

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services



Men's Health *Why You Need To Act Now!*

Brigette Settles Scott, MA and Kerrita McClaughlyn

Prevention plays an important role in determining how well and how long a man lives. But for many men, going to the doctor is not something they like to do, and despite the often-fatal consequences—men frequently don't seek routine medical intervention.

"There is an extreme reluctance to acknowledge medical problems regardless of age. Often, men's approach to their body is: if I don't see it or sense it, it must not be there," said Dr. Lyle Ignace, an internist at the Gallup Indian Medical Center in Gallup, New Mexico.

Men are less likely than women to engage in a variety of preventive and self-care techniques, which contributes to men's increased risk of disease. They are less likely to restrict their activities or stay in bed to treat both

acute and chronic conditions, and they are less likely to properly manage a major health problem.

Yet, many of the illnesses that kill men are either preventable or treatable with early detection and intervention.

"Preventive medicine is crucial to the strategy of a long and healthy life," said Dr. Donald Ware, attending physician in cardiology and internal medicine at Brotman Medical Center, a Tenet Hospital Systems facility in Culver City, California.

Fear and Distrust

It has been well documented that men visit physicians less often than women and they utilize significantly fewer health care services. "One reason minority men tend to not go to the doctor is because of their perceptions of their role in society. They feel that they need to work for

the benefit of the family. By not valuing themselves and their health enough to remain healthy, they die sooner, and become disabled more often than they have to," said Dr. Ware. We need to teach men that if they take care of themselves, then they can continue to provide and remain an important part of their family's future," he added.

Other reasons why minority men don't seek medical help are as varied as the diverse cultures they represent. For example, fear continues to exist within the African American community that has many of its roots in the Tuskegee

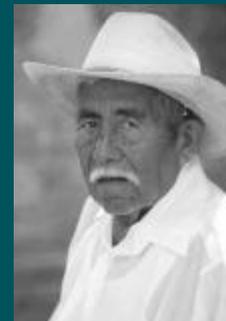
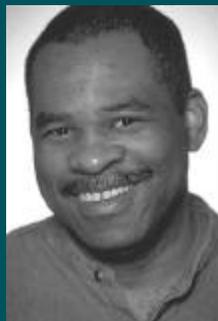
Experiment and its historical context.

Other groups, such as Native Americans, tend to distrust "modern" medicine because, culturally, it's alien to their way of thinking and lifestyle. In the Hispanic commu-

nity, macho attitudes force men to reject medical intervention as a sign of weakness. This fear and distrust also contributes to the wide gap between the life expectancy of White men and minority men.

Diseases At-A-Glance

According to the National Center for Health Statistics' *Health, United States, 2001*, the ten leading causes of death in men are heart disease, cancer (including lung and prostate), stroke, accidents and unintentional injuries, lung disease, diabetes, pneumonia and influenza, suicide, chronic liver disease and cirrhosis, and kidney disease. These diseases significantly affect minority men, which in turn, have contributed to their low life expectancy rates. For example, the average life expectancy for African American males is 67.6 years, which is almost seven years less than



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...continued on page 2

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Staff

Executive Editor:

Blake Crawford

Managing Editor:

Brigette Settles Scott, MA

Guest Editorials:

Donald Ware, MD, MPH
Matthew Murguía

Writers:

Kerrita McClaughlyn
Jody Vilschick
John I. West

Production Coordinator:

John I. West

Graphic Designer:

Stephanie L. Singleton

Inside

Minority Health Perspective	3
A Guide to Good Health	4
Colorectal Screening	6
Gay Men's Health Concerns	7
A Tribal Fight Against Diabetes	8
The Silent Killer	10
Lowering Your Blood Pressure	11
Fatherlessness	12
AAPAPI Tobacco Use	14
Youth Violence	16
Resources	19
Conferences	20

White men (averaging 74.5 years) and over 12 years less than White women—averaging 80 years.

“The fatality rates are high for minority men because they die from diseases that are usually more advanced by the time they are diagnosed, and there are often frequent cases of co-existing medical problems that add to the mortality rate,” said Dr. Ware. Among the top ten leading causes of death, those that have the greatest impact on minority men include:

Heart Disease

Although heart disease is the leading cause of death and disability among all Americans, it takes a significant toll on minority men. According to the American Heart Association's 2001 Heart and Stroke Statistical Update, among Asian American and Pacific Islander men, cardiovascular disease accounts for 36.1 percent of all deaths. They were second only to White males—where cardiovascular disease accounts for 39.2 percent of all deaths. The disease also adversely affects African American males—where cardiovascular disease accounts for 34.2 percent of all deaths, and who experience an earlier onset of the disease, experience the disease more severely, and have higher rates of complications. While Hispanic males had the lowest percent of total deaths from cardiovascular disease at 27.9 percent, they continue to face significant health challenges that are directly related to heart disease (e.g., high incidence of hypertension, elevated cholesterol, and diabetes).

Cancer

Lung cancer is the deadliest cancer in men. According to the American Cancer Society, tobacco smoking is by far the leading cause of lung cancer. More than 80 percent of lung cancer cases are caused by smoking—with the remainder largely attributed to passive exposure to tobacco smoke. According to the American Heart Association, the greatest incidence of smoking occurs among American Indian/Alaska Native men (42%) and, smaller percentages of African American men (29%), Hispanic men (25%), and Asian/Pacific Islander men (18%) are also smokers.

Colorectal (colon and rectum) cancer and prostate cancer are also common, but when caught early are highly treatable. Skin

cancer is the most common cancer among men next to prostate cancer. Melanoma, the developing cancer with the greatest increase in incidence since 1973, kills nearly twice as many men as women.

Prostate cancer is second only to lung cancer in killing men, and African American men develop prostate cancer at a higher rate than men in any other racial or ethnic group. Black men have a 60 percent higher incidence rate of the disease than White men, with Asian American and Native American men having the lowest rates, according to the National Cancer Institute.

Lung Disease

Lung disease (e.g., chronic bronchitis, asthma, emphysema) kills more than 100,000 Americans annually, with nearly twice as many men as women dying from the disease each year. It is one of the leading causes of death and disability for minority men. Smoking causes approximately 80 to 90 percent of lung disease cases, and a smoker is 10 times more likely than a non-smoker to die of the disease.

Stroke

Stroke is the third leading cause of death, behind heart disease and cancer. It is also the leading cause of serious, long-term disability, and accounts for nearly 1 out of 15 deaths in the U.S. Minority men face a higher risk of fatality from stroke than their White counterparts. And, compared with Whites, young African-Americans have a two to threefold greater risk of stroke.

Diabetes

Type 2 diabetes accounts for 90 to 95 percent of diabetes cases, and is nearing epidemic proportions due to an increased number of older Americans, and a greater prevalence of obesity and sedentary lifestyles. Approximately 7.5 million or 8.2 percent of all men in the U.S have diabetes, however, more than one third of these do not know it. With its complications—blindness, amputations, heart attack, stroke and impotence—diabetes is the seventh leading cause of death in America. Although diabetes affects all racial and ethnic minority groups, according to the National Institutes of Health, American Indians have the highest rates of diabetes in the world.

...continued on page 18

September/October 2001

Improving Men's Health

A Call to Action for Social Organizations

Guest Editorial by Donald R. Ware, MD, MPH
Imperial Medical Director, Health Education, Training and Preventive Medicine, A.E.A.O.N.M.S. (Prince Hall Shrine)

The overall health status of the African American male is in crisis. On average, the African American male who retires at age 65 will not live long enough to enjoy the fruits of his labor. With a shortened life span, and high morbidity and mortality rates for all the major diseases (e.g., heart disease, stroke, cancer, HIV, diabetes), it became abundantly clear that as an African American organization we have a responsibility to be on the front line in the fight to reduce these health disparities.

Promoters of Health Awareness and Prevention

Males have certain behaviors in common, no matter what race. The challenge is to change the thinking of men regarding health if we expect them to change unhealthy behavior. The African American male must value health in a meaningful way—and one way to create value is to involve people and organizations which are of value to him.

Over the last 25 years, the Prince Hall Shriners has been involved in health education and promotion. With more than 50,000 people attending our annual convention each year, we have been afforded a unique opportunity to provide actual medical management services. Through the years, our health clinics have discovered thousands of people with high blood pressure and diabetes—with some even requiring emergency treatment.

In 1986, the Shriners appointed health coordinators in every Temple and Court around the world. These individuals were trained to measure blood pressure and to perform basic CPR through a six-year agreement involving the American Red Cross and underwritten by the G.D. Searle Company. Since that time, other health related efforts were introduced—e.g., first aid and fluid management services during our parades, and training and certification of our members in CPR.

Similarly, in 1993, the Shriners created a health education and screening seminar on prostate health as part of a comprehensive health fair. As part of the seminar, we conducted prostate exams. To obtain the test results quickly, we administered the blood test for prostate-specific antigen (PSA), and used a local university-based laboratory for processing. Results were returned to our members at the convention, where we also provided counseling. For those with a positive PSA screening we made a reminder telephone call, and one to the member's physician if available.

Since then, the Prince Hall Grand Lodges have moved forward on a variety of health promotion issues. In California, the primary emphasis has been on stroke education—50 percent more males die from stroke than from prostate cancer. In conducting our screenings, we discovered that many also suffer from high blood pressure, diabe-

tes, and high cholesterol—all risk factors for stroke. Through this effort, we've learned that it is vitally important for all organizations participating in health education activities not to overemphasize any one condition without discussion of possible co-existing conditions. While we may do well in increasing awareness on one disease, many will suffer from another equally preventable co-occurring condition.

