HEALTH PROBLEMS AMONG AFRICAN AMERICAN WOMEN AGE 35-64 IN ALLEGHENY COUNTY

A BLACK PAPER FOR THE URBAN LEAGUE OF PITTSBURGH

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Trista N. Sims, MPH
University Center for Social and Urban Research
University of Pittsburgh

Ralph Bangs, PhD, Research Associate
University Center for Social and Urban Research
University of Pittsburgh

Ken Thompson, MD
Associate Professor of Psychiatry
Soros Foundation Physician Advocate Fellow/Consumer Health Coalition
University of Pittsburgh

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Esther L. Bush
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Richard Benfer, MPH
University of Pittsburgh Medical Center Health System

Bruce Dixon, MD
Allegheny County Health Department

Pamela D. Dodge, RN and MSN
Magee-Womens Hospital

Angela F. Ford, MSW and LSW
Center for Minority Health
University of Pittsburgh

Rachel A. Freund, BS
United Way of Allegheny County

Ebony Hughes, RN
Magee-Womens Hospital

Karen Sampson Johnson, JD
Urban League of Pittsburgh

Prisca M. Moeti, MS PT
University of Pittsburgh

Mary Phan-Gruber, MSW
Birmingham Foundation

John Pierce, PhD
Allegheny County Department of Human Services

Velma P. Scantlebury, MD, FACS
University of Pittsburgh Medical Center Health System

P. Max Simms, MSW
Allegheny County Health Department

Eileen O. Smith, RN
Injury Prevention Coordinator
PA Department of Health

Stephen Thomas, PhD
Center for Minority Health
University of Pittsburgh

Margaret L. Watt-Morse, MD and MPH
University of Pittsburgh/Magee-Womens Hospital

EXECUTIVE SUMMARY

Introduction

This is the third report in a series of "Black Papers" for the Urban League of Pittsburgh. These three papers analyze health disparities by race in Allegheny County (referred to as "the County" for the remainder of the report). Since the social and economic status of African Americans in the County is among the worst in the United States[1] and a high percentage of African American adults and children are living in poverty in the County,[2] one would expect serious health problems to exist among local African Americans.

The first report provided an overview of the health problems of African Americans in the County. One of the major findings of this report was the significant disparity of chlamydia and gonorrhea cases observed among African American adolescents in the County. Due to these findings, the second report focused on sexually transmitted diseases (STDs) and suggested local actions to address this problem among young African Americans.

This third report examines chronic and acute diseases that are the leading causes of morbidity and mortality among African American women age 35 to 64 in the County. We found that local data were available for this demographic group for the following chronic and acute diseases: heart disease, cancer (lung cancer, colorectal cancer, breast cancer), cerebrovascular disease, all injuries (unintentional and intentional), diabetes mellitus, chronic obstructive pulmonary disease (COPD), influenza/pneumonia, gonorrhea, chlamydia, and AIDS. We focused on middle-aged African American women because this population has higher mortality and morbidity rates than white women within the same age group and the health problems of this group appear to have received less attention than the health problems of African American children or older women.

The first section examines the health conditions and trends of African American women versus white women age 35 to 64 in the County and selected areas within the County. For the purpose of this paper, a critical health problem among African American females is assumed to be an African American female disease ratio that is at least 30 percent greater than the rate for white females. The standard of 30 percent was used as a rule of thumb to identify the priority problems and to avoid the difficulty of calculating statistical significance for every race and age group, every geographic area, and every time period. Thirty percent represents a substantial difference that would not usually be due to chance.

The 30 percent standard was applied to the ratio of black and white average rates for the last five years of data and to the current black female rate in the County compared to black female rates in Pennsylvania and the US. Also, change in average black rates from the previous five-year period to the current five-year period and change in black-white ratios over the two five-year periods were utilized to determine trends in the County. In addition, health disparities were examined in four sub-county areas: the South Side, Uptown and Oakland, East End, and McKeesport and Mon Valley. These four areas were

chosen because they possess a large African American population and have been targeted by local organizations to address health disparities.

Note that the goals in Healthy People 2010 could not be used in this report to identify health problems since Healthy People 2010 does not contain information for the specific race, gender, and age group analyzed in this report (Healthy People 2010 is a comprehensive, nationwide health promotion and disease prevention agenda which contains 467 objectives designed to serve as a road map for improving the health of all people in the US during the first decade of the 21st century)[3].

The second section focuses on the national risk factors for the specific diseases listed above among African American women age 35 to 64. There is a direct relationship between health status and associated risk factors and examining this on a national level can be helpful in addressing the significant health disparities in the County.

The third section contains examples of local programs that focus on heart disease, stroke, diabetes, cancer, HIV/AIDS and other STDs. Also, this section contains a summary of formally evaluated programs that were aimed at least in part at African American women age 35-64. Evaluations were found for programs that addressed cardiovascular diseases, diabetes mellitus, breast cancer, and HIV/AIDS and STDs.

Findings

This report finds that in the County, Pennsylvania, and the US, African American women age 35-64 have higher morbidity and mortality rates due to various chronic and sexually-transmitted diseases than that of white women within the same age group. For the County and the four sub-county areas studied, we find that deaths from cancer and from heart disease are the most serious problems among the ten leading causes of death for African American women age 35-64. The most serious mortality and morbidity problems among African American women age 35 to 64 in the County are:

- Heart disease and stroke in the age group 35 to 44 – according to black-white disparities in the County
- Gonorrhea and chlamydia in the age group 35 to 54 – according to black-white disparities in the County
- Lung cancer and stroke in the age group 35 to 44 – according to black rates in the County compared to black rates in Pennsylvania and the US
- Heart disease in the age group 35 to 44 – according to the data on change in black rates from the prior five years to the most recent five years
- COPD in the age group 55 to 64 – according to the data on change in black rates from the prior five years to the most recent five years
- Heart disease in the age group 35 to 44 – according to change in black-white disparities from the prior five years to the most recent five years
- Diabetes in the age group 45 to 54 – according to change in black-white disparities from the prior five years to the most recent five years

While inadequate health care, lack of access to health care, lack of awareness, distrust of the health care system, and cultural and religious beliefs may have attributed to racial health disparities in the County, socioeconomic status (SES) and racial and gender bias plays a significant role in the health status of middle-aged African American women. Therefore, these issues must be taken into account when designing effective interventions aimed at reducing risk factors associated with these diseases.

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INTRODUCTION

This is the third report in a series of "Black Papers" for the Urban League of Pittsburgh. The first report provided an overview of the health problems of African Americans in Allegheny County. One of the major findings of this report was the significant disparity of chlamydia and gonorrhea rates observed among African American young adults in Allegheny County. Due to these findings, the second report focused on sexually transmitted diseases (STDs) and suggested local actions to address this problem among the target population.

This report examines the leading causes of morbidity and mortality among African American women age 35 to 64 in Allegheny County. We focused on middle-aged African American women because this population has higher mortality and morbidity rates than white women within the same age group and the health problems of this group appear to have received less attention than the health problems of African American children or older women.

The diseases examined are:

- Heart disease
- Cancer
  - Lung cancer
  - Colorectal cancer
  - Breast cancer
- Cerebrovascular disease
- All injuries
  - Unintentional injury
  - Intentional injury
- Diabetes mellitus
- Chronic obstructive pulmonary disease (COPD)
- Influenza/pneumonia
- Gonorrhea
- Chlamydia
- AIDS

The diseases will also be examined in four sub-county areas. These areas were chosen because they possess a large African American population and have been targeted by local organizations to address health disparities. The areas are:

- South Side
- Uptown and Oakland
- East End
- McKeesport and the Mon Valley

Also, national risk factors strongly associated with the diseases listed above will be discussed. In addition, a summary of formally evaluated programs as well as local programs aimed at reducing the incidence and/or prevalence of certain diseases among this target population will be provided.

HEALTH CONDITIONS AND TRENDS

This section examines current health conditions and trends of African American women age 35 to 64 in Allegheny County and selected areas within the County. Four methods were used to determine which health conditions and trends represent critical problems in the County. First, racial disparities in health conditions in the County were calculated by dividing the African American female rate for a health condition by the white female rate for the same health condition. When the local African American female rate exceeded the local white female rate by 30 percent or more, that particular health condition was considered a critical problem among African American females. This standard was also used to determine critical problems among specific age groups of African American females. The standard of 30 percent was used as a rule of thumb to identify the priority problems and to avoid the difficulty of calculating statistical significance for every race and age group, every geographic area, and every time period. Thirty percent represents a substantial difference that would not usually be due to chance.

Second, the current black female rate in the County was compared to that of Pennsylvania and the US. When the local African American rate exceeded the state or US African American rate by 30 percent or more, that particular health condition among African American females in the County was considered a critical problem. This also was used to determine critical problems among specific age groups.

Third, average rates for African American females in the County during the last five years were compared to average rates from the prior five years to determine trends. If a health condition was a critical problem for African American females in the County according to the above criteria and if local rates stayed the same or increased substantially (with the same level of surveillance or testing), then this lack of improvement was considered a problem.

Fourth, the black-white female ratios from the last five years were compared to those of the prior five years to determine trends. If ratios stayed the same or increased substantially, then this lack of improvement was considered a problem.

In order to determine health problems within the four sub-county areas, the number of cases during the last five years is shown for each cause of death in each area. It was not possible to calculate rates per population because population counts for African American females in neighborhood areas had not been released for the 2000 Census at the time of this publication.

