were culturally indigenous, while researchers mingled with the attendees. Following the meal, an orientation of the research project was given, which provided an explanation of why the two conditions were chosen to be studied, an explanation of the correlation between personal behavior and the health disparities dilemma, and an educational component about hypertension and diabetes. Persons were recruited to participate in the upcoming interview session for which they would be paid $25 in merchandise certificates, to complete two surveys, and to participate in an open discussion about living with their conditions. The merchandise certificates were redeemable at places of value determined by the gatekeeper from each racial/ethnic community (with input from the participants).

Participants were also recruited from the general public through two community outreach efforts at two public locations: an open market in downtown Baltimore, and a shopping mall located in Baltimore's Inner Harbor.

Over two hundred people were identified, representing four racial/ethnic groups, through the following diverse sources:

- Korean Senior Center (Asians)
- Park West Medical Center (African Americans)
- Peoples' Community Health Center (Hispanics)
- Baltimore City Health Department's Men's Health Center (African American Males)
- East Baltimore Church of God (Native Americans)
- Lexington Market [downtown Baltimore open market] (African Americans and Hispanics)
- The Gallery [in the heart of Baltimore's Inner Harbor – upscale shopping and business center] (African Americans and Asians)
- Lifelines Community Foundation (Native Americans)
- Hispanic Apostolate (Hispanics)

The filming process limited the size of the group that could be accommodated for each filming session; therefore, all of the persons identified could not be interviewed. Eighty-seven volunteers were able to be included in the study. Demographic data was collected through a survey conducted at the beginning of the interview session, and a behavioral self-assessment was completed, which gathered detailed information from participants about their dietary, exercise, smoking, routine medical care, and health services utilization habits. Through an open discussion utilizing a 31-question interview guide, participants engaged in a group discussion that revealed insight into the collective mindset of the group about its health, health behaviors, attitudes, environment, culture, and history. In meetings with non-English speaking participants, the same questions were asked and information discussed, but in Korean and Spanish, facilitated by the gatekeeper(s) for each group.

Stages-of-Change

This study utilized the Stages-of-Change theory (Prochaska, 1992) to match behavioral change interventions to the appropriate stage to test the "readiness" of interviewees to make health-related changes in their lives. Interviewees completed a *Health and Lifestyle Profile* (see Appendix) that required them to indicate their behavior relative to 27 behaviors in 5 categories. The categories described behavioral activity but did not include the labels associated with the stage-of-change each represented. Participants were advised to check the box that most accurately described their actions relative to the behaviors listed under the five categories. In cases where a behavior was not applicable, participants were instructed to circle the N/A box. An explanation of the Stages-of-Change theory was provided to participants as the survey was distributed.

Sampling Plan

Arcury and Quandt's 1999 site-based sampling technique was implemented to generate a representative sample for the study. This technique has five steps:

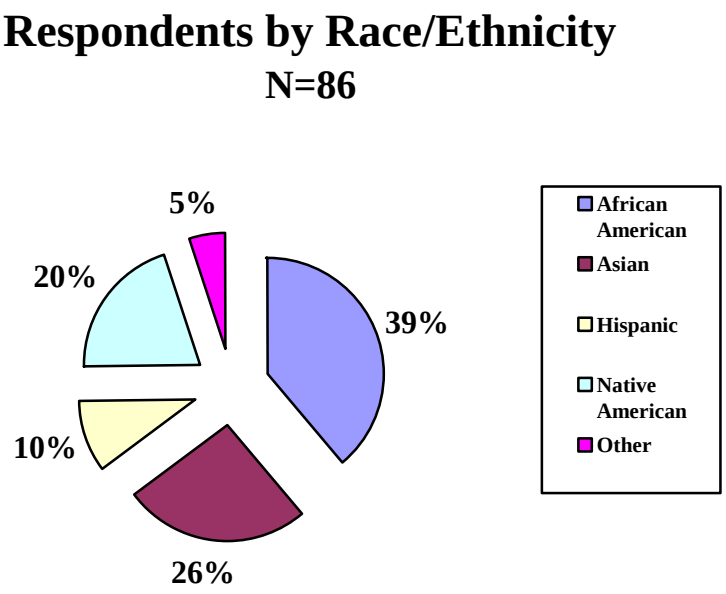
1. Identify specific study characteristics: To participate in the study, persons had to be members of a racial or ethnic minority group, diagnosed with either diabetes and/or hypertension, a resident of Baltimore City, and over the age of 21.
2. Generate a list of sites: Churches, health centers, senior centers, health clinics, and public gathering places were identified from which participants were recruited.
3. Estimate the composition of the clientele at each site: Researchers met with each gatekeeper individually to determine the realistic probability that persons with the conditions could be identified at each site.
4. Participant Recruitment: Researchers addressed a gathering, organized by each gatekeeper, at an orientation meeting where the research project was explained, and persons meeting the study's inclusion criteria were recruited to be interviewed.
5. Maintain a table indicating the characteristics of the participants in the sample: Two surveys were conducted to collect and compile demographic and behavioral data on all participants in the study.

C. Data

This section highlights information collected about the study population including demographics, a disease profile, and a description of responses to the Stages-of-Change assessment.