All of these Prince Hall Shrine efforts have made certain issues very clear—more education on preventive health screenings is needed. More must be done at the local level, and on a regular basis, if we are to succeed in significantly improving the mortality rates of men.

Building on Our Success

In 1999, we approached the Office of Minority Health Resource Center and asked for assistance in developing a tool-kit that each locality could use to conduct routine health promotion and disease prevention activities. Developed specifically to address those health issues that disproportionately impact African Americans, we created a monthly health observances calendar with related activities and materials that highlighted those issues. The key advantages of developing this tool kit include:

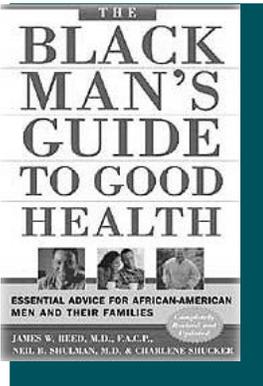
- Allowing all units to work on the same issues at the same time;
- Allowing for coordination of messages with print, electronic and other mass media to reinforce the overall message;
- Providing uniformity in message content—all members are educated and trained from the same materials;
- Offering variety and flexibility—allowing for regional variation and opportunities for the health coordinators to choose a topic to emphasize; and
- Tying all health information to screening opportunities—either in the form of a yearly health fair or during monthly meetings.

Strategies for the Future

Clearly, we have a long fight ahead, but we recognize the importance of organizations like ours, serving as promoters of health awareness and disease prevention within the African American community. The Prince Hall Masonic Movement challenges other social, civic, and professional organizations to not only put health care on their agendas, but to actively implement programs to help eliminate racial and ethnic health disparities. Through our collective efforts, we can be successful in closing the gaps we face in the health care arena. ❖

Talking with Dr. Hilton M. Hudson About *The Black Man's Guide to Good Health*

By Brigette Settles Scott, MA



As a practicing cardiac surgeon and currently the clinical director of cardiothoracic surgery at Rockford Health Systems in Rockford, IL, Dr. Hilton M. Hudson, II knows first hand that there is a tremendous need for timely, accurate health information in the African American community. To help fill this information void, and to help eliminate racial and ethnic disparities in health status and in access to health care, Dr. Hudson launched Hilton Publishing Company in 1997, with the

hopes of bringing reliable information not only to African Americans, but to other underserved communities as well.

The underlying goal of each publication is to empower individuals to make healthy lifestyle choices for themselves and their families. Along with the revised 2nd edition of *The Black Man's Guide to Good Health*, Hilton Publishing currently has available books on heart disease and management of cancer.

CTG: Why a book specifically for African American men on health?

Dr. Hudson: African American men are disproportionately affected by nearly all diseases known to man. Cancer, heart disease, kidney disease, high blood pressure, and the like, plague our community. Yet, despite this horrible fact, African American men are less likely to be informed, and more likely to be ignorant about the necessary treatments and preventative measures that we can take among ourselves to make ourselves more healthy and to live longer healthier lives.

We die sooner than any other men in America. As a matter of fact, there are underdeveloped nations that have statistics similar to the morbidity and mortality rates of African American men in this country. In other words, if you are an African American man, you will have about the same chance of living if you're in an underdeveloped country as you have living in certain cities in the U.S. In my opinion, we have lost our sense of pride and self-love. Without it, we fall victim to diseases. We don't take care of ourselves. This book is meant to help regain that pride and self-respect.

CTG: As you know, there is tremendous diversity within the African American community. Who do you hope to reach with this book (e.g., specific age group, socioeconomic group, etc.)?

Dr. Hudson: This book is developed for anybody who can read and has a sense of pride in himself. I think African American people in

general are more health conscious than the majority thinks we are. I also realize that we are lagging behind White America tremendously—in terms of going to health clubs, taking care of ourselves, and eating right—but we do care about our health. So, the book is primarily directed toward lower to upper middle class people. I think that if you're extremely poor, and you can't even afford the basic necessities, or if you're homeless, then you're not going to read this book. Similarly, I think if you're doing extremely well you may not read it either. It's my hope, if more African American people read this and other health books, it will become the "in" thing to do. So, even though this book may not appeal to the person down on his luck, out on the street, I feel that it is going to appeal to the great majority of African American men. If you can empower folks to take better care of themselves, then that knowledge will then be passed onto their loved ones—which in turn, will create an entire generation of folks concerned about their health.

CTG: Traditionally, women are the gatekeepers for the family—especially as it pertains to health care. Do you feel the book's title will encourage or discourage women from reading it?

Dr. Hudson: We chose this title because we couldn't think of another way to tell Black men that "you are important." While it is our hope that the book will draw in African American men, we know through our research that African American readers are largely Black women. And out of concern and love for the men in their lives, and their families, we believe the title won't keep them from reading it.

CTG: In your opinion, what keeps men from going to the doctor?

Dr. Hudson: Fear is the number one reason why people don't go to the doctor—especially men. Men are trained and grow up feeling invincible, indestructible, strong, and often emotionless. It's often viewed as a sign of weakness to even submit yourself to a diagnostic exam. For men, it's the perception of not being in control, whereas women don't have that particular problem.

Secondly, a feeling of apathy prevents one from going to the doctor. You're not going to take care of yourself if you don't care about life anymore. Lastly, there's a feeling of invincibility, that you're going to live forever. We've been misinformed. This misinformation leads to fear, and that fear prevents us from going to the doctor.

CTG: So, how do you deal with fear?

Dr. Hudson: You deal with fear by educating people. It's basically a lack of knowledge. We believe that by educating people about what

...continued on page 5

really happens when you go to the doctor and telling them the good news—that you CAN live longer and have a healthier life—even if you do have high blood pressure or diabetes. The common misconception is that if you do have a certain disease, it was going to happen anyway, and that it was only a matter of time before it caught up with you. What we're hoping to do with this and other books is to educate in a way that's sensitive to the needs of our people—lessening the fear.

CTG: How can we get men to the doctor?

Dr. Hudson: Again, through education. Simply increase the awareness bar and demystify medicine. By dealing with the fear head-on, we create a sense of empowerment and pride, which then leads to a change in behavior. In some ways, the fear is warranted. White Americans did not have to deal with Tuskegee and the whole mistrust of the medical profession.

CTG: Do you feel this book will serve as a springboard to encourage African American men to go the doctor?

Dr. Hudson: I sure hope so, because right now, there are no resources available in America today that specifically talk to African American men about health issues in a culturally sensitive and responsible way. Moreover, there are no books written for the lay Black public on hypertension, despite the fact that it is the number one killer of our people today. These books are written by Black doctors, reviewed and edited by Black experts.

CTG: Research has shown that African Americans—especially African American men—die at an earlier age, and from chronic diseases at a higher rate than most other racial/ethnic groups. What do you think can be done from both a public health perspective and on the community level to reduce this disparity?

Dr. Hudson: Education is the key to eliminating the health disparity. If you educate people on what should and should not happen, then you empower them. You are more likely to get what you ask for, and what you need, if you are prepared with a baseline knowledge level. I hate to admit it, but as a physician, the people you treat best in the hospital are often those that you know you have to be accountable to—those that have done their homework. It's not about providing a bunch of free clinics. It's about holding people accountable. This isn't the whole answer...but from a guy who practices medicine every day and who goes around the country listening and speaking with people, it's the easiest way to be effective.

CTG: In your opinion, what do you feel are the cultural beliefs or attitudes towards the prevention and treatment of disease that affect the overall health status of African American men?

Dr. Hudson: We've bought into all the misconceptions about disease and about what's going to happen to us if we get sick and have to see a doctor or go to the hospital. Distrust and mistrust of the medical field have paralyzed us. Although warranted—it's a result of what's happened to us—but we can't continue to allow this to be an excuse.

CTG: What's next for Hilton Publishing?

Dr. Hudson: Our next book titled, *8 Weeks to Better Health—Weight Loss for African American Women*, is coming out this Fall. Written by Dr. Edmond Smith, it's not a diet book. It's about loving oneself, how to get in physical shape, how to eat better and how to take better control of one's health. We're putting this book through the test. We've had three major medical editors review this book, and we will be focus group testing it with consumers to see if we really are being as effective as we think we are.

We are also doing a book on sickle cell anemia. Although there is a lot out there, this is a subject that we thought warranted revisiting. I will be writing another book similar to the one I wrote titled *The Heart of the Matter* on hypertension for African Americans. Along with my colleagues, Dr. James Reed, President of the International Society for Hypertension in Blacks and author of *The Black Man's Guide to Good Health*, Dr. Wayne Kong from the Association of Black Cardiologists, and others, we plan to cover this topic at length. Next year, we will be publishing a book on AIDS, written by Dr. Eric Goosby, former director of the White House Office of National AIDS Policy. This book will be for all minorities—not just African Americans—and will include information particularly relevant to Asians, Hispanics, and others because we know, the virus doesn't distinguish by race.

We're developing a book on cultural competency for doctors and other front line health care professionals to try and teach them how to deal with cultural differences. This book is designed to not only teach what the cultural differences are, but how to apply them, how to make them real, and how to make them work in your practice. For example, how do you counsel a Latino who is also diabetic on his diet, when his diet is completely different? How do you tell a 70-year old hypertensive patient who has heart disease, and is used to eating fried plantains and refried beans, how to eat differently? Most books are based on the non-Asian, non-Latino, non-African American diet. There is a critical need for this information.

CTG: What's the most important message you want African American men (and women) who read this article to remember? What is their call to action?