Black-White Female Health Disparities in Allegheny County (Tables 1-13)

According to the black-white ratios, the critical health problems among African American middle-aged women in the County are:

For ages 35-44 in the County during 1994-1998

- The death rate for heart disease among African American females was 5.4 times the rate of white females
- The death rate for all types of cancers among African American females was 2.0 times the rate of white females
- The death rate for lung cancer among African American females was 2.7 times the rate of white females
- The death rate for breast cancer among African American females was 1.9 times the rate of white females
- The death rate for stroke among African American females was 5.3 times the rate of white females
- The death rate for unintentional injuries among African American females was 2.6 times the rate of white females

For ages 35-44 in the County

- The morbidity rate for gonorrhea among African American females during 1995-1999 was 29.2 times the rate of white females
- The morbidity rate for chlamydia among African American females during 1996-1999 was 15.6 times the rate of white females

For ages 45-54 in the County during 1994-1998

- The death rate for heart disease among African American females was 3.4 times the rate of white females
- The death rate for all types of cancers among African American females was 1.3 times the rate of white females
- The death rate for breast cancer among African American females was 1.3 times the rate of white females
- The death rate for stroke among African American females was 1.9 times the rate of white females
- The death rate for unintentional injuries among African American females was 2.3 times the rate of white females
- The death rate for diabetes among African American females was 4.8 times the rate of white females

For ages 45-54 in the County

- The morbidity rate for chlamydia among African American females during 1996-1999 was 25.1 times the rate of white females

For ages 55-64 in the County during 1994-1998

- The death rate for heart disease among African American females was 1.9 times the rate of white females
- The death rate for lung cancer among African American females was 1.4 times the rate of white females
- The death rate for stroke among African American females was 2.7 times the rate of white females
- The death rate for diabetes among African American females was 3.6 times the rate of white females
- The death rate for COPD among African American females was 1.4 times the rate of white females

Comparison of Black Female Rates in the County, PA, and US (Tables 1-13)

Black female rates in the County compared to rates in the state and nation show that the critical health problems of African American females age 35 to 64 in the County are:

For ages 35-44 during 1994-1998

- The death rate for heart disease among African American females in the County was 1.5 times the rate in the US and 1.3 times the rate in PA
- The death rate for lung cancer among African American females in the County was 2.1 times the rate in the US and 1.6 times the rate in PA
- The death rate for stroke among African American females in the County was 2.2 times the rate in the US and 1.3 times the rate in PA

For ages 45-54

- The death rate for diabetes among African American females in the County during 1994-1998 was 1.4 times the rate in the US and 1.5 times the rate in PA
- The morbidity rate for chlamydia among African American females in the County during 1996-1999 was 1.3 times the rate in the US

For ages 55-64 during 1994-1998

- The death rate for lung cancer among African American females in the County was 1.5 times the rate in the US
- The death rate for stroke among African American females in the County was 1.4 times the rate in the US
- The death rate for COPD among African American females in the County was 1.5 times the rate in the US and 1.3 times the rate in PA

Comparison of Black Female Rates in the Current Five Years to Rates in the Prior Five Years (Tables 1-10)

The health conditions that did not have a decrease in death rates from 1989-1993 to 1994-1998 among African American females ages 35 to 64 in the County are:

For ages 35-44

- The heart disease death rate increased by 57%
- The unintentional injury death rate increased by 11%

For ages 45-54

- The heart disease death rate increase by .07%
- The diabetes death rate increased by 25%

For ages 55-64

- The stroke death rate increased by 12%
- The diabetes death rate increased by 11%
- The COPD death rate increased by 41%

Comparison of Black-White Female Rates in the Current Five Years to Rates in the Prior Five Years (Tables 1-10)

The health conditions that did not have a decrease in black-white ratios of death rates from 1989-1993 to 1994-1998 among African American females ages 35 to 64 in the County are:

For ages 35-44

- The heart disease ratio increased from 2.8 to 5.4
- The breast cancer ratio increased from 1.5 to 1.9

For ages 45-54

- The heart disease ratio increased from 2.7 to 3.4
- The breast cancer ratio remained the same at 1.3
- The diabetes ratio increased from 3.3 to 4.8

For ages 55-64

- The breast cancer ratio increased from 1.1 to 1.2
- The diabetes ratio increased from 3.5 to 3.6
- The COPD ratio increased from .93 to 1.4

Black Female Deaths in Selected Sub-County Areas (Tables 14-25)

According to number of deaths among African American women age 35 to 64 during 1994-1998, the most serious health problems in all four of the sub-county areas are:

- Cancer
- Heart disease

NATIONAL RISK FACTORS

This section examines risk factors for the 13 diseases listed above that are prevalent among African American women age 35 to 64 in the US. There's a direct relationship between health status and associated risk factors and examining this on a national level can be helpful in addressing the significant health disparities in the County.

Heart Disease

The primary risk factors that are associated with heart disease and are the most prevalent among black women include: tobacco use, obesity, diabetes, hypertension, insufficient physical activity, poor nutrition, and socioeconomic status (SES).[4,5] Other underlying factors which may have contributed to poor health outcomes among black women are genetics, distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, and racial and gender bias.[6]

Another risk factor that has been examined is geographic location. According to CDC's new maps of heart disease death rates among US women 35 and older, a woman's risk of dying from heart disease may largely depend on where she resides. Counties with the highest death rates among African American women were found to be in the rural South including the Mississippi River Valley and Delta regions. Also, a band of high-rate counties were seen across Alabama, Georgia, South Carolina and pockets of high-rate counties were scattered throughout the Midwest, Northeast, and parts of Texas and Oklahoma. Counties with lower heart disease death rates for African American women were found to be in the western and southwestern states of Washington, Nevada, and New Mexico, but also throughout the Midwest, Northeast, Mid-Atlantic states, and Florida. Also, it was found that African American women in Hawaii were least likely to die from heart disease.[7]

Lung Cancer

Generally, lung cancer death rates have been much lower for African American women than for African American men, but may be slightly higher than those for white men and women. This pattern has been suggested to reflect historically lower smoking prevalences among women in comparison to men and has risen more slowly with age in the older birth cohorts. For example, as rates for men began to decline in cohorts born after 1930, rates continued to rise among women, reflecting their slower adoption and increasing

prevalence of cigarette smoking. African American and white women have indicated similar patterns of smoking initiation, maintenance, and quitting, which has reflected similar mortality rates between the two.[8]

The primary risk factor for lung cancer among all races is cigarette smoking. Risk has been shown to increase with the number of cigarettes smoked, the duration of smoking, an earlier age at onset of smoking, degree of inhalation, the tar and nicotine content, and the use of unfiltered cigarettes. Exposure to second-hand smoke, radon, and occupational exposures (i.e., asbestos, chloromethyl, polycyclic aromatic hydrocarbons, chromium, nickel, and inorganic arsenic) have also been shown to increase lung cancer risk.[9]

Other underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, inadequate screening and treatment, and racial and gender bias.[6]

Colorectal Cancer

Colorectal cancer is the third most common cancer in African American women following breast and lung cancers.[10,11] African American women are at a higher risk than white women for acquiring the disease.[12] Also, they are more likely to die from this disease than any other racial or ethnic group in the US.[13]

The disparity between black and white women may be attributed to the lack of early detection among black women.[12] However, other underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, inadequate screening and treatment, and racial and gender bias.[6]

The major risk factors associated with colorectal cancer among all races and gender include inflammatory bowel disease, a family history of colorectal cancer or colorectal polyps, and certain hereditary syndromes. Additional conditions that have contributed to increased risk include a history of colorectal cancer or polyps, or ovarian, endometrial, or breast cancers. Lack of regular physical activity, low fruit and vegetable intake, a diet low in fiber and high in fat, obesity, and alcohol consumption are possible additional risk factors.[11]

Breast Cancer

The two most established risk factors for breast cancer in all women are a personal history of breast, endometrial, or ovarian cancer and a family history of breast cancer. Even though only 1 to 5 percent of breast cancer is hereditary, there is an increased risk among women whose close relatives have had breast cancer. Also, women who are diagnosed at an earlier age have been found to be more likely to have a hereditary basis to their cancer.

For African American women, there has been recent identification of genetic mutations linked to early onset breast cancer, which may explain at least part of the disparities that exist between black and white women.[9] Underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, inadequate screening and treatment, and racial and gender bias.[6]

Other established risk factors found in all women include age and gender. The risk of breast cancer increases with age and 50 percent of women who get breast cancer have no identifiable risk factors beyond gender and age. Also, as many as 70 percent of women diagnosed with breast cancer may not have any identifiable risk factors. In addition, breast cancer is 100 times more common among women than men. Higher SES, never being married, exposure to high doses of ionizing radiation, certain breast tissue abnormalities, and factors related to reproductive history such as early onset of first menarche, late onset of menopause, and late age or first full-term pregnancy or nulliparity have contributed to the development of breast cancer. The effects of alcohol consumption, oral contraceptive use, postmenopausal estrogen therapy, diet, and pesticide exposure are still being considered.