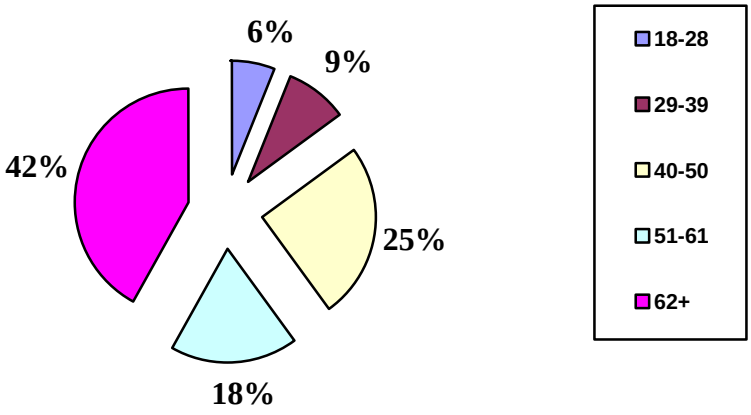
Demographic Characteristics of the Study Population

***(87 persons were interviewed; however the *N* for each graphic depicts the number of persons who responded to that question.)**



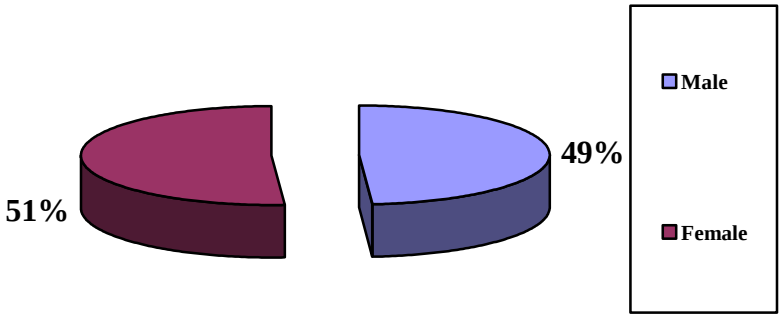
- Race/Ethnicity: N=86
  - African American 39%
  - Asian 26%
  - Hispanic 10%
  - Native American 20%
  - Other 5%

Respondents by Age
N=85

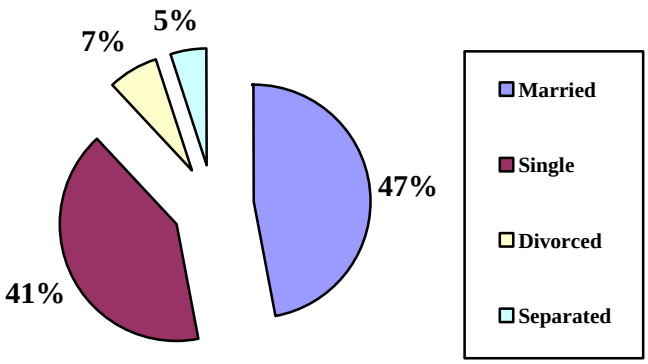


- Age: N=85
  - 18-28 6%
  - 29-39 9%
  - 40-50 25%
  - 51-61 18%
  - 62+ 42%

Respondents by Gender
N=86

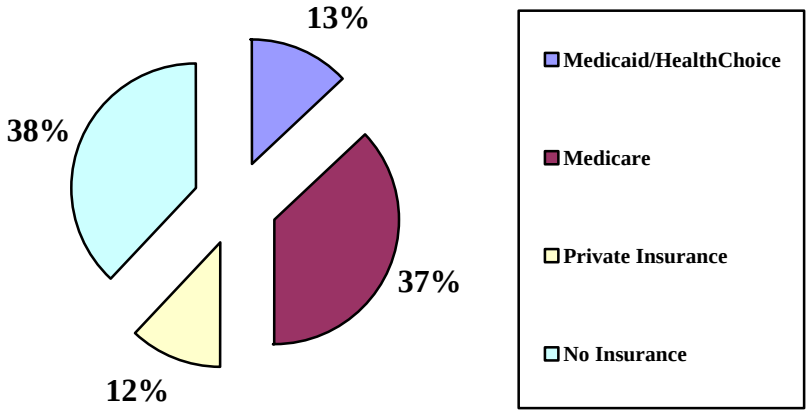


Respondents by Marital Status
N=81



- Marital Status: N=81
  - Married 47%
  - Single 41%
  - Divorced 7%
  - Separated 5%

Respondents by Insurance Type
N=76



- Insurance Type: N=76
  - Medicaid/HealthChoice 13%
  - Medicare 37%
  - Private Insurance 12%
  - No Insurance 38%

Demographic Characteristics by Race*

- **Native Americans**
  - 20% of the study's participants
  - 61% female
  - 63% single
  - 75% Medicare
  - 78% - 62+ years old

- **African Americans**
  - 39% of the study's participants
  - 71% male
  - 49% single
  - 49% un-insured
  - 50% - 40-50 years old

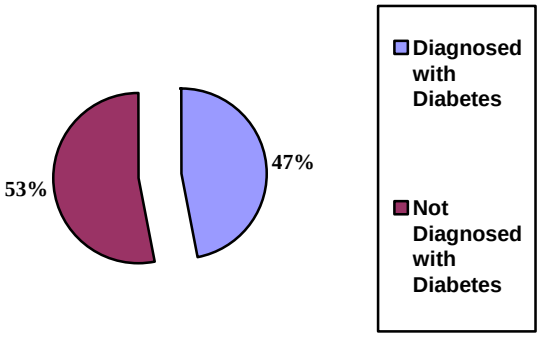
- **Asians**
  - 26% of the study's participants
  - 73% female
  - 85% married
  - 76% Medicare
  - 90% - 62+ years old