Dr. Hudson: Have some pride in oneself. Enough to believe in oneself, take care of oneself and to have confidence in oneself. That's what we're missing the most. I want people to pick up this book, not only because it's going to help you live healthier, but for what takes you to that road of picking it up—pride. Lack of awareness and missing pride are killing us. So, what I want people to feel is empowerment, knowledge and a sense of pride. I'm convinced, they're going to get more than just health information.

For more information on other Hilton Publishing Company publications, write to: P.O. Box 737, Roscoe, IL 61073, call 815-885-1070 or go to: <http://www.hiltonpub.com>❖

Colorectal Screening

Getting Tested Can Save Your Life

By Kerrita McClaghlynn

Colorectal cancer will kill more than 48,000 people this year, including 23,000 men, yet it is a disease that can be detected early through screening and treated early to prevent fatalities. Studies have concluded that many minority men are either afraid to be screened or are simply unaware that screening is available for the disease.

“In my opinion, men are afraid to get screened because of their perception that the procedures will be painful. The other factor is the cost. It’s expensive to be screened for colorectal cancer and if you don’t have insurance it becomes a problem. It’s hard to recommend to poor minority men,” said Dr. Kimoon Bang, senior epidemiologist of the National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention.

Colorectal cancer develops in the colon or rectum. Most begin as a *polyp* (adenoma) and over many years develop into cancer. Screening tests can detect cancer, polyps that may eventually become cancerous, and other abnormal conditions.

“Blacks and other minority men are at a higher risk for colorectal cancer. For minority men over age 50, it’s worth it to do a screening once a year. If you detect the cancer early,

there’s a much better survival rate,” said Dr. Bang.

According to the American Cancer Society, colorectal cancer is the third most common cancer diagnosed in men and women in the United States. They estimate that about 98,200 new cases of colon cancer, (46,200 men), and 37,200 new cases of rectal cancer (21,100 men), will be diagnosed this year.

“Because of diet, excess weight, genetic factors, smoking and inactivity, minority men are at higher-risk of developing colorectal cancer,” Dr. Bang said. “Occupational factors such as working with dust can also lead to high risk.”

Other risk factors include age, because colorectal cancer is more likely to develop as people get older; presence and growth of polyps; and a family history of the disease.

Despite minority men’s high-risk status and fear of screening, the death rate for colorectal cancer has been going down for the past 20 years. Many cases are being found early, and treatment methods have improved.

Screening Tests

There are a number of standard tests used to screen for and detect colon cancer or abnormalities that may indicate disease.

These tests include:

Fecal Occult Blood Test (FOBT)—a test for hidden blood in the stool. Studies show that a FOBT performed every one or two years in people between the ages of 50 and 80 decreases the number of deaths due to colorectal cancer.

Sigmoidoscopy—an examination of the rectum and lower colon with a lighted instrument. Studies suggest that fewer people may die of colorectal cancer if they have regular screening by sigmoidoscopy after the age of 50.

Digital Rectal Exam (DRE)—a test in which the doctor inserts a lubricated, gloved finger into the rectum to feel for abnormal areas. DRE is often included as part of a routine physical examination, but it is not recommended as a stand-alone test for finding colorectal cancer. The evidence available does not suggest that digital rectal examination is effective in decreasing mortality from colorectal cancer.

Double Contrast Barium Enema—a series of x-rays of the colon and rectum. The x-rays are taken after the patient is given an enema with a white, chalky solution that contains barium to outline the colon and rectum on the x-rays. Barium enema may be effective in detecting large polyps.

Colonoscopy—an examination of the rectum and entire colon with a lighted instrument. If a doctor sees polyps or other abnormal tissue during the procedure, they can be removed and further examined under a microscope. Studies suggest that colonoscopy is a more effective screening method than barium enema.

For more information, call the National Cancer Institute’s Cancer Information Service at 1-800-4-CANCER (1-800-422-6237), or go to <http://cancer.net.nci.nih.gov>

Common Signs of Colorectal Cancer

A change in bowel movements

Diarrhea, constipation, or feeling that the bowel does not empty completely

Blood in the stool (either bright red or very dark in color)

Stools that are narrower than usual

General abdominal discomfort (frequent gas pains, bloating, fullness and/or cramps)

Weight loss with no known reason

Constant tiredness

Vomiting

AIDS is *NOT* Our Only Problem *Health Concerns of Gay and Bisexual Men*

Guest Editorial by Matthew Murguía
Senior Public Health Analyst, Office of Minority Health

Throughout this issue of *Closing the Gap*, there are numerous stories discussing health care access, disparities, specific diseases, and a range of issues that minority men face as they try to stay healthy. Yet, there is one issue that is rarely discussed by health care professionals—how to adequately meet the health care needs of gay and bisexual men of color. Many gay and bisexual men are still ‘in the closet’ when it comes to health care in general, and more specifically, to issues affecting them as gay or bisexual men of color.

It should also be pointed out that information on the health needs of gay and bisexual men of color is lacking. Very little research focuses on sexual orientation, and very little funding is provided to conduct this type of research. A recent search on MEDLINE for “men and smoking” yielded 10,396 hits, while a search for “gay men and smoking” resulted in only 18 hits, with more than one-half of them related to HIV. A similar search for “men and alcoholism” resulted in 2,689 hits, but “gay men and alcoholism” resulted in only 25 hits, with more than one-third of those related to HIV.

This article will not focus on the impact that HIV/AIDS is having on gay and bisexual men of color—suffice it to say the picture is not good. In one study of young gay men in six cities in the U.S., nearly 14 percent of young Black gay men were infected. New infection rates for young gay men in these communities were equal to rates in some of the hardest hit communities in Africa. Some 70 percent of new HIV infections in males are in minority males, and more than one-half of new infections are related to either drug use or heterosexual contact. We know that HIV/AIDS is killing minority men, especially gay and bisexual minority men, and many of us have yet to pay attention to this fact.

However, there are a host of other health issues affecting gay and bisexual minority men. For example, it is estimated that up to one-third of gay and bisexual individuals have attempted suicide. Smoking, alcoholism and other drug use, Hepatitis A, B, and C, genital warts, and gonorrhea are all believed to disproportionately affect gay and bisexual men. Some studies suggest gay and bisexual minority men may be at greater risk for anal cancer, which is exacerbated by their HIV infection. Other studies have suggested higher lung cancer and heart disease rates. While not disease specific, incidences of gay bashing and domestic violence within gay relationships are issues that are rarely addressed by health care professionals, or in some communities, by law enforcement officials.

Similarly, mental health issues cannot be ignored. Many gay men suffer from depression and low self-esteem. Gay men live in a world

where they are often told that they are “bad,” while others are abandoned by their families. Discrimination against gays is all too common, and in many minority communities, gay men simply do not exist. Families don’t talk about their son, uncle, cousin, or brother who is gay, and the church—often the pillar of many minority communities—has not always been welcoming and has often ostracized individuals. All of this can result in the lowering of self-esteem, which in turn, can lead to depression and may result in unsafe sexual or drug using behaviors, suicide, or other health-affecting activities. It is clear that individuals who have low self-esteem are more likely to be risk takers since they don’t have a sense of self-worth and thus self-preservation. They are less likely to protect themselves in risky situations, less likely to consider the consequences of their actions, and less likely to look to the future. They value their life (and their health) less seriously.

Many of the health issues that affect gay minority men are preventable. HIV, STDs, alcoholism, liver disease, smoking, and violence, are all possible to address. There is a vaccine to prevent infection with hepatitis; gonorrhea is treatable; suicide is preventable; education helps prevent gay bashing and domestic violence, and the like. Yet, not many programs addressing the health needs of gay and bisexual men exist. However, there is some glimmer of hope. With the recent issuance of the Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual and Transgender Health published by the Gay and Lesbian Medical Association, and the recently created National Coalition for Lesbian, Gay, Bisexual and Transgender Health, this may change.

Health care professionals and the programs that serve gay and bisexual men of color need to be aware of the issues affecting gay men outside of HIV/AIDS. Programs must be developed that allow gay men to feel comfortable in the health care setting, and that are non-judgmental in their approach to providing health services. Most importantly, a health care provider should never assume a person’s sexual orientation. This assumption could potentially lead to not recognizing a health issue that could easily be addressed through prevention efforts rather than through treatment years later.

For more information on health issues affecting gay, lesbians, bisexual and transgendered individuals, or to receive a copy of the September/October 1999 issue of Closing the Gap that includes “Access to Health Care for Gay and Lesbian Patient,” contact the Office of Minority Health Resource Center at 800-444-6472 or online at <http://www.omhrc.gov>❖

Back to the Future

Oglala Lakota Tribesmen Fight to Prevent Diabetes

By John I. West

Life on the Pine Ridge Indian Reservation in South Dakota is anything but easy. Located on more than 3,100 square miles of South Dakota “Badlands” which are hot in the summer and freezing cold in the winter, Pine Ridge is home to nearly 25,000 members of the Oglala Lakota Tribe. Its territory takes in the southwest corner of South Dakota and includes the infamous Wounded Knee, site of the massacre of 350 Sioux men, women, and children more than 111 years ago. Pine Ridge has only 82 miles of paved road and has an unemployment rate of nearly 80 percent. Life expectancy on the reservation for males is 56 years, nearly 20 years below the rest of the country. Pine Ridge can also claim one of the highest incidence rates of diabetes. More than 44 percent of the adults living on the reservation have been diagnosed with Type 2 diabetes. Pine Ridge is in the poorest county in the United States where the average yearly income is only \$3,700.