In addition, research has shown that breast cancer mortality rates vary by geographic region for black and white women. For example, between 1950 and 1980, the highest breast cancer death rates for both races were found in the urban areas of the New England and Mid-Atlantic regions, although the north-south differences diminished over this period. High rates for postmenopausal white females were concentrated in the urban areas of the northeastern states, but much of this excess could be explained by regional differences of recognized risk factors and premenopausal rates varied little by region. A comparison of the age-specific and age-adjusted maps for 1988 to 1992 showed that the higher age-adjusted rates in the northeast are still predominantly due to geographic differences among older white women. High rates among black females appeared to be scattered across the southern states for both younger and older age groups.[9]

Stroke

The primary risk factors associated with stroke which are the most prevalent among African American women include high blood pressure, diabetes, and obesity. Researchers have found that African American women had the greatest number of these risk factors than the other racial groups and were at a much greater risk of early death compared with women without these conditions. Other studies have speculated that SES and lifestyle may play a role in the increased risk factors due to poverty.[14] In addition, age, smoking, gender, cholesterol levels, and depression are other risk factors associated with stroke among African American women.[15]

Underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, inadequate screening and treatment, and racial and gender bias.[6]

All Injuries

There are two types of injuries: unintentional and intentional (intentional injuries can be self-inflicted or a result of assault). Deaths due to all injuries can result from: drowning, natural or environmental causes, fires, suffocation, poisoning, falls, motor vehicle accidents, firearms, suicide, homicide, spousal abuse, child abuse, elderly abuse, etc.[16] The risk of sustaining a fatal injury increases with exposure to potentially fatal materials such as poisonous substances, or events such as a dangerous work environment. Also, the use of alcohol is a risk factor contributing to drowning and motor vehicle crashes.[9]

While overall injury rates may be lower in females, the risks of certain types of injuries may approach and even exceed those for males for particular age and other demographic (age, race, ethnicity) groups.[16] For example, the very young and males are more prone to unintentional injuries due to high-risk behavior.[9] Younger women are more at risk for nonfatal poisonings and spousal abuse.[16] Elevated death rates among elderly women have been attributed to diminishing physical capacity, which can lead to a higher frequency of accidents (i.e., falls), a higher likelihood of sustaining an injury in the accident, and a greater difficulty recovering from the injury.[9,16] In addition, women, children, and the elderly are most at risk for physical abuse.[16]

The highest unintentional injury death rates are seen in the East South Central region for whites and the South Atlantic-South region for blacks, with scattered high-rate areas in the western States. Rates are also higher in rural than in urban areas.[9]

Diabetes

Research has suggested certain risk factors for diabetes in African American women. For instance, genetic predisposition and higher rates of obesity have been found to play a role in the development of both noninsulin and insulin-dependent diabetes mellitus. African American women between the ages of 25 and 74 have been found to be more overweight compared to white women of the same age group. Also, the location of body fat plays a role in the risk for African American women. Women who have most of their body fat in the abdominal area are more at risk for diabetes than women who carry their weight on their hips and buttocks. Another risk factor is the lack of physical activity. The NHANES III survey found that 67 percent of black women reported that they participated in little or no leisure time physical activity.[17]

Several other factors have influenced the increasing burden of Type 2 diabetes in the African American female population such as improper nutrition, demographics (aging, population growth), ascertainment, culture or community traditions, social or economic factors, nature of chronic diseases, scientific breakthroughs, the health system (including

health care professionals), and individual behavior in community settings.[18] Also, underlying factors which may have contributed to poor health outcomes among black women are lack of awareness, language barriers, and racial and gender bias.[6]

Also, research has shown that there may be particular geographical regions that contain the lowest and highest death rates. For example, death rates among whites are highest in the Mid-Atlantic and East North Central states, southern Texas, and New Mexico. Rates among blacks have been found to be highest along the Gulf and south Atlantic coasts.[9]

Chronic Obstructive Pulmonary Disease (COPD)

The most prevalent risk factors among all racial and ethnic groups for COPD are cigarette smoking and coal dust exposure. Other suggested risk factors include occupational dust and fume exposures, childhood lung disease, passive cigarette smoke exposure, prenatal cigarette smoke exposure, and low SES as related to poor housing. Familial aggregation of COPD has been noted, but it has not been made clear whether this is due to genetic predisposition or to shared environmental factors, such as dust or passive smoking.[9]

Underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, inadequate screening and treatment, and racial and gender bias.[6]

Age-adjusted death rates are highest in the Mountain regions for whites and the South Atlantic regions for blacks. Rates have been seen to also be higher in other areas depending on race, sex, and age.[9]

Influenza/Pneumonia

The risk factors for acute pneumonia infection among all ages and race include disruptions of the natural pulmonary host defense mechanisms such as cigarette smoke, preexisting diseases, alcohol, certain medical procedures bypassing the upper airways, and some prescribed medications. Secondary bacterial pneumonia most commonly occurs among persons ages 65 and older who have a chronic disease. Both types of pneumonia can occur as a complication of influenza. Persons at a greater risk for death due to pneumonia and influenza are infants, older persons, and those with preexisting diseases. Although persons with HIV infection are at a higher risk for developing and dying from pneumonia, these deaths may be coded to HIV infection as an underlying cause of death.[9]

Underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, barriers to accessing adequate health care, inadequate screening and treatment, and racial and gender bias.[6]

Rates are high in the East South Central states for older whites. In particular, rates are high in the Pacific region for older white females and in the South Atlantic-North region

for older white males. Rates for blacks and whites have been seen in several Pacific and Mountain-South states, particularly for the younger age group. Research has also shown no elevated rates in the western region, but rates of death due to HIV infection are high in several of these states.[9]

Gonorrhea and Chlamydia

Risk factors associated with gonorrhea and chlamydia among all African American women include living in poverty, access to quality health care, health care seeking behaviors, illicit drug use, and living in communities with a high prevalence of STDs. Other factors contributing to the disparity between African American and white females is reporting bias. Surveillance data are based on cases of STDs reported to state and local health departments. In many areas, reporting from public sources, for example STD clinics, is more complete than reporting from private sources. Since African Americans are more likely to seek care in public clinics that report STDs, this may lead to a reporting bias.[19,20]

Underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, inadequate screening and treatment, and racial and gender bias.[6]

AIDS

In 1996, an estimated 6,750 African American women in the US were diagnosed with AIDS. Of these, 53 percent (3,620) were among women infected heterosexually and 43 percent (2,910) were attributed to injection drug use (IDU). Over the last decade, AIDS incidence among African American women increased most dramatically among women infected heterosexually. Prior to the impact of treatment, AIDS incidence in African American women infected heterosexually was increasing at a rate between 15 percent to 30 percent. In 1996, this increase continued, but slowed slightly to an increase of 11 percent. AIDS incidence among African American women infected through IDU also increased over the decade, but at a rate of approximately 10 percent to 20 percent each year. In addition to the direct impact of IDU on the spread of AIDS among African American women, IDU also contributes to the heterosexual spread of the epidemic in these women. A large proportion of African American women infected heterosexually are infected through sex with a male IDU.[21]

Common ways of acquiring HIV infection are having unprotected sex with multiple partners or those with HIV, sharing needles and/or syringes used in IDU, blood transfusions, or pregnant women with HIV can give it to her baby during childbirth or while breastfeeding. Several factors have contributed to the increasing AIDS epidemic among African American women. One factor is the structure of the female genital tract in which women run a higher risk of contracting the AIDS virus from a man then men do from women. Also, Black women who have unprotected sex with men who have sex with

men increase their risk of acquiring HIV. The disease is increasingly transmitted through heterosexual activity and is claiming the lives of African Americans at an alarming rate.[22]

Underlying factors which may have contributed to poor health outcomes among black women are distrust of the health care system, lack of awareness, cultural differences, religious beliefs, language barriers, inadequate screening and treatment, and racial and gender bias.[6]

PROGRAMS

Local Programs

As mentioned previously, the most serious health problems in all four of the sub-county areas are cancer and heart disease. Due to this fact, we have listed a few examples of programs that are addressing these serious health problems. However, we are aware that there is a wide array of local programs that are addressing the health problems of middle-aged African American women in the County.

Centers for Healthy Hearts and Souls (CHHS)

Program Goal/Objective: To address the high-risk of cardiovascular disease in the African American community through African American churches by dealing with smoking, fitness and nutrition, and education.

Program Description: CHHS is a self-governed, faith-based community organization that develops and runs programs, manages funds, and participates in evaluation, research, and planning. Funding has been obtained from local hospital systems, local health insurance carriers, the PA Department of Health, and the federal Agency for Healthcare Research and Quality. Four programs are examined: the Smoking Cessation Program, the Healthy Lifestyles Program, the Diabetes Support Program, and the Centers for Healthy Hearts (CHH) Disease Management Program.

> Smoking Cessation Program: A faith-based modification of the FreshStart Plus Program that involves meetings with experts in smoking cessation, a review of best practices, and discussions with health ministry leaders.
>
> Healthy Lifestyles Program: A review of the literature and meetings with local community physical education experts led to the development of fitness activities appropriate for the African American community. Nutritional programming was based on the medically-approved DASH diet and application of eating plan techniques used in behavior modification programs. Health ministry members developed an integrated program of spiritual conditioning. Also, fitness assessment and outcomes monitoring were added to the program. The Healthy Lifestyles Program consists of a women's and men's program. In the first two years, the Women's Healthy Lifestyle Program had almost 6,975 visits to 483 separate sessions in five church locations by nearly 839 people.

Diabetes Support Program: The PA-DOH Grant, "Diabetes in Disparate Populations," began in October 2000 for the development of community and practice-based diabetes interventions.