- **Hispanics**
  - 10% of the study's participants
  - 75% female
  - 50% single
  - 75% un-insured
  - 25% - 19-28 years old
  - 25% - 29-39 years old
  - 25% - 40-50 years old
  - 25% - 51-61 years old

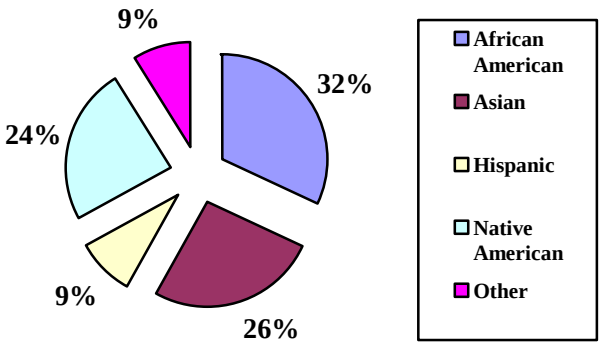
* Five percent (5 percent) of the participants in the study identified *Other* as their racial classification.

Disease Profile

Diabetes
N=76



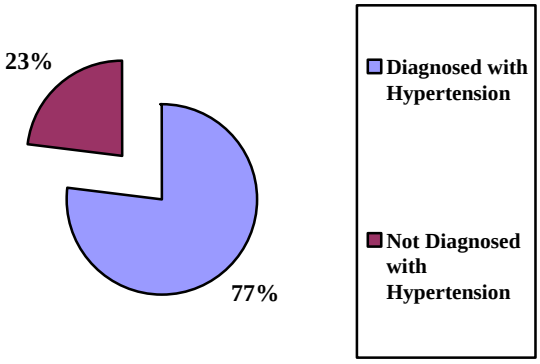
Respondents Diagnosed with Diabetes by Race
N=35



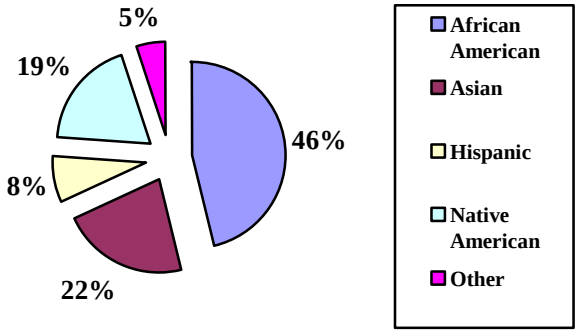
Diagnosed with Diabetes: N=35

- African American 32%
- Asian 26%
- Hispanic 9%
- Native American 24%
- Other 9%

Hypertension
N=82



Respondents Diagnosed with Hypertension by Race
N=63



Diagnosed with Hypertension: N=63

- African American 46%
- Asian 22%
- Hispanic 8%
- Native American 19%
- Other 5%

D. Survey and Interview Findings

The following findings represent the responses made by the majority of the participants in the study.

1. General Disease Knowledge

- 100 percent of the Hispanic respondents correctly defined both conditions.

- 97 percent of the African Americans surveyed correctly defined hypertension; 82 percent of whom reported having been diagnosed with the condition (highest incidence in the group).

- 86 percent of the Asians surveyed correctly defined diabetes; 56 percent of them reported having been diagnosed with the disease (highest incidence in the group).

- From a list of six symptoms, the Asians least often (76 percent) correctly identified the major symptoms of diabetes (frequent urination, excessive thirst, and blurred vision).

- From a list of six symptoms, the overwhelming majority of African Americans, Native Americans, and Hispanics (over 85 percent), correctly identified frequent urination, excessive thirst, and blurred vision as major symptoms of diabetes.

- More than 50 percent of the respondents from every racial and ethnic group incorrectly thought that shortness of breath was a symptom of diabetes.

- The majority (67 percent -88 percent), of each of the four racial and ethnic groups studied incorrectly thought that heart failure and stroke were symptoms, rather than consequences /complications, of hypertension.

- More than 60 percent of each racial and ethnic group correctly identified headaches, nosebleeds, and dizziness as symptoms of hypertension. However, while African Americans had the highest incidence of hypertension, only 48 percent of them correctly identified nosebleeds as symptomatic of the disease.

2. Beliefs and Attitudes

- All four racial and ethnic groups said that health was a priority.

- Asians were the only group that felt that they were as healthy as they could be. They indicated that they were healthy because “they take care of themselves” and “put a lot of effort” into being healthy.