In 1995, the Porcupine staff recognized that diabetes was running rampant and taking a serious toll on the Lakota people, especially men. With the help of a mere \$10,000 grant, the Porcupine Clinic set out to initiate a program for diabetes and began to screen children to find those at high risk for the disease. The staff identified 25 percent of the students screened at high risk for diabetes. The project proved to be a significant factor in the clinic receiving a major grant for diabetes prevention.

According to Iron Cloud, prevention always plays an important role at the Porcupine Clinic. There is an ongoing emphasis by the clinic to encourage tribal members to grow their own healthy foods. “At the beginning of our project, we contracted with the Cooper Institute out of Dallas,” Iron Cloud said. “There was a 70-year old fitness trainer who came to Pine Ridge to help with setting up our diabetes prevention program. He said ‘you don’t inherit disease, you inherit a lifestyle.... When we moved away from gardens, we moved toward disease.’ There is some truth in that,” Iron Cloud added.

Iron Cloud and other Oglala Lakota tribal members were recently successful in getting the only grocery store for miles to start stocking fresh fruits and vegetables. “Some tribal members have started gardens to grow their own vegetables,” he said.

Iron Cloud and other Oglala Lakota tribal members were recently successful in getting the only grocery store for miles to start stocking fresh fruits and vegetables. “Some tribal members have started gardens to grow their own vegetables,” he said.

Community Outreach

In addition to running the Porcupine Clinic, Iron Cloud hosts a weekly radio show on health at the reservation’s only radio station, KILI-FM. The 100,000-watt station is the largest Indian-owned and operated public radio station in America, broadcasting both in Lakota and English. Iron Cloud’s radio show, “The Diabetes Prevention Hour,” is broadcast every Wednesday morning in the Lakota language.

“We talk about topics such as: nutrition, cooking with commodities, tips on reducing fat and sugar in cooking, and walking, with personal testimonies of how walking has helped change individual lives,” he said. “Our message reaches the whole reservation and the border towns, too,” he added.

The show has won several awards for broadcast excellence from the KILI Radio Board of Directors and spawned the on air slogan: “KILI Radio—The Healthy Voice of the Lakota Nation.”

Recognizing the Need for Better Health

Despite all the negative health and social indicators, the Oglala Lakota Tribe is trying to turn back the clock. Several generations of eating foods high in fat and sugar, combined with the consumption of alcohol and a sedentary lifestyle, have introduced widespread and deadly health problems foreign to this formerly nomadic, and previously active and healthy tribe. Enter the Porcupine Clinic. Recognizing the need for better health care, a group of Lakota leaders built the Porcupine Clinic in 1992. The clinic, which is the only independent clinic on a reservation in this country, now serves more than 3,200 patients with nearly 12,500 visits each year. Many of the clinic’s patients are tribal elders who do not speak English and would not go to a clinic that did not have bilingual services.

“The Porcupine Clinic is testimony to what a community can do if it starts with a prayer and begins a journey not knowing for sure how you are going to get there yet knowing that you will eventually get to the desired destination,” said Richard Iron Cloud, acting director of the Porcupine Clinic at Pine Ridge. “The clinic has had its ups and downs but it has continued to provide services to the people. People look to it as a comfortable place to be, and it doesn’t have the lifeless quality of other health care institutions.”

...continued on page 9

"In the beginning, I had to carry the show all by myself," Iron Cloud said. "Recently, I went to the studio and there were so many people lined up for the program that I didn't get a chance to speak," he added.

Perhaps more importantly, the show inspired a group of men to start a walking club. Iron Cloud recalled a story about one of his listeners who took up walking for better health.

"A woman told me that the radio often had non-Lakota people come on the air talking about different health issues," Iron Cloud said. "She said that it was not until a Lakota man got on the air and began talking in his own language about the benefits of walking that the men began listening. Before then, they thought the people talking on the radio were referring to someone else," Iron Cloud added.

Combining the Old and New

It has not always been that way. History shows that the Oglala Lakota Tribe had a nomadic hunting lifestyle, with large herds of migrating buffalo and antelope. The tribe followed the migrating buffalo and hunted them for food and fur, trading the fur to mainly the French. Lakota people could eat large quantities of food prior to big hunts. They would go days without eating very much and were able to cover a lot of ground. When Tribe members returned, they would eat again.

"I believe that genetics play a very important role in our health and our history," said Iron Cloud. According to Iron Cloud, historical accounts written by noted western artist George Caitlin* in his Journal, show that Caitlin was surprised to see how much the Lakota people were able to consume in one sitting, especially during a feast.

"The same mechanism that allowed the Lakota people to survive long periods of time without food is now working against us," Iron Cloud said. "It is estimated that the Lakota people were able to burn 5000 calories a day in their active lifestyle and now it is less than 2000 per day," Iron Cloud added.

Buffalo occupy a hallowed place in the customs, culture, and history of the Lakota people. The meat, fur, hide, and horns are all put to use. Learning from the old ways, some of the tribal members have acquired buffalo and re-introduced them to the tribal lands. Many of the owners are now taking classes at the tribal college in ecology, genetics, and other sciences in the hope of combining the old and new.

Iron Cloud said the buffalo are being used to bring about a spiritual balance in life as well as a more genetic friendly diet. According to the National Bison Association, buffalo meat is at least 72 percent leaner than beef depending on the cut and has 50 percent less cholesterol. This is a big change from the fat and sodium laden, commodity-type processed meat, which was supplied to the tribe in the past.

"Personally, I love buffalo meat and many of our outreach workers are using buffalo meat in their cooking demonstrations. Many of our ceremonials use the buffalo meat because we consider it a sacred

food," he said. "I believe there is a lot of truth to the old adage that you are what you eat. The Lakota people were at their most healthy when their primary food source was the buffalo," Iron Cloud added.

Wellness Programs

Iron Cloud said that he thinks there are several ways to improve on the prevention of diabetes within the Lakota Tribe. "I believe in my heart and in my mind that we need to start with our babies by breast feeding," he said. "It is proven that breast-fed babies have fewer health problems and getting our youngsters accustomed to eating healthy foods at a younger age. Getting back to our cultural roots seems to be the healthiest disciplined lifestyle," he added.

According to Iron Cloud, most people do not get enough exercise. "Exercise would help in curbing obesity. We need to take a look at European cities where people walk or bike everywhere," he said. "We need to plan our towns and communities so that we can walk, too. This is why the Europeans do not have obesity problems like we do. On the reservation, we drive everywhere. Even to the post office, which is only a few hundred yards away," he added.

As for the future, Iron Cloud said that the Lakotas need to make several lifestyle changes in order to extend their lives. "First, one can begin to change by looking at his or her spiritual, emotional self," he said.

In a recent editorial for *Well Nations Magazine*, a health and wellness publication for North American Indians, Iron Cloud talked about the meaning of Lakota spirituality and being an "ikce wicasa" or common man. Oglala Lakotas believe that the "ikce wicasa" is a person untainted by other societies or their values and must embody humility, generosity, respect, and courage.

"As an 'ikce wicasa', I need to work on myself first. All major religions and philosophies teach that to understand one's self, was to understand God, that by going deep within, one could transmute fear into love, ignorance into wisdom, and lack into abundance. In other words, if I focus only on my needs, I will always be needy," he said.

Iron Cloud also emphasized the necessity for regular health check-ups. "We need to get a physical examination and begin an exercise program," he said. "Experts in physical fitness say that for every day of exercise, one extends his or her life by one day," he added.

Last month, U.S. Health and Human Services (HHS) Secretary, Tommy Thompson visited the Pine Ridge Reservation and announced HHS grants of \$1.1 million for the Oglala Lakota Tribal diabetes-prevention programs.

Thompson said that he wants the grants to help shift the emphasis from treatment to prevention. "We wait until people get sick, and we spend thousands to get them well again," he said.

For more information on the Porcupine Clinic, call 605-867-5319 and for information on diabetes, call the National Diabetes Information Clearinghouse at 800-860-8747. ♦

* (George Caitlin (1796-1872) traveled thousands of miles from 1830 to 1836 making sketches and portraits of Native Americans. Most of his work now hangs in the Smithsonian).

Hypertension

A Silent, Deadly Killer

By John I. West

That Ronald Cook. What a crazy guy. He could drive the cover off a golf ball and stay up all night playing cards with the best of them. We shared a lot of things together during a friendship that started back when we both enlisted in the U.S. Army in 1969. I went off to train for Airborne, jumping out of perfectly good airplanes, and then journalism school, while Ronald pursued a career as an on-the-ground military photographer. After Vietnam, we ended up working and training together off and on over the next 25 years. Ronald even got me to attend his church once, promising that I would really like the gospel music. Little did I know the music would add about another hour or so to the hour of preaching. But, it went by quickly and I did really like the gospel music.

One hot and muggy Saturday morning last year, we met at the golf course to have our usual “starter” breakfast. It was always too much, especially if you were going to hoof it with your golf bag as we usually did. He ordered the creamed beef on toast, a very large breakfast for the hearty ex-Army paparazzi, who had gained a few pounds since leaving the daily grind of military life. I had cereal and fruit. We ate quickly and teed it up, and away we went. It was a normal day until the second hole. After hitting his tee shot, right down the middle, Ronald took two steps, collapsed and died. Cardiac Arrest. There was nothing we could do. For one of the few times in my life, I felt totally helpless. Why? Why Ronald?

The answer to my “why” came after Ronald’s funeral when Stacy, his wife of almost 25 years, told me that Ronald had been diagnosed with high blood pressure during his exit physical from the Army five years ago. He was advised to schedule an appointment with Internal Medicine. He never did.