CHH Disease Management Program: The CHH Disease Management Program involved programs targeting intensified care of hypertension and diabetes. First, a research study conducted in 1997, "Care of Hypertension over 12 Years at an Urban Family Practice Center," characterized practice data on co-morbidity, appointment behavior, visit frequency, continuity of care, medication use, and blood pressure control. A second study, "Care of Hypertension over 5 Years at an Urban Academic and at a Community Family Practice Center," compared data in two large practices serving the East End. As a result, lack of continuity of care emerged as the most important deficiency in care. The program involved an automated record at the UPMC practices (Shadyside FHC and East End FHC) that was modified to display blood pressure trends and to remind doctors of desired care intervals. Charts at the East Liberty Family Healthcare practice were provided with "hypertension" labels as the sole intervention. Also, patients at the UPMC practices were reminded of lapsed care by telephone call or letter if they were not seen in the prior three months. Transportation assistance, help with obtaining medications, and care advice were offered at each telephone contact. After two years, statistically significant improvements in continuity of care were demonstrated and data on blood pressure control is still being analyzed.

Target Population: Middle-aged African Americans in the East End area, but it doesn't exclude whites.

Target Setting: Programs are marketed to over 12,000 congregants from member churches, but also to the community at-large through leaflets, billboards, health fairs, TV and radio spots, and pamphlets at health care centers. Currently, five churches have part-time church program leaders who coordinate health programs and provide liaison between their health ministries and the CHHS administration.

Evaluation Methods: The Smoking Cessation Program disseminated a congregational survey to over 750 people in which the risks of smoking and its effects on the life of community members was affirmed. Over 30 facilitators were trained and certified to run smoking cessation groups in cooperation with the American Cancer Society. Over 160 people attended sessions with an initial quit rate of over 40%. Thirty-six percent of program participants had an average follow-up of 387 days.

The Healthy Lifestyles Program conducted a congregational survey of approximately 400 people and this survey demonstrated a need for convenient, inexpensive, low-impact exercise programs for congregants. Also, the program conducted baseline fitness evaluations on 440 women with the average age of late 30's. Most participants were high-risk for body composition and 25% were on medication for cardiovascular, diabetes, or pulmonary conditions. Follow-up fitness evaluations were conducted on 105 women

and there were notable improvements in BMI, flexibility, and strength after at least twelve weeks in the program.

The Diabetes Support Program conducted five focus groups with diabetic members of East End congregations to assess needs and methods. Since January 2001, 26 diabetics have made 115 visits to 12 biweekly support group sessions held at the St. James AME Center for Healthy Hearts.

The CHH Disease Management Program conducted baseline studies which demonstrated a lack of continuity of care for diabetes, but also inadequate attention to patient education and clinical care interventions. An appointment reminder system was developed for diabetics and outcome data remains to be analyzed. Also, an automated reminder system for physicians and patients was implemented to improve the accomplishment of diabetes clinical care goals. Follow-up studies showed improvements of 20% to 400% in the accomplishment of diabetes care tasks. A formal nursing education program was initiated in the UPMC practices and a clinical advice system was added to improve clinical interventions. As a result, use of ACE inhibitors for hypertensive diabetics increased from 76% to 90% in two years.

Contact Information: Mattie Woods, Executive Director
Centers for Healthy Hearts and Souls
100 North Braddock Avenue, Suite 304
Pittsburgh, PA 15208
Phone: (412) 371-3282
Fax: (412) 371-6373
E-mail: centerhhs@aol.com
Web: healthyheartsandsouls.com

Sister-to-Sister Heart Health Project

Program Goals/Objectives: In conjunction with all of the cardiovascular disease (CVD) and stroke programs within the American Heart Association, the mission of the Project is to drastically reduce the number of women who die from CVD and stroke in the state's Western regions by implementing community-based grassroots initiatives designed to educate women and their health care providers about these health conditions. One objective of the Project is to improve the health status of women, especially African American women, through education, empowerment, and awareness of risk factors for CVD and stroke. Another objective is to increase health care provider and employer awareness of heart disease and stroke as it affects women.

Program Description: The Sister-to-Sister Heart Health Project was established by the American Heart Association to address health issues pertaining to CVD and stroke in African American women. The Project offers health education workshops, cardiovascular risk screenings, and conferences. The health education workshop provides information to inform and educate participants regarding the risk factors and warning signs for CVD and stroke. The cardiovascular screenings include completion of a medical history, blood

cholesterol and pressure measurements, carotid bruit detection, pulse taking, and if possible, diabetes testing. Once screened, participants are counseled on their results, given appropriate educational materials, and referred to their health care provider, if indicated. The conferences are a one-day heart health awareness conference for African American women in western Pennsylvania.

Target Population: African American women of all ages

Target Setting: Pittsburgh/Allegheny County

Evaluation Methods: An evaluation was conducted of the 5th Annual Sister-to-Sister Conference in which 410 participants returned the evaluations. Of the 410 participants who returned the evaluations, 210 completed the Behavior Change section. As a result of attending the conference, 61% reported that they will stay informed on new findings in CVD, 63% reported that they will increase physical activity, 60% will employ stress reducing activities into their everyday lives, and 65% reported that they will modify their current eating pattern to include heart healthy choices.

Contact Information: Alice L. Pittrell, Prevention Coordinator/Prevention Initiatives
American Heart Association
10 Duff Road, Suite 304
Pittsburgh, PA 15235
Phone: (412) 243-5393, ext.: 150
Fax: (412) 243-5497
E-mail: apittrel@heart.org
Web: www.americanheart.org

<u>African American Cancer Program</u>

Program Goal/Objective: UPCI is addressing the problems of higher cancer morbidity and mortality in the regional African American population through efforts to increase awareness of cancer prevention and early detection strategies and through the identification and elimination of barriers that prevent African Americans from obtaining access to cancer diagnostic and treatment services.

Program Description: The African American Cancer Program was established by the University of Pittsburgh Cancer Institute (UPCI), UPCI Early Detection and Prevention Services. It focuses on western Pennsylvania's African American population, whose cancer education, diagnostic, and treatment needs often go undetected or unaddressed for a variety of socioeconomic reasons.

Program efforts include the African American Advisory Council, the African American Self-Help Cancer Group (AASHCG), cancer screenings, health fairs, an annual "Celebration of Life" for African American cancer survivors, and the Cancer Awareness coalition (composed of more than 15 health care and community organizations in Allegheny County). The African American Advisory Council was established as a

mechanism by which cancer care information could be acquired by the African American community. The goal is to educate and work in cooperation with community and health care organizations, businesses, and other agencies to stimulate the establishment of community-based cancer education and early detection. The Council was restructured in 1996 to be more reflective of the local population and provides advice regarding reduced barriers to care and how to increase information within this community. AASHCG was established in 1994 and is composed of self-help groups that serve the needs of cancer patients and survivors. The purpose of the group is to provide support and information to African American cancer survivors and their friends and families. The group initially focused on women survivor issues, but now includes both men and women. Also, cancer screenings are offered through the African American Cancer Program free of charge in Homewood, Braddock, Duquesne, and Aliquippa.

Target Population: African Americans

Target Setting: Western Pennsylvania

Evaluation Methods: Not known

Contact Information: Betty Dowdy
University of Pittsburgh Cancer Institute
Behavioral Medicine & Oncology
Suite 405 Iroquois Building
Pittsburgh, PA 15213
Phone: (412) 624-1314
Fax: (412) 647-1936
Web: www.upci.upmc.edu

African American Women's Speakers Bureau (AAWSB)

Program Goal/Objective: To increase breast and cervical cancer awareness and screening among African American women.

Program Description: The African American Women's Speakers Bureau was first organized in February of 1996 by members of the African American Cancer Awareness Coalition (AACAC). The initial purpose of the group was to increase breast cancer screening and early detection practices among African American women. This was accomplished through the implementation of a Community Based Breast Health Education Campaign. One year after the completion of the initial project, members of AAWSB continued to provide breast cancer information and assistance to women interested in obtaining free and reduced cost mammograms. In October, 1997, the group expanded their focus to include information on cervical cancer. In 1998, the focus was expanded again to include information on clinical trials.

The Speakers Bureau provides information on breast and cervical cancer, including information about service providers and opportunities for participation in both treatment and prevention clinical trials.

The Speakers Bureau membership is comprised of African American breast cancer survivors, professional and non-professional health care workers, and community resource people. It is operated and maintained by volunteers who, also, serve as speakers and community resource people. Staff support is provided by the University of Pittsburgh Cancer Institute, Magee Womens Hospital, the National Surgical Adjuvant Breast and Bowel Project (NSABP), and the YWCA ENCOREplus program.

Target Population: African American women

Target Setting: Greater Pittsburgh and surrounding communities

Evaluation Methods: Not known

Contact Information: Derietra L. Neal-Ferguson, President
AAWSB
PO Box 8400
Pittsburgh, PA 15218
Phone: (412) 647-9052
Fax: (412) 647-1936
E-mail: Ferguson@pcicirs.pci.pitt.edu
Web: trfn.clpgh.org/aawsb/mission.html

Black Women and Health Outreach for Longer Life and Empowerment (BWHOLE)

Program Goals/Objectives: To connect black women to health information, resources, support, and sisterhood.