- The Hispanics, African Americans, and Native Americans, all of whom felt they were not as healthy as they could be, listed the following as primary reasons:
    - Lack of exercise

- Poor eating habits
- Existing medical problems
- Lack of health insurance
- Cannot afford healthier foods

- All four groups consistently identified the following as reasons for doing things known to be unhealthy:
  - **Tradition/culture**: to cook and eat the way they do; that is how they were raised
  - **Survival issues/economics**: poor people have to think about what they can buy in bulk, that is cheap, and will last a long time and feed a lot of people (they do not read the nutrition labels to see how healthy an item is, they read the price labels to see how much it costs and how much of it they can buy for the least amount of money)
  - **Habits**: that is all they know; no self control
  - **Lack of motivation**: lazy; do not care; unable to resist the excessive and constant influence of commercial advertisements; denial about being at-risk

3. Barriers to Health

- All four racial and ethnic groups identified the following as barriers to health or to getting health care services:
  - Abundance of fast and/or unhealthy food establishments in the community
  - Cynical attitudes of family members and friends about health
  - Fear for personal safety/neighborhood violence/drug activity
  - Environmental hazards (e.g., trash, fumes, rats, abandoned property)
  - Fear of not being told about negative outcomes from medications/treatments
  - Cost of medication/lack of health insurance
  - Language barriers
  - Waiting room times are too long

4. Health-Related Behaviors

- **Diabetes Treatment:** More than half of the Native American, Hispanic, and Asian participants were being treated by a doctor for diabetes. However, more than half of the African American respondents were *not* being treated by a doctor for diabetes.

- **Hypertension Treatment:** While at least two-thirds of all the respondents were being treated by a doctor for hypertension, African Americans respondents were being treated least often by a doctor for the disease (African Americans had the highest incidence rate (82 percent) for hypertension of the groups included in the study).

- **Medication Compliance:** The majority of all four groups studied take their diabetes and hypertension medications as prescribed.

- **Health Services Utilization:** Of the four racial and ethnic groups included in the study, African Americans reported being treated least often for both diabetes and hypertension.

- **Reasons why people do not follow the doctor's orders:**
    - Laziness; do not want to change their behavior/lifestyle; denial/do not want to face the fact that they are sick
    - Cannot afford to implement or maintain the lifestyle changes that the doctor recommends/requires (e.g., better diet, healthier food (which is more expensive), joining exercise clubs/programs)
    - Side effects from medications that would affect sexual ability/desire, (some men will choose death over impotence)
    - Going to the doctor is an admission of illness to men; therefore it is simultaneously an admission of weakness (which they do not want conveyed to the opposite sex)
    - Fear of knowledge/the notion that health problems will not be discovered if you do not go to the doctor

5. Behavioral Assessment by Race

- Native Americans
  - The majority of Native Americans agreed on the following items:
    - Reading food labels for salt and sugar content
    - Not thinking about walking 1-2 miles a day
    - Not interested in changing any of their smoking behaviors
    - Taking their diabetes medication as prescribed
    - Taking their hypertension medication as prescribed
    - Visiting the doctor for follow-up appointments

- African Americans
  - The majority of African Americans agreed on the following items:
    - Already eating fruits and vegetables daily
    - Already walking 1-2 miles a day
    - Not interested in seeking help to quit smoking
    - Taking their diabetes medication as prescribed
    - Taking their hypertension medication as prescribed
    - Visiting the doctor for follow-up appointments

- Asians
  - The majority of Asians agreed on the following items:
    - Already eating a diet low in fat
    - Already exercising at least 2 times a week
    - Not interested in changing their smoking behaviors (*less than 20 percent reported smoking)
    - Taking their diabetes medication as prescribed
    - Taking their hypertension medication as prescribed
    - Visiting the doctor for follow-up appointments

- Hispanics
  - The majority of Hispanics agreed on the following items:
    - Not interested in buying low-fat and fat-free foods
    - Not interested in taking the stairs, joining a gym, or starting an exercise program
    - Not interested in entirely quitting smoking
    - Taking their diabetes medication as prescribed
    - Taking their hypertension medication as prescribed
    - Not thinking about attending support group activities for their health conditions

6. Stages-of-Change

The Stages-of-Change model provided a framework that permitted an analysis of the group's readiness to make behavioral change. The results of the survey show that the majority of respondents were in one of two stages: ***pre-contemplation*** or ***maintenance.*** The theory indicates that persons in the *pre-contemplation stage* have no intention to change and often have no awareness that there may be reasons to consider behavior change. The *maintenance stage*, which is considered the final stage, refers to the ability to sustain the behavior change.

The following describes the stage-of-change that the majority of respondents were in regarding the five behaviors in the *Health and Lifestyle Profile*:

Diet: Respondents indicated that they were not thinking about buying foods with the words "low fat" or "fat free" on the label. The behaviors that respondents were already maintaining were "eating a low fat diet," "eating foods with less salt," "avoiding eating fried foods," and "eating fruits and vegetables daily."

Exercise: Respondents indicated that they were not interested in "physical fitness" activities such as walking stairs and "working out," but indicated that exercising was already a part of their lifestyles at least twice a week. Therefore, respondents' definition of "exercise" in their lives may deviate from standard definitions.

Smoking: The vast majority of interviewees did not respond to the questions related to smoking behaviors. Based on the discussions with the interviewees, researchers concluded that this was because large numbers of participants were non-smokers. However, of those that responded, the majority indicated that they were not thinking about changing their smoking behaviors; specifically, quitting, reducing, or seeking help to quit.

Routine Medical Care: Respondents overwhelmingly indicated that they were maintaining their behaviors relative to routine medical care. Routinely taking medications and regularly monitoring their conditions were behaviors that the majority of respondents were already doing.