Prevalence

In the United States, the prevalence of high blood pressure in African Americans is among the highest in the world. Left untreated, it can cause cardiovascular disease (including stroke and congestive heart failure), and diabetes. According to the American Heart Association (AHA), the leading cause of death for African American males is cardiovascular disease. Simply put, uncontrolled hypertension/high blood pressure is deadly, and it should be taken seriously. As many as 30 percent of all deaths in African American men and 20 percent of all deaths in African American women can be attributed to high blood pressure, AHA said. Also alarming is the fact that high blood pressure develops at an earlier age in African Americans than it does in whites. Contributing factors to cardiovascular disease, such as cholesterol, also punish African Americans at an alarming rate. According to the National Center for Health Statistics, 45 percent of non-Hispanic black men and 46 percent of non-Hispanic black women ages 20-74 have high cholesterol.

Other Health Concerns

High blood pressure can also lead to other serious health problems. High blood pressure and kidney disease are closely related. Uncontrolled or poorly controlled high blood pressure is the primary diagnosis for about 25 percent of the patients who have chronic kidney failure. The National Kidney Foundation said African-Americans are eight times more likely than whites to have kidney failure as a result of uncontrolled high blood pressure. High blood pressure accounts for 26 percent of all new cases of kidney failure each year, and is second only to diabetes as the leading cause of end stage renal disease, which requires treatment with an artificial kidney machine (dialysis) or kidney transplantation to stay alive.

Left untreated, high blood pressure can also be a major cause of strokes. A stroke is another form of cardiovascular disease and occurs when the blood supply to the brain is interrupted. This interruption occurs from a buildup of fatty deposits blocking the artery or when a blood vessel bursts in your brain causing bleeding or hemorrhaging. According to the American Stroke Association, African American men are twice as likely as whites to have a stroke and almost twice as likely as whites to die from a stroke.

What is High Blood Pressure?

So what is high blood pressure/hypertension? Blood pressure is the force of blood against the walls of arteries. Blood pressure rises and falls throughout the day. But, when the pressure stays elevated over time, then it is called high blood pressure.

The National Institutes of Health’s (NIH) National Heart, Lung, and Blood Institute said that blood pressure is usually measured in millimeters of mercury (mm Hg) and recorded as two numbers—systolic pressure (as the heart beats) over diastolic pressure (as the heart relaxes between beats).

For example, a blood pressure reading would look like this: 130/80 mm Hg. To accomplish measurement, a cuff is placed, usually on the upper arm, and inflated. Air is slowly let out of the cuff and the doctor or nurse listens to blood flow with a stethoscope. A blood pressure of less than 120 mm Hg systolic and 80 mm Hg diastolic are optimal.

For most of us, it’s not too late to modify our behavior. Had Ronald gone to his doctor as recommended, his doctor would have told him to follow some simple steps to lower his blood pressure. (See ‘Ten Steps to Lowering Your Blood Pressure’ on page 11).

...continued on page 11

The Silent Killer

Treatment

If high blood pressure is treated aggressively, the risk of coronary artery disease, congestive heart failure, or stroke is greatly decreased. Controlling blood pressure means you lower the risk of suffering coronary disease. Untreated, high blood pressure will eventually lead to damage to and weakening of the walls of the arteries. The arteries become weak over time and plugged with cholesterol, red blood cells, and fat. It kind of reminds you of a sink full of potato peelings before the garbage disposal is turned on.

Sometimes treatment means medication. There are many drugs available now under a doctor's prescription. These medications sometimes have side effects but none nearly as bad as the result without them. The longer high blood pressure is left untreated, the more serious its complications can become. Because this disease is so serious, early detection and treatment are very important.

After losing one of my best friends, I started going to my doctor for regular checkups. Like Ronald, I was diagnosed with high blood pressure. The doctor immediately started me on a regimen of several tablets a day, which was confusing at first, but I got used to it.

But the doctor wasn't done with me yet. In a subsequent office visit, I found out that I had Type 2 Diabetes. I learned I needed to begin an aggressive program of diet and exercise to help lower the risks of becoming insulin dependant or worse, and developing serious coronary heart disease. The doctor definitely has my attention right now. Isn't it time you thought about having your blood pressure checked?

For more information on high blood pressure, call the American Heart Association at 800-AHA-USA1. ❖

Percent of Total Deaths Caused by Diseases of the Heart in Minority Males, United States, 1998



Information source: National Center for Health Statistics

Lowering Your Blood Pressure

Ten Steps to Lowering Your Blood Pressure

1. Make sure your blood pressure is under 140/90 mm Hg. If your systolic pressure (the top number) is over 140, ask your doctor what you can do to lower it.
2. Take your high blood pressure medicine, if prescribed, every day. If you have questions, talk to your doctor.
3. Aim for a healthy weight. If you are overweight or obese, carrying this extra weight increases your risk of high blood pressure. One way to determine if you need to lose weight is to find out your body mass index or BMI. If your BMI is above the healthy range (i.e., 25 or greater), or if your waist measurement is greater than 35 inches (women) or 40 inches (men) you probably have excess abdominal weight and you may benefit from weight loss especially if you have other risk factors. Talk to your doctor to see if you are at increased risk for high blood pressure and need to lose weight.
4. Increase your physical activity. Do at least 30 minutes of moderate activity, such as walking, most days of the week. You can do 30 minutes in three 10-minute segments.
5. Choose foods low in salt and sodium. Most Americans should consume no more than 2.4 grams (2,400 milligrams) of sodium a day. That is nearly one teaspoon of table salt a day. For someone with high blood pressure, the doctor may advise less.
6. Read nutrition labels. Almost all packaged foods contain sodium. Every time you prepare or eat a packaged food, know how much sodium is in one serving.
7. Keep a sodium diary. You may be surprised at how much sodium you consume each day and the diary will help you decide which foods to decrease or eliminate.
8. Use spices and herbs instead of salt to season the food you prepare at home.
9. Eat more fruits, vegetables, grains, and low-fat dairy foods. Check out the DASH Diet plan for delicious menu ideas. (Go to <http://www.nhlbi.nih.gov/health/pub/ic/heart/hbp/dash/index.htm> for more information on the DASH Diet Plan.)
10. If you consume alcohol at all, consume moderate amounts. For men, this is less than two 12 oz servings of beer, or two 5 oz glasses of wine, or two 1½ oz servings of "hard" alcohol a day. Women or lighter weight people should have no more than a single serving of any one of these beverages in a given day.

Information Source: National Heart, Lung, and Blood Institute

Fighting the Fatherlessness Epidemic

By Brigette Settles Scott, MA and Jody Vilschick

“**I**nvolvement of a responsible male—be it custodial or non-custodial, biological or not—can significantly affect the health outcomes of young children,” said Dwaine Simms, replication manager, Minnesota Early Learning Design (MELD) for Young Dads, in Minneapolis, MN. “Even before the child is born, a father can affect the health status of his child—from encouraging mom to eat properly and attending pre-natal appointments to advocating for early preventative care after birth.”

Yet, today, more than 22 million children live in homes away from their fathers—up from fewer than 8 million in 1960—according to the National Fatherhood Initiative (NFI), a non-profit, non-governmental organization that works to counter the growing problem of fatherlessness by stimulating a broad-based social movement to restore responsible fatherhood as a national priority.

“There’s an epidemic of father absence in American society,” declares Edward E. Bartlett, Ph.D., senior policy advisor and founder of Men’s Health America. “In some communities, a large number—even a majority—of children are growing up without meaningful contact with their father.” This lack of contact can significantly impact the overall health status of children.

“Tonight nearly four out of ten children in America will go to sleep in a home in which their father does not live. While at times, it is easy to throw around statistics such as these to make a point, the plain truth of the matter is that for every frightening statistic, there is a frail human life attached to it,” says Wade F. Horn, Ph.D., former president of NFI, and currently the assistant secretary at the Administration for Children and Families.

Children who grow up in single-parent households, are also at great risk of not having health care coverage. According to the June 2000, Medical Child Support Working Group Report, children living in one parent households (largely fatherless) have substantially less access to health care services, including preventive care that ensures childhood immunizations, vision and hearing screening, and dental care. Health care services are also far more likely to be delayed due to cost.

The MELD for Young Dads program is one local effort to address the unique needs of young fathers. The program reaches out to both custodial and non-custodial fathers, typically between 15 and 25 years old, and aims to prevent paternal neglect by helping young fathers handle the societal and interpersonal problems that can be barriers to involvement with their children.

“A major component of our curriculum is to bring information to fathers which will allow them to make informed decisions about how to support the health care of their children,” added Simms.

Research shows that children benefit from positive relationships not only with their mothers, but also with their fathers:

- Father involvement is important even for very young children. Good fathering during infancy and early childhood contributes to the development of emotional security, curiosity, and math and verbal skills.
 - Higher levels of involvement by fathers in activities with their children, such as eating meals together, going to the park or other outings, and helping with homework, are associated with fewer behavior problems, higher levels of sociability, and a higher level of school performance among children and adolescents.
- Involvement by fathers in children’s schooling, such as volunteering at school and attending school meetings, parent-teacher conferences and class events, is associated with higher grades, greater school enjoyment, and lower chances of suspension or expulsion from school.
- The father-child relationship affects daughters as well as sons. Girls who live with both their mother and father do better academically. In addition, they are less likely to engage in early sexual involvement and alcohol or drug use.
- Although negative peer influence is the major reason kids use drugs, research suggests that positive family influence is the main reason kids don’t use drugs. Both boys and girls have reduced risk of drug and alcohol use if their fathers are involved in their lives.

“Even before the child is born, a father can affect the health status of his child...”