Program Description: BWHOLE provides a monthly Sister Chat forum where women can raise and address issues related to the wholeness and health of black women, maintains a database of resource persons for educational programs and information on women's health, and serves as a repository of programs for health prevention, promotion, and intervention.

Target Population: African American women

Target Setting: Not available.

Evaluation Methods: Not available.

Contact Information: Angela F. Ford, MSW, LSW
Associate Director, Center for Minority Health
Graduate School of Public Health, University of Pittsburgh

130 DeSoto Street, 125 Parran Hall
Pittsburgh, PA 15261
Voice: (412) 624-3402
Fax: (412) 624-8679
Email: afford@cmh.pitt.edu

Giving Incarcerated Females Tangible Support (Gifts Program)

Statement of the Problem: For minority women racial disparities in breast and cervical cancer mortality still exist. Early detection has proven a major component in reducing mortality. At the Allegheny County Jail in Pittsburgh, Pennsylvania, 66% of the incarcerated women are minorities. These women are a frequently forgotten group of women who typically neglect their personal health care needs. This captive audience provides an ideal opportunity to empower women through health education to consider ways of becoming proactive in their own healthcare.

Statement of Purpose: To provide on-site opportunities for women's health support including:

- Breast and cervical health education
- Screening mammograms
- Community linkage after incarceration to free or low cost health screening
- Establish a link to caring and positive role models

Statement of Method:

- Including the prison administration/personnel in strategic development
- Quarterly interactive breast and cervical health promotion presentations
- Culturally appropriate educational materials
- On-site mammography screening
- Information on community resources

Statement of Results: An ongoing support/working relationship with prison personnel an increase awareness of early detection against breast and cervical cancer. With the women population being educated quarterly and resulting in the women being screened on site twice a year with the help and support of the Allegheny General Hospital Mobile Mammography Unit.

Primary organization: GIFTS is a project initiated in 1999 by of the YWCA ENCOREplus program of Greater Pittsburgh, a system of health promotion through education, clinical service delivery, and patient "navigation" and advocacy. This community based program targets women in need of early detection and breast and cervical screening and support services.

Collaborating organizations: GIFTS is done in collaboration with the African American Women's Speakers Bureau. This group includes health educators, cancer survivors, and community activist trained to provide community-based breast and cervical health education. The Mammogram Voucher Program (MVP), which is underwritten by the

Komen Pittsburgh RACE FOR THE CURE, provides mammograms and follow-up diagnostic services to medically under-insured and uninsured women in Western Pennsylvania. The MVP is locally administered by the American Cancer Society, Southwest Region, and Family Health Council, Inc. Allegheny General Hospital Mobile Mammography Unit provides low cost on-site, mammography screening typically under-served communities. Magee Women's Hospital, one of the largest women's hospitals in the United States, with an extensive community outreach and one of the few nationally designated Centers of Excellence in women's health.

Target Population: All women, with special focus on women of color and lesbians.

Contact Information: Yvonne D. Durham, Program Coordinator
YWCA Homewood Brushton
6907 Frankstown Avenue
Pittsburgh, PA 15208
Phone (412) 365-1915
Fax: (412) 361-8601
E-Mail: ydurham@ywcapgh.org

ENCOREplus Program

Program Objectives: To increase breast and cervical cancer awareness and screening among medically underserved women in order to reduce breast and cervical cancer morbidity and mortality. The long-term objective of this program is to provide women with a continuum of care so that breast and cervical screenings are supported as a lifelong habit.

Program Description: The ENCOREplus program is a national program first created by the YWCA of the U.S.A. and introduced to the YWCA of Greater Pittsburgh in October of 1994. The initiative builds upon the YWCA's 20-year history of support for women with breast and/or cervical cancer.

The ENCOREplus program consists of two components. Component 1 provides education and enabling and referral services for breast and cervical cancer screening. Component 2 focuses on post diagnosis support systems for women diagnosed with breast and/or cervical cancer.

The program is funded by the AVON's Breast Care Fund, since 1994 the YWCA has been one of the largest, community-based beneficiary of the proceeds of the Crusade. Our partnerships and collaborations with the University of Pittsburgh Cancer Institute African American Cancer Screening Program enables the staff to link women to no-cost clinical breast exams, pap test screenings and referrals to mammogram screenings. The Mammogram Voucher Program, which is administered by the American Cancer Society which is underwritten by the Komen Pittsburgh Race for the Cure makes it possible for the women to receive vouchers to pay for the mammogram screenings and other diagnostic services.

Community outreach and public education activities (one-on-one, group) to raise awareness and motivate women to adhere to recommended screening guidelines.

Target Population: All women, with special focus on women of color and lesbians.

Contact Information: Yvonne D. Durham, Program Coordinator
YWCA Homewood Brushton
6907 Frankstown Avenue
Pittsburgh, PA 15208
Phone (412) 365-1915
Fax: (412) 361-8601
E-Mail: ydurham@ywcapgh.org

Mental Health Association Of Allegheny County Minority/Community Outreach Program

Program Goals/Objectives: To provide unserved and underserved individuals, primarily minorities, with sufficient information regarding available health services to they may make informed healthcare decisions, particularly behavioral health services.
To empower these individuals to access these services and use them on a consistent basis to enhance their total wellness.

Program Description: The Mental Health Association of Allegheny County's Minority/Community Outreach Program provides education and outreach services to individuals who are utilizing, or may need to utilize various healthcare systems, including the behavioral healthcare systems in Allegheny County. The program uses nontraditional means or outreach and establishes community partnerships with indigenous members of the community as well as community businesses, churches and other organizations. The project uses a holistic approach by providing information about a variety of health related services that could have an impact on the wellbeing of those we reach.

Target Population: The target population is primarily minorities in Allegheny County, particularly women, those on public assistance and those who are either receiving Medicaid or are Medicaid eligible.

Evaluation Method and Results: The program is in the third year of a three year grant and will be evaluated at the end of the three years. The program's goal in Year One was to provide information on available healthcare to 1,000 individuals. Information was actually provided to 1,238. In Year Two the goal was 1,500. Information, education and advocacy services were actually provided to 1,800 individuals. Year Three of the grant was just begun. Because many of the people with work with wish to be anonymous and do not want to give last names, addresses or phone numbers, it is very difficult to follow-up. A component of the project for Year Three will be devoted to designing a follow-up system that reaches more individuals.

Contact Information:

Delores Burgess, Coordinator, Minority/Community Outreach Advocate
Mental Health Association of Allegheny County
1945 Fifth Avenue
Pittsburgh, PA 15219
P: 412.391.3820
F: 412.391.3825
E: dburgess@mhaac.net

Brenda E. Lee, Executive Director
Mental Health Association of Allegheny County
1945 Fifth Avenue
Pittsburgh, PA 15219
P: 412.391.3820
F: 412.391.3825
E: belee@mhaac.net

Formally Evaluated Programs

Through a literature search, this section examines formally evaluated programs aimed at reducing cardiovascular diseases, diabetes mellitus, breast cancer, and HIV/AIDS and STDs. Evaluation studies were either not conducted or are currently in the process of evaluation for the remaining diseases examined.

Baltimore, Maryland - Project Joy

Program Goals/Objectives: To promote the health of African American women through the reduction of cardiovascular health risks.

Program Description: A five-year study conducted by the Prevention Research Center at Johns Hopkins University that commenced in 1995. The program study consisted of 16 moderate size (>250 members) churches. The churches were randomized into one of three interventions including: (1) a spiritually based behavior modification program with individual recommendations, weekly sessions with a health educator for four months and weekly sessions with lay leaders for eight months, (2) a non spiritually based behavior modification program with individual recommendations, weekly sessions with a health educator for four months and weekly sessions with lay leaders for eight months, or (3) a self-help behavior modification program with individual recommendations and no weekly sessions.

Target Population: 529 economically and socially heterogeneous, church-going, African American women aged 40-88 (mean age = 57).

Target Setting: Baltimore City

Methodology: This multiple risk factor cohort study was designed to test a progressive and additive gradient of spiritually based lifestyle interventions to foster smoking

cessation, weight optimization, physical activity, and good nutrition in African American women aged 40 years and older.

Findings: African American women responded well to group support of any kind. A significant number of women made sustained positive changes in eating patterns and body weight and fat, accompanied by positive changes in risk factors, blood pressure and blood lipids. Physical activity was more difficult to construct largely because the women were seriously physically deconditioned. Some were physically limited and had been exposed to years of uncontrolled hypertension and obesity. The strongest predictors of improved eating habits and weight loss were the number of sessions attended and the magnitude of overweight at baseline.

Contact Information: Lisa R.Yanek, MPH
E-mail: lryanek@mail.jhmi.edu

Chicago, Illinois – PATHWAYS

Program Goal/Objective: A study was carried out to test the effectiveness of PATHWAYS.

Program Description: This study was supported in part by a grant to the University of Chicago Diabetes Research and Training Center from the National Institute of Diabetes, Digestive, and Kidney Diseases. PATHWAYS is a weight loss program designed specifically for urban African American women and is administered in urban churches by trained lay facilitators. It was designed specifically to address behavioral and sociocultural factors related to urban African American women. The program consists of 14 sessions conducted on a weekly basis for 1.5 hours each. It is administered in a small group format with almost all content delivered via guided learning activities and small group instruction. Group leaders assist and facilitate the completion of learning activities and very little lecturing is done.