Health care Services Utilization: Respondents were overwhelmingly not interested in talking to a dietician or attending support groups. They reported going to the doctor regularly and indicated that they already participate in special programs for their health condition.

The following provides the responses for the majority of persons who described their behavior under the stage of change that is listed. Participant's responses across the other three stages-of-change [contemplation, preparation, and action] did not reveal a pattern of predominance in any of the areas:

Pre-Contemplation (*not thinking about it)*

- Dietary
  - Checking food labels for sodium and sugar content*
  - Avoid eating sweets like cookies, cakes, and candy*
  - Buying foods with the words "low fat" or "fat free" on the label
  - Monitoring the amount of carbohydrates eaten daily*

- Exercise
  - Walking 1 to 2 miles per day*
  - Taking the stairs rather than the elevator
  - Joining a gym or starting an exercise program

- Smoking
  - Not smoking for at least 24 hours**
  - Seeking help to quit smoking**
  - Reducing the number of cigarettes smoked per day**
  - Quitting smoking entirely**

- Health Care Services Utilization
  - Attending support group activities for your health condition
  - Talking to a dietician to help you develop an eating plan

Contemplation (*thinking about starting in the next 6 months)*

- No majority responses

Preparation (*definitely planning to start in the next 30 days)*

- No majority responses

Action (*already doing it for less than 6 months)*

- No majority responses

Maintenance (*already doing it for more than 6 months)*

- Dietary
  - Eating a diet low in fat
  - Eating foods with less salt
  - Avoiding eating fried foods
  - Checking food labels for sodium and sugar content*
  - Avoiding eating sweets like cookies, cakes, and candy*
  - Eating fruits and vegetables daily
  - Reducing your alcohol consumption**
  - Eating foods high in fiber
  - Monitoring the amount of carbohydrates eaten daily*

- Exercise
  - Exercising at least 2 times per week
  - Walking 1 to 2 miles per day*

- Routine Medical Care
  - Taking your diabetes medicine daily as prescribed**
  - Testing your blood sugar daily**
  - Taking your blood pressure medicine as prescribed
  - Monitoring your blood pressure regularly

- Health Care Services Utilization
  - Visiting the doctor for follow-up appointments
  - Participating in a special program for your health condition
  - Visiting the doctor when you feel sick

*Behavior appears in two stages because there was only a one-percentage point difference between the two.

**Behaviors for which there were low response rates.

7. Summary of Major Findings

1. The range of participants' readiness to make behavioral changes was not broad; they either had already changed their behavior(s) to more health-promoting behaviors or were not interested in changing their behaviors at all.

2. All four racial/ethnic groups incorrectly thought that heart failure and stroke were symptoms of hypertension (rather than consequences).

3. More than half of each racial/ethnic group incorrectly identified shortness of breath as a symptom of diabetes.

4. Eighty-two percent of the African Americans studied were diagnosed with hypertension (the highest incidence in the group), most of whom knew the correct definition of the condition and were able to identify the major symptoms of the disease. However, when compared to the other groups, they reported being treated least often for the condition.

5. Fifty-six percent of the Asians studied were diagnosed with diabetes and the majority of them knew the correct definition of the condition. However, they ranked lowest among all the respondents in correctly identifying the major symptoms of the disease.

6. Of the four groups studied, Asians were the only group that felt they were as healthy as they could be.

7. Of the four groups studied, African Americans had the highest and Hispanics had the lowest incidence of both conditions.

8. The four groups consistently identified tradition/culture, economics, bad habits, and lack of motivation as the key reasons for why they have unhealthy behaviors.

9. All four groups agreed that the following factors are barriers to health and/or receiving health care services:
    - Abundance of fast and/or unhealthy food establishments in the community
    - The cynical attitudes of family members and friends about health
    - The cost of medical care/lack of insurance
    - Language barriers
    - Lack of trust that the medical community will tell them about negative/harmful side-effects of medications and/or medical treatments to their health

10. Forty-seven percent of the respondents were diagnosed with diabetes.

11. Seventy-seven percent of the respondents were diagnosed with hypertension.

12. The majority of the participants were uninsured (38 percent) or receiving Medicare (37 percent).

13. Among the four racial/ethnic groups studied, African Americans had the highest incidence of diabetes; however, 65 percent of them <u>were not</u> being treated by a doctor for the condition.

14. The four groups studied cited the following as the primary reasons why people do not follow the doctor's orders:
    - Laziness
    - Inability to afford the costs to implement the lifestyle changes recommended by the doctor
    - Sexual attitudes/beliefs/fears about the side effects of medications
    - Illness being equated with weakness

15. The respondents overwhelmingly indicated that they were not interested in buying "low fat" or "fat-free" foods.

16. Of the list of options available to gatekeepers from which to select merchandise cards for the participants they represented, <u>all</u> of the gatekeepers requested merchandise cards to <u>grocery stores</u> (as the gift that participants would value most).

17. The majority of respondents who smoke indicated that they were not interested in changing their smoking behaviors, (specifically quitting, reducing, or seeking help to quit smoking).

18. The respondents overwhelmingly reported that they monitor their health conditions, go to the doctor regularly, and routinely take their medications as prescribed.