Promoting Responsible Fatherhood

Also responding to the critical problem of “fatherlessness” in the nation, The Institute for Responsible Fatherhood & Family Revitalization (IRFFR), headquartered in Washington, D.C., has created a program designed to bring young African American fathers back to their children and families. The program hinges on the theory that the life of the father has tremendous impact on the lives of both his children and their mother. The fathers receive intense, non-traditional, one-on-one support, group support, family outreach, father-

...continued on page 13

ing skills, health and nutrition information, medical and housing referrals, and education and career guidance.

“Our goal is to create good, loving, compassionate, and secure fathers,” said Charles Ballard, founder and chief executive officer, IRFFR. The Institute’s approach is to teach fathers to be good models for his children. “Children learn from us first—not their friends. We, as husbands and fathers, have major responsibilities that we must carry out in order to have good healthy families. We teach our fathers that in order to create longevity among our people we must do three things: 1) change our life style from at-risk to risk-free, 2) we must eat better and practice proper nutrition habits, and 3) we must exercise. In turn, he becomes the model of good health that is then passed on to his children,” added Ballard.

The program hinges on seven primary approaches to creating responsible fathers:

- Enhance intrapersonal development—mental health;
- Enhance health and wellness—be good models of good health for the family;
- Enhance family development—creating a healthier family model;
- Enhance educational development—e.g., completion of GED, high school, college;
- Enhance financial development—e.g., savings, investments;
- Enhance entrepreneurship—e.g., employment, enterprise; and
- Enhance community development—strive to become pillars in the community.

To date, IRFFR has reached over 7,000 fathers nationwide since 1982, and can claim over a 90 percent success rate in some cities.

Government Support

While government cannot make good fathers, it can, and does, support efforts to help men become the best fathers they can be. The U.S. Department of Health and Human Services (HHS) is promoting respon-

sible fatherhood by funding programs whose goal is to improve work opportunities for low-income fathers, increase child support collections, enhance parenting skills, and support access and visitation by non-custodial parents. One of HHS’ programs—Responsible Fatherhood Management Information System (RFMIS)—is a computer database program that supports the information-management efforts of programs serving fathers through its ready-made evaluation tool. Specifically for community-based organizations serving men and fathers, RFMIS is currently being used by 15 HHS fatherhood project sites across the country and in eight fatherhood projects funded by the Sisters of Charity Foundation of South Carolina.

According to Linda Mellgren, social science analyst, in the Office of the Assistant Secretary for Planning and Evaluation, RFMIS was created because after a review of existing fatherhood programs, one of the primary areas identified as needing improvement was to have better tools for assessing and tracking their client caseload. “The RFMIS has allowed projects running on very tight budgets to have access to a sophisticated management tool that can be adapted to meet their program’s needs,” she says.

“It’s helped us provide the services really needed to allow individuals to become more responsible fathers,” says Stan McLearn, director of the Father Friendly Initiative of the Boston Public Health Commission. The Father Friendly Initiative serves about 130 men at any given time. “Our clients need services of varying levels of intensity—some just need a job or help getting a GED. Others need counseling and mental health services, or substance abuse treatment.”

McLearn especially appreciates how RFMIS allows him to focus on providing the services a father needs most. “In one case, the father was caught up in a ‘he-said, she-said’ situation involving him, his child’s mother, his girlfriend, and her boyfriend,” says McLearn. “Now he has an excellent relationship with his child’s mother and he’s getting married to his girlfriend—and his child’s mother is invited to the wedding. Another father, through counseling and anger management courses, was able to establish a good relationship with his child’s mother, and as a result, ended up marrying her.”

The RFMIS makes it possible for programs to identify who they are serving, what needs they have, and what services are being delivered. This allows programs to monitor their activities on an on-going basis, and to make changes when they are not meeting clients needs. Irene Luckey, director of programs for the Fatherhood Initiative of the University of South Carolina’s Institute on Families and Society, which works closely with the Sisters of Charity Foundation in South Carolina, is enthusiastic about RFMIS’ ability to help them track trends. “When we started we expected that finding jobs for the men would be the main issue,” she said. “We learned from the data that due to their educational level and other factors, they are working, but below the minimum wage. We also saw that a lot of the men don’t have long work histories—they may stay at a job for two years or less. So we’ve had to focus on not just getting a job, but getting and keeping a sustainable job.” The 16 Sisters of Charity projects serve more than 500 men throughout South Carolina.

As good as RFMIS is now, there are some changes in the works, according to Mellgren. “A client outcomes section is being developed that will contain a broad set of outcomes data relevant to the fatherhood field, that projects can adapt to their own service model,” she says.

All this is good news for fathers and their children everywhere. Having a father involved in children’s lives also adds non-quantifiable emotional well-being and richness. “As fathers, we will have opportunities to make either the blooper reel or the highlight film. Through continuous, meaningful contact with our children, we will create lasting memories,” writes Jack Petrash, in the Spring 2001 issue of *Fatherhood Today*, an NFI publication.

For more information on the fatherhood programs mentioned, go to the Department of Health and Human Services Fatherhood Initiative web site at <http://fatherhood.hhs.gov/>

For more information on the Guidebook to the Responsible Fatherhood Project Participant Management Information System (RFMIS), go to <http://fatherhood.hhs.gov/guidebook99/index.htm>

For more information on the MELD Program, go to <http://www.meld.org>❖

Tobacco Use

Health Threat to Asian and Pacific Islander Communities

By Jody Vilschick

Tonganeses Americans can take heart that their former king, King Taufa'ahau Tupou IV, is working to help improve their health by collaborating in the making of an anti-tobacco video for youth in Tongan and English. "He still has great influence among Tongans in the U.S." says Percival Leha'uli, the director of the Tobacco Control Program at the Tongan Community Center in Los Angeles.

Still, according to *Tobacco or Health: A Global Status Report*, by the World Health Organization, 1997, the smoking rate among Tongan-American men is an astounding 65%, compared with an average of 24% among other Americans. But the statistics for other Asian American/ Pacific Islander (AA/PI) groups—72% of Laotian American men and 71% of Cambodian American men smoke—underline the need for tobacco cessation and prevention programs that can appropriately communicate with the AA/PI communities.

Complicating the lack of culturally competent and translated materials and resources for the AA/PI community is the diversity among the AA/PI communities. "There are more than 50 distinct ethnic and language groups within the umbrella of the AA/PI community," says Rod Lew, founder and current executive director of the Asian Pacific Partners for Empowerment and Leadership (APPEAL). "There are very limited cessation resources even for the very large groups." Founded seven years ago, APPEAL is a national network of individuals and organizations that work to prevent tobacco use among the AA/PI community.

Yet creating such resources is critically important. "If the services are culturally competent and language appropriate, then that will build a higher trust—and ultimately have a greater effect," says Elaine Hishiwara, who runs the Washington Asian Pacific Islander Families Against Substance Abuse (WAPIFASA). WAPIFASA, located in Seattle, provides a variety of substance abuse outreach activities that incorporate anti-tobacco messages.

Tobacco Advertising—A Cause for Concern

The tobacco industry spends almost \$7 billion every year on advertising—contributing, in part, to the high incidence of smoking within the AA/PI community. "Many within the AA/PI community receive the tobacco industry's targeted messages again and again," says Lew. He notes that many American and international tobacco compa-

nies market their products extensively in Asian countries—where many immigrants to America originate—then, these companies reach these same people again—once they assimilate into American culture.

China, for example, produces more tobacco than any other country in the world, and is also its greatest consumer of tobacco, according to the World Health Organization. And, as a true testament to advertising and marketing ingenuity, a store in Seattle's Little Saigon neighborhood cleverly integrates the Marlboro logo with Asian cultural icons like Buddha. Marlboro signs also hang adjacent to rice bags, cash registers and other high-traffic areas, Lew added. "It's a shame that until a few years ago, the tobacco companies knew more about getting their message out to the AA/PI community than the public health tobacco cessation programs," he said.

Addressing Cultural Barriers

"If the services are culturally competent and language appropriate, then that will build a higher trust—and ultimately have a greater effect."

Alison Shigaki is a physician with International Community Health Services, a community health clinic that primarily serves members of Seattle's AA/PI community. Shigaki has come face-to-face with some of the cultural barriers to the anti-tobacco message her clinic promotes. "Smoking is a big part of some Asian cultures," she says, pointing out that men in many Asian countries use smoking to socialize and transact business. "If someone offers you a cigarette, you need to be polite and accept it. You also need your own cigarettes to offer others," she says. "Then they come to the U.S. and it takes them a long while to realize cigarettes aren't so important."

Shigaki's clinic, which is funded by grants from Seattle King County Health Department, has recently started a pilot six-week-long smoking cessation program in Vietnamese targeting Vietnamese men. "Men in the class at the beginning can bring someone else as support—even up to week five," she says. "We hadn't expected it to be this way, but it's now a rolling admission. Men who started the class later are now attending the second round of classes to catch up on what they missed in the first few meetings."

She notes however, that most of these men are already highly motivated—of the 20 that finished the first set of classes, two had already quit smoking and 12 others were starting the nicotine patch.

APPEAL offers a tool-kit, "Making Tobacco Relevant for Asian American and Pacific Islander Communities," that recommends that community organizations follow these steps:

...continued on page 15

1. Identify the people in the community already active in cessation efforts to approach about tobacco and smoking cessation efforts.
2. Cultivate relationships with that group, or establish contacts to collaborate with them.
3. Know the community at first hand: learn about what concerns motivate them to act.
4. Find ways to relate tobacco to those concerns.
5. Provide information about tobacco control in a way that interests the community.
6. Provide opportunities for the organization to be involved in tobacco control.