Target Population: 39 obese, African American women

Target Setting: Three urban African American churches

Methodology: After randomization and the collection of baseline data on weight and lifestyle practices, subjects in the experimental group (n=19) were assigned to receive the 14-week weight loss program conducted by trained lay volunteers and the control group subjects (n=20) were put on a waiting list to receive the program at the conclusion of the study period.

Findings: Of the 39 women enrolled, 15 experimental group subjects and 18 control group subjects were available for post-treatment data collection. After completing the program, PATHWAYS participants lost an average of 5 percent of their body weight (10.0 lb), while the control group subjects gained an average of 1 percent of their body weight (1.9 lb). In addition to the primary outcome measures of weight, several

secondary measures of program impact were obtained. Twelve of the experimental group subjects and 16 of the control group subjects completed both baseline and post-treatment measures of waist circumference, eating behavior, and exercise behavior. Waist circumference among PATHWAYS participants decreased 2.5 inches (from 38.2 inches at baseline to 35.7 inches at posttreatment), while the waist circumference among control group subjects remained relatively the same (37.7 inches at baseline to 37.3 inches at posttreatment). Also, PATHWAYS subjects reported a decrease in the amount of high-fat foods eaten at posttreatment over baseline, while control group subjects increased the number of high-fat foods eaten. PATHWAYS subjects reported an increase in the amount of common high-fiber foods eaten, while control group subjects reported a decrease. On the PATHWAYS Weight Loss Behavior Index, PATHWAYS subjects reported an increase in the number of positive eating behaviors and a decrease in the number of negative eating behaviors, while control group subjects reported little or no change in either.

The conclusions of the weight loss program showed that it was effective in producing significant and clinically meaningful weight loss among African American women who often do not benefit from typical weight loss programs. Ongoing research is focusing on whether the weight loss can be maintained or enhanced through monthly reinforcement sessions. Because studies have shown that African American women may be less likely to stay with a diet plan, current plans are to continue monthly PATHWAYS sessions for one year to provide ongoing treatment in an effort to sustain or enhance the level of weight observed in the preliminary phase of the study.

Contact Information: http://www.niddk.nih.gov/health/diabetes/pubs/drtc/

Little Rock, Arkansas - The Witness Project

Program Goal/Objective: To reduce the mortality and morbidity from breast and cervical cancer in the African American population.

Program Description: The Witness Project was established in 1991 by the Arkansas Cancer Research Center, University of Arkansas for Medical Sciences in Little Rock and was initially funded by the Komen Foundation. In October 1997, CDC provided a $1 million, 4-year grant for replicating the program nationwide. It is a culturally competent, community-based, breast and cervical cancer education program through which cancer survivors and lay health advisors increase awareness, knowledge, screening, and early detection behaviors in the African American population.

Target Population: African Americans

Target Setting: Churches and community centers

Methodology: Witness Project programs are presented in churches and community centers by Witness Role Models (WRMs) and Lay Health Advisors. WRMs are African American women who are breast or cervical cancer survivors. Survivors talk about their

cancer experiences to educate other women about the importance of finding cancer early. They are used as positive examples of the effectiveness of early diagnosis and treatment. From 6 to 8 weeks after the initial meeting, witnesses follow up with each woman and help set up mammography appointments. They also help with any barriers to screening such as arranging for transportation and child care. Also, witnesses reach out to men because the program believes that more women will seek screening if the men in their lives are involved. These programs are designed to meet the specific cultural, educational, knowledge, and learning-style levels of medically underserved African American women.

Findings: Intervention research in east Arkansas with 204 African American women demonstrated a significant increase in the practice of breast self-examination and mammography after participation in the Witness Project. These results demonstrated that culturally appropriate cancer education programs were able to change behavior by meeting the beliefs of participants rather than attempting to change their beliefs.

Contact Information: Deborah O. Erwin, PhD, CTR
Associate Director for Education
University of Arkansas for Medical Sciences
ACRC – Cancer Education
Department – Slot 629 A
4301 West Markham
Little Rock, AR 72205
Phone: 1-800-275-1183/ (501) 686-8801
Fax: (501) 686-6479
E-mail: erwindeboraho@exchange.uams.edu

Detroit, Michigan – NJIDEKA; An HIV Intervention Program for African American Women

Program Goal/Objective: To increase effective gender specific, culturally relevant prevention strategies for African American women at risk for acquiring HIV/AIDS.

Program Description: NJIDEKA (Swahili for "Survival is Paramount") was established in 1994 by the Michigan AIDS Foundation, Early Intervention Project at the Michigan Department of Community Health, Bureau of Substance Abuse.

Target Population: African Americans women who are at a high risk for acquiring HIV.

Target Setting: The nine NJIDEKA program sites are located in the Detroit metropolitan area. They include substance abuse treatment facilities, correctional institutions, and youth programs for females.

Methodology: NJIDEKA is a theoretically based intervention program consisting of a ten-week series of HIV empowerment workshops designed to eliminate barriers to HIV risk reduction for African American women. It consists of promoting a sense of self,

dignity, pride, and community; imparting skills that will empower women not only to deal effectively with intra- and interpersonal relationships, but also to better confront or negotiate the social context; and producing group participants who will be a source of social support required to initiate and sustain risk reduction. Women who successfully completed the program received certificates and books of daily meditations or journals. Also, on-site HIV counseling and testing was offered to program participants.

Findings: Evaluation results indicated that NJIDEKA workshop participants had demonstrated significant increases in knowledge about HIV and STDs, a more realistic shift in their perceived vulnerability to acquire HIV, an increase in self reported condom use, and shifts in their levels of readiness to change risk behaviors.

Contact Information: Sandra Cook
HIV/AIDS Programs
Detroit Health Department
1151 Taylor, Room 409C
Detroit, MI 148202
Phone: (313) 745-6903

CONCLUSIONS

Our findings have demonstrated that in Allegheny County, Pennsylvania, and the US, African American women age 35 to 64 have higher morbidity and mortality rates than white women within the same age group. It is important to note that this report deals with illnesses that are reported. There are other illnesses that affect this population that were not mentioned because they are not usually reported. Effective interventions aimed at reducing risk factors associated with these diseases are needed. Effective interventions in the Pittsburgh region could be expanded or effective interventions used in other parts of the US could be applied locally in promoting healthy behaviors, thus reducing risk factors, among the African American female population. For example, the following are recommendations to address this issue: community mobilization, the development of a directory of local health programs for each disease, and supporting and strengthening existing local programs.

REFERENCES

[1]Bangs, Ralph L. and Jun Hyun Hong. "Benchmarks Reports." University Center for Social and Urban Research, University of Pittsburgh. 1994-1996.

[2]Bangs, Ralph L. et al. "Basic Living Cost and Living Wage Estimates for Pittsburgh and Allegheny County." University Center for Social and Urban Research, University of Pittsburgh. June 1997.

[3]Centers for Disease Control and Prevention (CDC). National Center for Health Statistics. "About Healthy People 2010." Available at: http:www.cdc.gov/nchs/about/otheract/hpdata2010/abouthp.htm. Accessed on 6/26/01.

[4] MMWR Weekly. "Age-Specific Excess Deaths Associated With Stroke Among Racial/Ethnic Minority Populations-United States, 1997." Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4905a2.htm. Accessed on 1/17/2001.

[5]Centers for Disease Control and Prevention (CDC). "Chronic Diseases and Their Risk Factors." Available at: http://www.cdc.gov/nccdphp/statbook/pdf/cdrf1999.pdf. Accessed on 1/17/2001.

[6]The Henry J. Kaiser Family Foundation. "A Synthesis of the Literature: Racial & Ethnic Differences in Access to Medical Care." October 1999.

[7]Centers for Disease Control and Prevention (CDC). Office of Communication. "First Atlas of Geographic and Racial and Ethnic Disparities in US Women's Heart Disease Death Rates Released." Available at: http://www.cdc.gov/od/oc/media/pressrel/r2k0216a.htm. Accessed on 1/10/01.

[8] Centers for Disease Control and Prevention (CDC). "Chapter 3 – Health Consequences of Tobacco Use Among Four Racial/Ethnic Minority Groups". Available at: http://www.cdc.gov/tobacco/sgr/sgr1998/sgr-min-pdf/chap3.pdf. Accessed on 3/14/2001.

[9]National Center for Health Statistics. "Monthly Vital Statistics Report." Available at: http://www.cdc.gov/nchs/data/atlasres.pdf. Accessed on 3/14/2001.

[10]American Cancer Society. "Statistics 2000, Cancer Facts & Figures for African Americans, Selected Cancers." Available at: http://www3.cancer.org/cancerinfo/sitcenter.asp?SCDoc=42106&CTID=8&PNT=2&SCS. Accessed on 3/20/2001.

[11]Centers for Disease and Control and Prevention (CDC). "Colorectal Cancer: The Importance of Early Detection." Available at: http://www.cdc.gov/nccdphp/dcpc. Accessed on 3/20/2001.

[12]Allegheny County Health Department. Bureau of Policy Development and Assessment. "Women and Chronic Disease – 25 Year Trends for Allegheny County, Pennsylvania 1970-1995." 1996.

[13]American Cancer Society. "Colorectal Rates Higher in the African American Population." Available at: http://www2.cancer.org/zine/index.cfm?fn=001_04212000_0. Accessed on 3/20/2001.