E. Participant Recommendations

1. Key Recommendations by Race

The following list the consensus of the recommendations made by each racial/ethnic group:

Native Americans

1. Health care services should be guaranteed and free for children and senior citizens.
2. More and simpler information about medications and their side effects should be given to consumers.
3. Make medications more affordable.
4. Embrace cultural remedies and consider their value in treating medical problems (e.g., taking vinegar and water to control hypertension).

African Americans

1. Help people arrange to pay medical bills or find other ways to pay for health care costs if they do not have a job (e.g., people could volunteer in the hospital or clinic to cover the costs of their health care).
2. Charge a reduced fee for medications that are being tested until the benefit is confirmed for the patient.
3. Develop billboard advertisements that focus on health prevention and treatment (with the same diligence as food and smoking advertisements).

Asians

1. Hire more bilingual personnel across agencies that provide health care-related services.
2. Make durable medical equipment more accessible.
3. Allow more refills on medications.

Hispanics

1. Do not make legal status a prerequisite for the receipt of health care services.
2. Hire more bilingual personnel to help doctors treat Hispanic patients.
3. Make medications more affordable.

2. Consensus Recommendations

The following describe a consensus of the recommendations made by all of the participants interviewed in the study:

a. What people can do to be healthier

- Begin routine medical care when you are young
- Do not drink alcohol or smoke cigarettes
- Follow doctor's orders and have routine medical care
- Avoid stress
- Eat a better diet earlier in life
- Attend condition-specific support groups
- Exercise; walk every day

- Take care of your feet (if diagnosed with diabetes)
- Take medications as prescribed

b. Improvements to the health care system

- Allow more refills on medications
- Make medications more affordable
- Hire more bilingual personnel across agencies that provide health care-related services
- Reduce costs of doctor's visits
- Make durable medical equipment more accessible and affordable
- Inform people how to pay medical bills or find other ways to pay for health care costs if they do not have a job (e.g., people could volunteer in the hospital or clinic to cover the costs of their health care)
- Charge a reduced fee for medications that are being tested until the benefit is confirmed for the patient
- Have more clinics for the unemployed-uninsured and the working-uninsured.
- Treat people with respect; do not humiliate them when they cannot afford to pay for health care or because of their insurance type (e.g., having Medicaid instead of private insurance)
- Give free eyeglasses and dental care to the elderly
- Have universal health care coverage for all
- Free health care services should be guaranteed for children and seniors
- Do not question a person's legal status as a prerequisite for the provision of health care services

c. Health outreach

- Have major, prime-time, talk shows that focus on health and health problems
- More press and more statistics should be publicized about positive outcomes, success in changing lifestyles, people living successfully with health problems, etc., instead of focusing on the "doom and gloom" and the negative (people feel that there is no hope for them if/when they get diagnosed with a condition)
- Develop billboard advertisements that focus on health prevention and treatment (with the same diligence as smoking and food advertisements)
- The FDA should be clear when conveying information to the public (advising people to include products/behaviors in their diets, then later changing their advice indicating that the recommendation is unhealthy, which causes people to distrust the government and be suspicious of messages it gives them)
- Provide simpler information to the public about medications and their side effects
- Hire more bilingual staff to work with health care providers who are not bilingual

F. Conclusions

Concerns about the health disparities problem in America provided the impetus to explore the impact of attitudes and beliefs on the health behaviors of minorities in Baltimore, Maryland. The goal was to identify the social, cultural, and environmental issues that could explain the personal aspects of the prevention and treatment of chronic diseases faced uniquely by members of four minority groups (Native Americans, Hispanics, African Americans, and Asians). As previously stated, hypertension and diabetes were the two conditions selected for examination in this study because they are among the top ten most frequent diagnoses for Baltimore City residents (Maryland Health Care Commission, 1998), and are listed among the major conditions for which there are disparities among minorities in the nation (Healthy People, 2010). Additionally, these two conditions are highly manageable diseases with well-understood diagnosis and treatment pathways. It was believed that an investigation of these two conditions could provide meaningful and valuable feedback for individuals and institutions to be used in personal, policy, and programmatic decision-making. Because of the health disparities dilemma among minorities, the researchers wanted to examine the dimensions of behavior and lifestyle that may be endemic to minorities and different from those of non-minorities, which contribute to the incidence and prevalence of these two diseases.

Through the surveys, participants in this study indicated that they were not interested in changing their unhealthy behaviors. According to Prochaska, et.al., this attitude is considered to be the "pre-contemplation stage-of-change" and argues that it is an indication that persons in this stage may not have an awareness of the reasons to consider behavior change. The notion that persons may not have an awareness of the reasons to consider behavior change is refuted however because the participants also revealed that they were already maintaining healthy behaviors in their lives with almost the same propensity as their disinterest in changing behaviors. The stages-of-change theory refers to the "maintenance" stage as the ability to "maintain and sustain" behavior change. The respondents demonstrate their own awareness of the importance of these behaviors by their history of already changing, sustaining, and successfully maintaining change. The respondents emphasized their disgruntlement that far too little attention is given to these successes, therefore the notion that minorities are viewed as "hopeless and helpless" pervades the media and discourages people from believing they can change. This lack of faith that change(s) can be made may provide insight into why more respondents did not indicate that they were contemplating or preparing to make changes. Policy makers and program planners must begin to develop initiatives that both identify the personal benefits of needed behavior change, as well as highlight the successes that minorities have already achieved in health. The key seems to be motivation, being able to motivate more people to contemplate, prepare, and eventually take action to improve their health behaviors.