AA/PI men are much more likely than AA/PI women to smoke, says Lew, although he notes that as AA/PI men become more acculturated, their rate of smoking tends to drop, while AA/PI women's rate of smoking increases with acculturation.

The good news of acculturation—according to Shigaki—is that, “now that they're in the United States, the wives are more vocal—they don't want the men to smoke in the house and they encourage the men to pay more attention to their health,” she says.

For more information, contact APPEAL at <http://www.APPEALforcommunities.org>



Smoking Behavior of Asian Americans and Pacific Islanders

Cigarette Smoking Behavior

Research shows an association between cigarette smoking and acculturation among Asian American and Pacific Islander adults from Southeast Asia. Those who had a higher English-language proficiency and those living in the United States longer were less likely to be smokers.

Among Chinese men, the average number of cigarettes smoked per day increased with the percentage of their lifetime spent in the United States.

Among Vietnamese, the prevalence of smoking was higher among men who immigrated to the United States in 1981 or later and who were not fluent in English.

Health Effects

Smoking is responsible for 87% of the lung cancer deaths in the United States. In 1993, lung cancer was the leading cause of cancer death (22.3%) among Asian Americans and Pacific Islanders.

The death rate for lung cancer was 27.9 per 100,000 for Asian American and Pacific Islander men and 11.4 per 100,000 for women.

Among subgroups, both Hawaiian men (88.9 per 100,000) and women (44.1 per 100,000) had the highest rate of lung cancer deaths, and Filipino men (29.8 per 100,000) and women (10.0 per 100,000) had the lowest.

Prevalence

The 1997 National Health Interview Survey data show that overall adult smoking prevalence was lower among Asian Americans and Pacific Islanders (16.9%) than among Hispanics (20.4%), whites (25.3%), African Americans (26.7%), and American Indians and Alaska Natives (34.1%).⁴

Smoking rates are much higher among Asian American and Pacific Islander men than among Asian American and Pacific Islander women, regardless of country of origin.

Quitting

Among current smokers, Asian Americans and Pacific Islanders were slightly more likely than white smokers to have quit for at least one day during the previous year (32.0%, compared with 26.0%).

Asian Americans and Pacific Islanders (2.5%), however, are less likely than whites (3.4%) to remain abstinent for up to 90 days.

A community intervention trial for Vietnamese men conducted in San Francisco significantly increased the likelihood of quitting smoking. This program included a long-running anti-tobacco media campaign and school- and family-based components.

Tobacco Industry

Among racial/ethnic minority communities in San Diego, the highest average number of tobacco displays was found in Asian American stores (6.4), compared with Hispanic (4.6) and African American (3.7) stores.

Source: U. S. Surgeon General's Report, Tobacco Use Among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics, 2000.

Fighting Youth Violence One Boy at a Time

By Jody Vilschick

Vladimir Joseph was left behind. His inner strength and a few helping hands allowed him to catch up, and in turn, extend a helping hand to the current generation of African American boys living the violent life on the streets.

The first time he was left behind, Joseph returned to an empty apartment where he had been living with his mother and sister since his parents were divorced when he was seven years old. His mother and sister moved out, leaving him alone. "I was thirteen and homeless, but I knew my way around," says Joseph. His life on the South Bronx streets, however, soon led to his being attacked, which turned out to be a positive. After a stint in the hospital, he was sent to a shelter. "That got me back to school," says Joseph. "I loved school. I could be myself and kick some academic ass. I could exchange ideas and be safe."

Outside of school, however, he was involved in gang activity. In eleventh grade his life was seriously threatened, and he thought he would have to kill or be killed. "I didn't bother people, but I had my gun when I got caught by the police," says Joseph. "If I didn't get locked up right then, I probably would have killed someone an hour later."

Those were bad times, he remembers. "Crooked cops, friends dying—it was nothing to see people die on the street," he says.

Eventually, he found his way to a group home run by a Catholic priest, who encouraged him to pursue his academic dreams and go to college. He chose Morehouse College. Located in Atlanta, Georgia, it was just about as far away from the streets of the South Bronx as a young boy could get. "In my environment, the only successful Black men were running guns and crack," he says. "At Morehouse, the students' dads were judges and professors."

After graduating from Morehouse, Joseph knew he wanted to help young boys, who, like him, needed a little help and encouragement to escape the violent street life. While working other jobs, he founded Inner Strength in 1996. "The group was just me for a while," he remembers.

The Morehouse College Family Life Center (MCFLC) collaborates with Inner Strength to reduce youth violence and the resulting fear of crime. They do this by providing mentors—college students from Morehouse, Spelman, Morris-Brown, and Clark-Atlanta, all nearby historically black

colleges and universities—who share how they stayed out of trouble and turned their lives around. They also take the troubled kids on overnight trips, usually hiking and camping. "We've witnessed that when you take a kid out of his environment and bring him to a different place and challenge him to look at himself in a different way, change becomes tangible," says Joseph. "You sit in the ghetto and tell him, 'you know you got to do something,' and he'll say, 'yeah, whatever.'"

The MCFLC also conducts a three-week "Summer Academy" for 30 boys, which is designed to sharpen participants' reading and basic math skills, and provide opportunities to focus on career development and job exploration. Field trips and sessions on African American history and current issues help the boys develop a sense of who they are and a better understanding of the history of African Americans in this country.

"We thrive on creating a safe space where kids feel it's okay to be vulnerable and ask questions," says Joseph. "We let them know we'll be there for them."

The MCFLC is part of the Family and Community Violence Program (FCVP), which was developed under a cooperative agreement between the Office of Minority Health and Central State University, in Wilberforce, OH. Its goal is to affect the increasing violence and abusive behavior in low-income, at-risk communities through the mobilization of community partners to address these issues. Now, the FCVP coordinates and directs the activities of Family Life Centers at 24 historically African American colleges and universities, institutions primarily serving Hispanics, Native American tribal colleges and universities, and other minority-focused institutions in 17 states, the District of Columbia, and the Virgin Islands.

"Every one of these kids has someone in his neighborhood who is a drug dealer and will help him get into that life if he wants to," says Joseph. "We provide another option." ❖

Violence Among Young Men

Intentional violence accounts for one-third of all injury deaths in the United States.

Intentional interpersonal violence disproportionately involves young people as both perpetrators and victims; young males between the ages of 15 and 24 are disproportionately involved in violent acts.

Among minority youth, particularly African Americans, violence has struck with unique force in recent years. Homicide has been the leading cause of death among African American males between the ages of 15-24 for more than ten years.

Nationally, in 1999, 83 percent of school homicide or suicide victims were males.

Information source: National Youth Violence Prevention Resource Center, 2001

Stopping Gang Violence in Texas *One Community's Effort*

The Corpus Christi Family Life Center, located at Texas A&M University's Corpus Christi branch, works primarily with young at-risk Hispanic men in Nueces County. For a community plagued with gang activity, and violence, this program primarily focuses on drug and violence prevention, and gang intervention strategies. Also core in the program's curriculum is a cultural component that provides the youth with positive images and information about their ethnicity and culture.

The program works with an at-risk population—characterized by low incomes, a high proportion of single parents, behavioral problems, truancy, and academic failure. Other services incorporated in the program include intensive case management that assists the youth's family with daily living needs and crisis intervention (e.g., food, school supplies, money to pay the bills), and a family-bonding program to encourage family support.

"We set up components to deal with any family issues they may have. We teach parents how to be involved in their children's lives. We send the family and the child to camps together, that we produce ourselves. We provide parenting and nutrition classes—like how to make a nutritious meal with little food," said Tony Elizondo, director, Texas A&M University's Corpus Christi Family Life Center.

Born out of a need for after-school programs to keep youth involved in positive activities—and not gangs—the Center's program also works to build self-esteem through activities that the kids would not normally partake in—like hunting and fishing. Because the Center is located near Padre Island, many of its activities focus on marine biology and the environment—instruction not normally taught in school. College students tutor the kids, and also serve as mentors.

"Gang activity and low economics are big factors. Kids don't have the resources to do positive things so they join gangs or steal to get what they need. With this program they don't need any money—it's free. They don't have to go out and steal to get what they need. We get them involved in hobbies and continue to support them so they won't need join gangs, or participate in illegal activities," said Elizondo.

The overall goal of the program is to develop young leaders in the community. The Center also collaborates with local businesses to do job shadowing and career exploration so that when the student leaves the program, he leaves with some job skills.

"We've also partnered with 15 different community organizations and businesses. They help us train our staff, supply us with incentives for the kids and their families, as well as donate food and door prizes," Elizondo added.

For more information, go to <http://www.fcvp.org/flcs/TAMU-CC.htm> ❖

Decreasing Violence Using Cultural Traditions

Sinte Gleska University Family Life Center is located on the Rosebud Indian Reservation in Mission, South Dakota. In existence for nearly two years, the Center helps students effectively deal with and manage anger. The curriculum—Violence Behavioral Cycle—teaches students that violence is continuous cycle.

"Native American youth—particularly the young men—often fall victim to the cycle of violence. They hold in anger until it builds, and then they unleash it on someone else. We use this program to help them work out their anger—before someone gets hurt," said Kevin DeCora, prevention specialist.

"One of our conflict resolution techniques is meditation that draws on our Native American heritage—something our people have been doing for centuries. We sit the kids in a circle, we have an eagle feather, we light sage for purification, and then we meditate on the problem. This connects them to their culture, provides spiritual significance, and provides them with a solution to their problem," DeCora added.