[14] "OnHealth: Heart Ills, Stroke More Likely to Kill Black Women." Available at: http://onhealth.webmd.com/conditions/briefs/item,33355.asp. Accessed on 3/20/2001.

[15]"OnHealth: Depression Raises Stroke Risk." Available at: http://onhealth.webmd.com/conditions/briefs/item,95308.asp. Accessed on 3/20/2001.

[16]Pennsylvania Department of Health. "Facts & Prevention Strategies: Female Injuries in Pennsylvania." April 1999.

[17]The National Women's Health Information Center. "Diabetes and African American Women." Available at: http://www.4woman.gov/faq/diabetesafrc.htm. Accessed on 3/20/01.

[18]Healthy People 2010 Objectives: Draft for Public Comment. "Diabetes."

[19]Centers for Disease Control and Prevention (CDC). "Tracking the Hidden Epidemics, Trends in STDs in the United States 2000."

[20]Centers for Disease Control and Prevention (CDC). STD Surveillance 1999. "STDs in Racial and Ethnic Minorities."

[21]The National Women's Health Information Center. Health Information for Minority Women – African American Women. "HIV/AIDS." Available at: http://www.4woman.gov/search/minority.cfm?Start=1&ar=false&S1=hiv&min=1. Accessed on 3/21/2001.

[22]Centers for Disease Control and Prevention (CDC). "Trends in the HIV/AIDS Epidemic." 1998.

Table 1. Heart Disease Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998
(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93 N	Rate	Ratio	Allegheny Co. Ave. 94-98 N	Rate	Ratio	PA Ave. 94-98 N	Rate	Ratio	US Ave. 94-98 N	Rate	Ratio
35-44	Black	25	42.5	2.8	43	66.7	5.4	252	53.3	3.9	6,471	45.8	3.5
	White	68	15.0		58	12.3		599	13.8		11,585	13.0	
45-54	Black	55	141.4	2.7	66	141.5	3.4	510	151.3	3.2	13,050	140.0	3.1
	White	170	52.1		154	41.2		1,656	48.0		31,727	45.6	
55-64	Black	156	434.5	2.0	124	373.3	1.9	980	400.4	2.2	23,248	378.0	2.3
	White	713	214.3		567	197.1		4,670	185.1		80,351	166.2	
Total	Black	236	176.5	2.1	233	154.5	2.2	1,742	165.0	2.5	42,769	144.5	2.4
35-64	White	951	85.6		779	68.7		6,925	67.0		123,663	59.6	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 2. Cancer Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998
(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93 N	Rate	Ratio	Allegheny Co. Ave. 94-98 N	Rate	Ratio	PA Ave. 94-98 N	Rate	Ratio	US Ave. 94-98 N	Rate	Ratio
35-44	Black	51	86.6	2.2	49	76.0	2.0	306	64.7	1.5	8,944	63.3	1.6
	White	175	38.7		178	37.7		1,820	41.8		36,510	40.8	
45-54	Black	87	223.6	1.4	85	182.3	1.3	723	214.1	1.6	17,287	185.5	1.4
	White	511	156.7		512	137.0		4,580	132.6		91,508	131.4	
55-64	Black	187	520.8	1.3	149	448.6	1.2	1,206	492.7	1.4	26,527	431.3	1.3
	White	1,329	399.5		1,063	369.5		8,761	347.3		166,411	344.2	
Total	Black	325	243.1	1.3	283	196.1	1.3	2,235	211.7	1.4	52,758	178.2	1.3
35-64	White	2,015	181.4		1,753	154.7		15,161	146.7		294,429	141.9	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 3. Lung Cancer Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998

(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	10	17.0	5.2	10	15.5	2.7	46	9.7	1.8	1,027	7.3	1.5
	White	15	3.3		27	5.7		230	5.3		4,415	4.9	
45-54	Black	18	46.3	1.4	16	34.3	1.1	184	54.4	2.1	3,157	33.9	1.2
	White	110	33.7		115	30.8		914	26.4		19,529	28.0	
55-64	Black	58	161.5	1.6	52	156.6	1.4	341	139.3	1.6	6,366	103.5	1.0
	White	343	103.1		314	109.2		2,258	89.5		49,633	102.7	
Total	Black	86	64.3	1.5	78	54.0	1.3	571	54.1	1.6	10,550	35.6	1.0
	White	468	42.1		456	40.2		3,402	32.9		73,577	35.5	
35-64													

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 4. Colorectal Cancer Death Rate in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998

(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	5	**	**	3	**	**	16	3.4	1.2	634	4.5	1.8
	White	8	**		8	**		120	2.8		2,227	2.5	
45-54	Black	7	**	**	3	**	**	44	13.1	1.4	1,526	16.4	1.8
	White	33	10.1		35	9.4		319	9.2		6,355	9.1	
55-64	Black	16	44.6	1.4	10	30.1	1.0	111	45.3	1.4	2,680	43.6	1.5
	White	108	32.5		87	30.2		827	32.8		13,659	28.3	
Total	Black	28	20.9	1.6	16	11.1	1.0	171	16.2	1.3	4,840	16.4	1.5
	White	149	13.4		130	11.5		1,266	12.2		22,241	10.7	
35-64													

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 5. Breast Cancer Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998
(rates are per 100,000)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	15	25.5	1.5	15	23.3	1.9	117	24.7	1.8	3,347	23.7	1.8
	White	79	17.5		57	12.1		605	13.9		11,822	13.2	
45-54	Black	25	64.3	1.3	25	53.6	1.3	200	59.2	1.5	5,433	58.3	1.6
	White	167	51.2		153	40.9		1,336	38.7		25,871	37.1	
55-64	Black	38	105.8	1.1	29	87.3	1.2	222	90.7	1.4	5,279	85.8	1.3
	White	313	94.1		210	73.0		1,690	67.0		31,722	65.6	
Total **35-64**	Black	78	58.3	1.2	69	47.8	1.3	539	51.1	1.5	14,059	47.5	1.4
	White	559	50.3		420	37.1		3,631	35.1		69,415	33.5	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 6. Stroke Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998
(rates are per 100,000)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	9	**	**	16	24.8	5.3	87	18.4	4.3	1,598	11.3	5.1
	White	15	3.3		22	4.7		189	4.3		1,986	2.2	
45-54	Black	11	28.3	2.4	10	21.4	1.9	112	33.1	3.0	2,930	31.4	4.1
	White	39	12.0		42	11.2		386	11.2		5,299	7.6	
55-64	Black	32	89.1	2.8	33	99.4	2.7	207	84.6	2.7	4,511	73.3	2.8
	White	104	31.3		105	36.5		780	30.9		12,610	26.1	
Total **35-64**	Black	52	38.9	2.7	59	40.9	2.7	406	38.5	2.9	9,039	30.5	3.2
	White	158	14.2		169	14.9		1,355	13.1		19,895	9.6	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 7. Unintentional Injuries Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the U. S., 1989-1998
(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	14	23.8	3.0	17	26.4	2.6	145	30.7	2.4	3,271	23.1	1.5
	White	36	8.0		47	10.0		567	13.0		14,144	15.8	
45-54	Black	2	**	**	13	27.9	2.3	95	28.0	2.1	2,145	23.0	1.5
	White	19	5.8		46	12.3		458	13.2		10,601	15.2	
55-64	Black	3	**	**	9	**	**	61	24.9	1.5	1,486	24.2	1.3
	White	48	14.4		52	18.1		430	17.1		9,115	18.9	
Total **35-64**	Black	19	14.2	1.5	39	27.0	2.1	301	28.5	2.0	6,902	23.3	1.4
	White	103	9.3		145	12.8		1,455	14.1		33,860	16.3	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 8. Diabetes Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the U. S., 1989-1998
(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	6	**	**	3	**	**	37	7.8	2.9	1,021	7.2	2.6
	White	10	2.2		18	3.8		116	2.7		2,531	2.8	
45-54	Black	12	30.8	3.3	18	38.6	4.8	90	26.6	3.4	2,562	27.5	3.1
	White	30	9.2		30	8.0		269	7.8		6,097	8.8	
55-64	Black	34	94.7	3.5	35	105.4	3.6	230	94.0	2.8	5,539	90.1	3.1
	White	91	27.4		84	29.2		834	33.1		13,921	28.8	
Total **35-64**	Black	52	38.9	3.3	56	38.8	3.3	357	33.8	2.9	9,122	30.8	2.8
	White	131	11.8		132	11.6		1,219	11.8		22,549	10.9	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 9. Chronic Obstructive Pulmonary Disease Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the US, 1989-1998
(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	2	**	**	2	**	**	30	6.4	4.0	718	5.1	3.2
	White	4	**		10	2.1		68	1.6		1,407	1.6	
45-54	Black	8	**	**	9	**	**	62	18.2	2.9	1,224	13.1	1.6
	White	21	6.4		18	4.8		216	6.3		5,542	8.0	
55-64	Black	13	36.2	.93	17	51.2	1.4	98	40.0	1.1	2,142	34.8	.79
	White	130	39.1		103	35.8		900	35.7		21,369	44.2	
Total **35-64**	Black	23	17.2	1.2	28	19.4	1.7	190	18.0	1.6	4,084	13.8	1.0
	White	155	14.0		131	11.6		1,184	11.5		28,318	13.7	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 10. Influenza/Pneumonia Death Rates in Females by Selected Race and Age Groups in Allegheny County, PA, and the U. S., 1989-1998
(rates are per 100,000 population)