The results of the survey also showed that a majority of the participants incorrectly thought that some of the major consequences of diabetes and hypertension were only symptoms. This is alarming because in some cases the consequences could become fatal. The fact that large numbers of respondents viewed heart attack and stroke as symptomatic of hypertension is an example of the need for more precise and focused health education campaigns so that the public can better understand the symptoms of disease before major consequences occur. Perhaps methods to communicate health education messages more effectively with minorities need to be developed.

Interviewees indicated that efforts must be focused on reducing the over-emphasis of fast food eateries in minority communities. The groups shared their feelings of being "targeted" by the fast and fried-food industry, and of being frustrated by being continually told to resist these temptations by the health/medical community. Because of the contradictions between the practices of the food industry to promote bigger and more food consumption and the national health policies to promote healthier living and personal responsibility, consumers are placed in a quagmire, making it difficult to make food choices that also translate into healthy behaviors.

Consumers conveyed that their economic realities precluded most of them from being able to make healthier food choices because of the high costs of healthier foods or the absence of them in the grocery stores in the communities in which they live. The message this sends about the affordability of health begs further investigation. There is no doubt that the food industry should respond to this cry from persons representing such a large part of the population about why healthier foods must cost more. To automatically make healthier food unobtainable by making it unaffordable to such large numbers of the population is a disservice to the public.

Three of the four groups in this study consistently agreed that they were not as healthy as they could be and listed lack of exercise, poor eating habits, and lack of health insurance among the primary reasons. All four groups listed how they were raised, laziness, inability to resist commercial advertisements, and no self-control among the reasons they do things that they know are unhealthy. Trying to confront and successfully combat these kinds of lifestyle issues will present quite a challenge for the health care community, but one that nonetheless must be addressed.

The four racial and ethnic groups cited laziness, inability to afford recommended lifestyle changes, and a fear of the side effects of medications that may interfere with sexual performance as primary reasons they do not follow doctor's orders. Because of the correlation between an improvement in health status and following the doctor's orders, it is imperative that the benefits of improved health become the motivation that helps people become compliant with medical treatment plans presented to them by their health care providers. Incorporating knowledge of the kinds of reasons that the interviewees revealed can assist clinicians and help health program developers plan interventions aimed at addressing these issues.

Some of the barriers to health and health care services most commonly cited by the interviewees centered around language, influence of family and friends, costs of medical care/lack of insurance, trash, abandoned property, rats, and the abundance of unhealthy food establishments in their communities. This plethora of issues does not convey a commonality between them. They represent financial, social, environmental, and behavioral/cultural factors that may be difficult to resolve for program planners in the public health arena. This highlights the notion that realistic health care interventions will require the inclusion of professionals from other disciplines in order to develop comprehensive approaches and solutions that speak to the broad range of issues raised by the participants.

Finally, the most compelling finding from this study was revealed through an analysis of the responses from each of the groups showing that people were either not interested in making changes or had already made them. This dichotomy in behavior, substantiated by the low numbers of respondents that were contemplating, preparing, or beginning to make changes, (the other three stages-of-change) must be addressed. The challenge becomes getting people to move from not thinking about changing their behaviors to at least thinking about it. Once this is overcome, the challenge changes to that of getting people to prepare to make change and then actually make it. All of the groups showed success in maintaining changes that they had already initiated, which

makes it clear that minority groups are already demonstrating desired behaviors that are similar to that of mainstream society. For example, taking medications as prescribed, routinely visiting the doctor, and monitoring their health conditions (blood sugar and blood pressure), are behaviors consistently reported by all four of the groups. This suggests that the behavior of racial and ethnic minorities is not as different from that of the majority population as may have been previously perceived.

If disparities in health are to be reduced and eliminated, the inclusion of racial and ethnic minorities in the planning and development of health programs could result in the creation of interventions that demonstrate a greater sensitivity and insight into helping minorities change unhealthy behaviors. The high costs of healthier foods, the over-saturation of fast food eateries in minority communities, and the lack of health insurance are major issues identified by participants that must be factored into the remedy for eliminating health disparities. Examining this problem using the Community-Based Participatory Research model gave the participants an opportunity to have a direct voice and role in how their attitudes, beliefs, and behaviors were conveyed. The researchers asked them to explain their behaviors and to make recommendations for improvements in the delivery of health care services and solutions to problems that contribute to health disparities. These culturally insightful responses could provide the road map for the journey to solving the health disparities dilemma. The next step will be to directly involve these populations in identifying, planning, and developing interventions that address the issues that they raised in this study.

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APPENDIX

THE URBAN HEALTH DOCUMENTARY

INTERVIEW GUIDE

(For use by Group Facilitator Only)

Urban Health Documentary

Interview Guide

1. In the list of things you have to deal with in your daily living, is your health a priority?

   YES NO

1a. If no, what keeps it from being a priority?

2. Do you think that you are as healthy as you can be?

   Answer: Yes

2a. If the answer is yes, why do you think you are?

2b. If the answer is yes, what do you do to stay healthy?

   Answer: No

2c. If the answer is no, why do you think you are not healthy?

2d. If the answer is no, what would help you to be more healthy?