Anger begets violence, and therefore, violence prevention is also a strong component of the Center's program. Violence has increased

tremendously on the Rosebud Indian Reservation—and is often more personal in nature. Often kids present with identity issues that lead to anger and violence. The Center's first priority is to help the kids realize the importance of, and to understand and be proud of their heritage as Lakota Indians, thereby taking pride in one another. This tactic helps to decrease the incidence of violence in the community.

"It's not like drive-bys in big cities where you never see your victim die because you're in a car or across the street. Here we have people beating each other to death. There are a lot of incidents of beatings with bats, jacks, and bars by youth on each other. We usually see the violence in the 13 to 25 age groups, with men usually the culprits. However, we've also seen a lot of women becoming more violent," said DeCora.

To date, Sinte Gleska University Family Life Center has made significant progress in reducing the incidence of violence on the reservation. According to DeCora, "We've had a lot of success stories, and we're seeing a lot of our kids applying the anger management techniques they learn here, in the community."

For more information, go to http://www.fcvp.org/flcs/sinte_gleska.htm. ❖

Homicide

Men are victims in four out of five homicides. For African American men, who are victims of homicide seven times more often than White men, homicide is the fourth leading cause of death, and the number one killer for those ages 15 to 24.

HIV Infection

The rate of HIV infection among minority men is a growing concern, with minority youth being at an increased risk. Males account for 9 out of 10 deaths due to HIV infection. The virus is the third leading cause of death for Hispanic males ages 25 to 44, and is the second leading cause of death among African American men of the same age. Today, one of the most at-risk groups

contracting HIV is young African American and Hispanic men-who-have sex-with-men (MSM).

According to the Centers for Disease Control and Prevention's Morbidity and Mortality Weekly Report from June 1, 2001, the prevalence of HIV among African American MSM (aged 18-22) is almost 15 percent, and among Hispanic gay men, the figure is closer to 7 percent.

Suicide and Depression

Males are four times more likely to die from suicide than females. Of growing concern, between 1979 and 1992, suicide rates for Native Americans were about 1.5 times the national rates. There were a disproportionate number of suicides among young male

Native Americans during this period with males between 15 and 24, accounting for 64 percent of all suicides by Native Americans.

While minority men tend to have higher morbidity and mortality rates for these chronic diseases, there is hope. Many of these diseases are either preventable or treatable. Many health researchers contend that health behaviors are among the most important factors influencing health, and that modifying health behaviors is probably the most effective way to prevent disease. Regular medical exams are critical to the early detection of many potentially fatal diseases, but the willingness to take subsequent action, and the availability of care for newly diagnosed problems must also be present. ❖

Leading Causes of Death in Minority Males

Health, United States, 2001. National Center for Health Statistics

African American Males		Total deaths 145,726	American Indian/Alaska Native Males		Total deaths 6,091
Diseases of the heart		37,528	Diseases of the heart		1,302
Malignant neoplasms (all cancers)		32,839	Malignant neoplasms (all cancers)		949
Unintentional injuries		8,709	Unintentional injuries		888
Cerebrovascular diseases		7,891	Diabetes mellitus		323
Assault (homicide)		6,204	Chronic liver disease and cirrhosis		299
Human immunodeficiency virus (HIV)		5,476	Cerebrovascular diseases (stroke)		236
Diabetes mellitus		4,759	Suicide		232
Chronic lower respiratory diseases		4,502	Chronic lower respiratory diseases		197
Nephritis, nephrotic syndrome, nephrosis (kidney diseases)		3,010	Pneumonia and influenza		147
Certain conditions originating in the perinatal period		2,909	Assault (homicide)		178
Asian/Pacific Islander Males		Total deaths 18,345	Hispanic Males		Total deaths 58,005
Diseases of heart		5,160	Diseases of heart		13,554
Malignant neoplasms (all cancers)		4,636	Malignant neoplasms (all cancers)		10,670
Cerebrovascular diseases		1,490	Unintentional injuries		6,572
Unintentional injuries		978	Cerebrovascular diseases		2,808
Chronic lower respiratory diseases		715	Assault (homicide)		2,399
Diabetes mellitus		523	Diabetes mellitus		2,336
Suicide		468	Chronic liver disease and cirrhosis		2,144
Pneumonia and influenza		463	Chronic lower respiratory diseases		1,547
Nephritis, nephrotic syndrome, nephrosis (kidney diseases)		296	Human immunodeficiency virus (HIV)		1,507
Assault (homicide)		229	Suicide		1,429

Only the top ten leading causes of death are shown - total death numbers include all causes of death.

Organizations

American Heart Association

National Center
7272 Greenville Avenue
Dallas, TX 75231
800-AHA-USA1
<http://www.americanheart.org>

Asian Pacific Partners for Empowerment and Leadership (APPEAL)

439-23rd Street
Oakland, CA 94612
510-272-9536
<http://www.APPEALforcommunities.org>

Institute for Responsible Fatherhood and Family Revitalization

National Office
9500 Arena Drive, Suite 400
Largo, MD 20774
800-7-FATHER (800-732-8437)
301-773-2044
301-773-4298 Fax
<http://www.responsiblefatherhood.org/>

Tobacco Educational Clearinghouse of California

P. O. Box 1830
Santa Cruz, CA 95061
831-438-4822

The Urban Fathering Project

P. O. Box 413888
Kansas City, MO 64141
913-384-4661
913-384-4665 Fax
<http://www.fathers.com/urban/>

Washington Asian Pacific Islander Family's Against Substance Abuse (WAPIFASA)

606 Maynard Avenue South
Suite 106
Seattle, WA 98104
206-223-9578

New HRSA Publication Focuses on Improving Cultural Competency

HRSA offers a new tool to help health care professionals become more culturally and linguistically competent in the delivery of health care to individuals and families from diverse backgrounds.

Called *Cultural Competence Works*, the publication shows that practicing cultural competence—the set of behaviors, attitudes, skills and policies that help organizations and staff work effectively with people of different cultures—can help expand and improve access to quality health care.

For a hard copy of Cultural Competence Works, go to the HRSA Information Center at <http://www.ask.hrsa.gov> or call 1-888-Ask-HRSA.

African American Health Publications

The following publications are each available in single, limited quantities through the Office of Minority Health Resource Center: *The Black Man's Guide To Good Health*, *The Heart of the Matter: The African American's Guide to Heart Disease, Heart Treatment, and Heart Wellness*, and *Managing Cancer: The African American's Guide to Prevention, Diagnosis and Treatment*.

For more information, contact OMHRC via e-mail at communications@omhrc.gov or call 800-444-6472.

The Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health is a comprehensive look at the multicultural LGBT community. Coordinated by the Gay and Lesbian Medical Association (GLMA), it is written by and for health care consumers, providers, researchers, educators, government agencies, schools, clinics, advocates, and health professionals in all settings. Based on HHS's Healthy People 2010, GLMA's document examines and makes recommendations in the following areas: quality health services, mental health, public health infrastructure, HIV, immunization and infectious diseases, tobacco, injury and violence prevention, and substance abuse.

For more information, go to the Gay and Lesbian Medical Association's web site at <http://www.glma.org/policy/hp2010>

Reducing Tobacco Use: A Report of the Surgeon General (2000) calls for the widespread use of approaches and methods that have proven to be effective in substantially reducing the number of people who will become addicted to nicotine: increasing the success rate of young people and adults trying to quit tobacco use; decreasing nonsmokers' exposure to environmental tobacco smoke; re-

ducing disparities related to tobacco use and its health effects among different population groups; and decreasing the future health burden of tobacco-related disease and death.

For more information, call 770-488-5705 or go to http://www.cdc.gov/tobacco/sgr_tobacco_use.htm

What You Need To Know About...Colon and Rectum Cancer is a booklet that provides information on the symptoms, detection and diagnosis, and treatment, in addition to information on possible causes and prevention of cancers of the colon and rectum. *For more information, go to the National Cancer Institute's CancerNet at http://cancer.net.nci.nih.gov/wyntk_pubs/colon.htm*

What You Need To Know About...Prostate Cancer is a booklet that mentions some possible causes of prostate cancer. It also describes symptoms, diagnosis, treatment, and followup care. It has information to help men with prostate cancer and their families cope with the disease. *For more information, go to the National Cancer Institute's CancerNet at http://cancer.net.nci.nih.gov/wyntk_pubs/prostate.htm*

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Public Health and Science
Office of Minority Health Resource Center
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Conferences: 2001

October 21-25, 2001

129th American Public Health Association Annual Meeting, *"One World: Global Health,"* Atlanta, GA. For more information, go to <http://www.apha.org>, or call 202-777-2479.

October 26-28, 2001

Asian Pacific American Medical Student Association National Conference, New York School of Medicine, New York, NY. For more information, go to <http://www.apamsa.org> or call 718-828-1254.

November 9-10, 2001

National Hispanic Council on aging 8th Biennial Conference, *"Luminarias: Celebrating our Elders,"* Patriotic Hall, Los Angeles, CA. For more information, go to <http://www.nhcoa.org>, or call 202-265-1288.

November 12-14, 2001

American Heart Association Scientific Session 2001, Anaheim Convention Center, Anaheim, CA. For more information, go to <http://www.americanheart.org>, or call 214-706-1575.

December 2-5, 2001

North American AIDS Treatment Action Forum 2001, Sheraton Vancouver Wall Center Hotel, Vancouver, Canada. For more information, go to <http://www.nmac.org>, or call 202-483-6622.

January 17-19, 2002

Families USA *"Health Action 2002,"* Mayflower Hotel, Washington, D.C. For more information, go to <http://www.familiesusa.org> or call 202-628-3030.