3. What things do you do that you ***know*** are unhealthy?

4. Why do you do these things?

5. When did you find out that you had your condition [diabetes/high blood pressure]? (age or amount of time known)

   Less that 1 year
   1 year ago
   2 years ago
   3 years ago
   5 years ago

6. How did you find out? (symptoms, diagnosed by a doctor, personal belief/judgment, etc.)

7. Do you think your health problem is serious?

8. How do you feel about having this condition?

9. What did you do to get treatment for your condition?

10. Are you currently being treated for your condition by a doctor or are you treating yourself?

11. Has anyone in your family ever been diagnosed with this condition?

12. Do you know a lot of people that have this condition?

13. Is there anything you think you could have done to prevent this condition?

14. Do you think you need to do what the doctor tells you to do?

15. Tell us reasons why people don't follow doctors' orders concerning what they should do to help their condition?

16. What has your doctor said or done that has **helped you most** with understanding and/or managing your condition?

17. What has your doctor said or done that has **helped you least** with managing and/or understanding your condition? (not feasible)

18. Has the type of help that has been offered to you been realistic?

19. What do you do that has helped you to successfully manage your condition that you would recommend to other people?

20. Do you think most people in your community share your opinions about health related issues/matters?

21. Is there anything you think <u>you</u> need to do to improve your health?

22. Are you willing to change your habits (diet, exercise, smoking, routine medical care, etc.) so that you can improve your health?
    - o Yes
    - o If no, why not?

23. Do you think most people you know think or act like you about changing their habits?

24. Is there anything the health system can do to help you with your diabetes/hypertension that it is not already doing?
    - o No
    - o If yes, what?

25. How can people be motivated to change their poor health habits?

26. What do you do that keeps you committed to following your medical regimen for your condition?

27. What advice can you offer people to help them maintain their health?

28. Is it important to you to care about the health of other people?

29. Is there anything in your community, where you live, that puts your health in jeopardy?

30. Do the following environmental or social factors affect your attitude or behavior about your health?

31. What can the health system do differently for the public that will:
    - o motivate them to take action to improve their health
    - o make health a priority?

Urban Health Documentary: *Participant Survey*

1. **Age:**
   - □ 18-28
   - □ 29-39
   - □ 40-50
   - □ 51-61
   - □ 62+

2. **Gender:**
   - □ Male
   - □ Female

3. **Race and Ethnicity**
   - African American
   - Asian
   - Hispanic
   - Native American
   - Other

4. **Are you:**
   - Married
   - Single
   - Divorced
   - Separated

5. **Baltimore City Zipcode:** _____

6. **Type of insurance:**
   - □ HealthChoice
   - □ Medicare
   - □ Private insurance
   - □ No Insurance

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7. **Do you have diabetes**? ___YES ___NO

8. **Are you being treated by a doctor for diabetes?** _____YES ____NO

9. **Diabetes is a…**
   - ❑ disease in which the body does not produce enough insulin
   - ❑ liver condition
   - ❑ problem that only affects children
   - ❑ disease that comes from eating "sugar"

10. **Some of the symptoms of diabetes are:**

Symptoms	**Yes**	**No**
Excessive thirst		
Frequent urination		
Shortness of breath		
Headaches		
Extreme hunger		
Blurred vision		

11. **Do you have hypertension (high blood pressure)?** ___YES ___NO

12. **Are you being treated by a doctor for hypertension?** ____YES ___NO

13. **Hypertension is…**
   - ❑ fear of heights
   - ❑ a condition that people with lots of energy have
   - ❑ another name for high blood pressure
   - ❑ a nervous condition

14. **Some of the symptoms of hypertension are:**

Symptoms	**Yes**	**No**
Dizziness		
Nervousness		
Nosebleeds		
Headaches		
Heart failure		
Stroke		

BEHAVIORS	Not thinking about it	Thinking about starting in the next 6 months	Definitely planning to start in the next 30 days	Already doing it for less than 6 months	Already doing it for more than 6 months	
Dietary						
1. Eating a diet low in fat						
2. Eating foods with less salt						
3. Avoid eating fried foods.						
4. Checking food labels for sodium and sugar content						
5. Avoid eating sweets like cookies, cakes, and candy.						
6. Buying foods with the words "low fat" or "fat free" on the label						
7. Eating fruits and vegetables daily						
8. Reducing your alcohol consumption						N/A
9. Eating foods high in fiber						
10. Monitoring the amount of carbohydrates you eat daily						
Exercise						
1. Exercising at least two times a week						
2. Walking 1 to 2 miles a day						
3. Taking the stairs rather than catching the elevator						
4. Joining a gym or starting an exercise program						
Smoking						
1. Not smoking for at least 24 hours						N/A
2. Seeking help to quit smoking						N/A
3. Reducing the number of cigarettes smoked per day						N/A
4. Quiting smoking entirely						N/A
Routine Medical Care						
1. Taking your diabetes medicine daily as prescribed						N/A
2. Testing your blood sugar daily						N/A
3. Taking your high blood pressure medicine as prescribed						N/A
4. Monitoring your blood pressure regularly						N/A
Healthcare Services Utilization						
1. Visiting the doctor for follow-up appointments						
2. Participating in a special program for your health condition						
3. Attending support group activities for your health condition						
4. Visiting the doctor when you feel sick						
5. Talking to a dietitian to help you develop an eating plan						

*Note: N/A=does not apply to me.