Age	Race	Allegheny Co. Ave. 89-93			Allegheny Co. Ave. 94-98			PA Ave. 94-98			US Ave. 94-98		
		N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio	N	Rate	Ratio
35-44	Black	5	**	**	3	**	**	24	8.5	5.7	882	6.2	3.0
	White	14	3.1		10	2.1		65	1.5		1,860	2.1	
45-54	Black	11	28.3	6.6	7	**	**	37	10.8	3.9	928	10.0	2.3
	White	14	4.3		11	2.9		95	2.8		2,963	4.3	
55-64	Black	8	**	**	5	**	**	56	22.9	2.3	1,322	21.5	1.8
	White	29	8.7		32	11.1		247	9.8		5,841	12.1	
Total **35-64**	Black	24	18.0	3.5	15	10.4	2.2	117	11.1	2.8	3,132	10.6	2.7
	White	57	5.1		53	4.7		407	3.9		10,664	3.9	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 11. Gonorrhea Morbidity Rates in Females by Selected Race and Age Groups in Allegheny County and the US, 1995-1999

(rates are per 100,000 population)

Age	Race	1995		1996		1997		1998		1999		Allegheny Co. Ave. 95-99		US Ave. 95-99		
		N	Rate	N	Rate	**N**	**Rate**	N	Rate	N	Rate	Rate	Ratio	**N**	**Rate**	**Ratio**
35-44	Black	32	247.2	22	169.9	21	162.1	17	131.2	29	223.6	186.8	29.2	31,890	499.4	18.2
	White	3	**	4	**	5	**	8	**	10	10.8	6.4		10,471	27.5	
45-54	Black	2	**	0	**	2	**	0	**	4	**	**	**	3,955	46.7	16.7
	White	0	**	2	**	2	**	0	**	0	**			1,748	2.8	
55-64	Black	0	**	0	**	0	**	0	**	0	**	**	**	586	10.8	15.4
	White	0	**	1	**	0	**	0	**	0	**	**		308	0.7	
Total	Black	34	119.8	22	76.3	23	78.5	17	**	33	109.1	88.0	28.4	36,431	556.9	17.9
35-64	White	3	**	7	**	7	**	8	**	10	4.3	3.1		12,527	31.1	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 12. Chlamydia Morbidity Rates in Females by Selected Race and Age Groups in Allegheny County and the US, 1995-1999

(rates are per 100,000 population)

Age	**Race**	1995		1996		1997		1998		1999		Allegheny Co. Ave. 96-99		US Ave. 96-99		
		N	**Rate**	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**	**N**	**Rate**	**Rate**	**Ratio**	**N**	**Rate**	**Ratio**
35-44	Black	17	131.1	30	231.7	53	409.1	33	254.6	39	300.8	239.3	15.6	16,347	404.1	7.8
	White	19	19.9	19	20.1	20	21.3	17	18.3	16	17.3	15.3		13,116	51.7	
45-54	Black	7	**	8	**	9	**	7	**	4	**	57.7	25.1	2,420	45.6	8.1
	White	4	**	2	**	1	**	3	**	3	**	2.3		2,305	5.6	
55-64	Black	2	**	0	**	1	**	0	**	1	**	**	**	491	14.2	10.1
	White	0	**	0	**	1	**	1	**	0	**	**		401	1.4	
Total	Black	26	91.6	38	131.7	63	214.9	40	134.3	44	145.5	126.2	17.3	19,258	463.9	7.9
35-64	White	23	10.2	21	9.3	22	9.7	21	9.2	19	8.2	7.3		15,822	58.7	

**Note: Did not calculate when number of cases is less than 10 for specific age groups and for the total age group. Total age group means only ages 35-64.

Table 13. AIDS Cases in Females by Selected Race and of All Ages in Allegheny County and the US, 1995-1999

(rates are per 100,000 population)

Race	1995		1996		1997		1998		1999		Allegheny Co. Ave. 95-99		US Ave. 95-99	
	N	Rate	N	Rate	N	Rate	N	Rate	N	Rate	Rate	Ratio	Rate	Ratio
Black	19	**	18	**	10	**	6	**	5	**	13.5	**	55.7	18.6
White	5	**	8	**	2	**	1	**	1	**	**		3.0	

**Note: Did not calculate when number of cases is less than 20 for the total population. Total population means all ages.

Table 14. Black Female Deaths in the South Side, Age 35-64, 1994-1998

Disease	*Area Codes	South Side Total Deaths	Allegheny Co. Total Deaths	South Side % of Total Deaths in the County
Heart Disease	1, 4, 7, 10, 11, 17, 18	12	233	5.2%
Cancer	1, 3, 4, 10, 11, 16, 18	21	283	7.4%
-Lung cancer	1, 3, 4, 10	7	78	9.0%
-Colorectal Cancer	10	1	16	6.3%
-Breast Cancer	10, 16, 18	6	69	8.7%
Stroke	4, 17	5	59	8.5%
Unintentional Injuries	11, 18	2	39	5.1%
Diabetes	11, 18	2	56	3.6%
COPD	18	1	28	3.6%
Influenza/Pneumonia	----	0	15	0%
Total		**57**	**876**	**6.5%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Table 15. White Female Deaths in the South Side, Age 35-64, 1994-1998

Disease	*Area Codes	South Side Total Deaths	Allegheny Co. Total Deaths	South Side % of Total Deaths in the County
Heart Disease	1, 2, 3, 5, 6, 7, 8, 10, 12, 13, 14, 16, 17	61	779	7.8%
Cancer	1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 16, 17	119	1,753	6.8%
-Lung cancer	1, 2, 6, 7, 8, 9, 10, 11, 12, 14, 16, 17	48	456	10.5%
-Colorectal Cancer	1, 2, 6, 7, 9, 14, 16, 17	9	130	6.9%
-Breast Cancer	1, 2, 6, 7, 8, 12, 14, 16, 17	23	420	5.5%
Stroke	1, 6, 7, 13, 16, 17	12	169	7.1%
Unintentional Injuries	2, 6, 7, 12, 14	6	145	4.1%
Diabetes	2, 7, 8, 10, 12, 14	8	132	6.1%
COPD	1, 7, 12, 13, 16, 17	10	131	7.6%
Influenza/Pneumonia	1, 4, 6, 7	5	53	9.4%
Total		**301**	**4,148**	**7.3%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths. **Area Codes:**

1 = Allentown
2 = Arlington
3 = Arlington Heights
4 = Beltzhoover
5 = Bon Air
6 = Brookline
7 = Carrick
8 = Duquesne Heights
9 = Hays
10 = Knoxville
11 = Mt. Washington
12 = Mt. Oliver
13 = Mt. Oliver Borough
14= Overbrook
15 = South Shore
16 = South Side Flats
17 = South Side Slopes

Table 16. Population By Race in the South Side, Pittsburgh, and Allegheny County, 2000

Race	South Side	Pittsburgh	Allegheny County
Black	*8,667	*93,902	159,058
White	62,393	226,258	1,080,800

*Note: Residents who marked "African American" as one of their races.

Table 17. Black Female Deaths in Uptown-Oakland, Age 35-64, 1994-1998

Disease	*Area Codes	Uptown-Oakland Total Deaths	Allegheny Co. Total Deaths	Uptown-Oakland % of Total Deaths in the County
Heart Disease	2, 3, 4, 5, 6, 7, 8, 9	25	233	10.7%
Cancer	2, 3, 4, 5, 6, 7, 8, 9	38	283	13.4%
-Lung cancer	4, 5, 6, 7, 8	14	78	17.9%
-Colorectal Cancer	----	0	16	0%
-Breast Cancer	3, 4, 6, 7, 8, 9	9	69	13.0%
Stroke	4, 5, 6, 7, 9	11	59	18.6%
Unintentional Injuries	5, 7, 8, 9	7	39	17.9%
Diabetes	4, 5, 6, 8	5	56	8.9%
COPD	4, 7	2	28	7.1%
Influenza/Pneumonia	3, 6	2	15	13.3%
Total		**113**	**876**	**12.9%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Table 18. White Female Deaths in Uptown-Oakland, Age 35-64, 1994-1998

Disease	*Area Codes	Uptown-Oakland Total Deaths	Allegheny Co. Total Deaths	Uptown-Oakland % of Total Deaths in the County
Heart Disease	1, 2, 3, 9	6	779	.77%
Cancer	2, 3, 4	6	1,753	.34%
-Lung cancer	3	1	456	.22%
-Colorectal Cancer	----	0	130	0%
-Breast Cancer	2, 4	2	420	.48%
Stroke	1, 3	2	169	1.2%
Unintentional Injuries	3, 6, 9	3	145	2.1%
Diabetes	----	0	132	0%
COPD	----	0	131	0%
Influenza/Pneumonia	----	0	53	0%
Total		**20**	**4,148**	**.48%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Area Codes:

Oakland
1 = Central
2 = North
3 = South
4 = West

Uptown
5 = Bedford Dwellings
6 = Crawford Roberts
7 = Middle Hill
8 = Terrace Village
9 = Upper Hill

Table 19. Population By Race in Uptown-Oakland, Pittsburgh, and Allegheny County, 2000

Race	Uptown-Oakland	Pittsburgh	Allegheny County
Black	*13,136	*93,902	159,058
White	15,113	226,258	1,080,800

*Note: Residents who marked "African American" as one of their races.

Table 20. Black Female Deaths in the East End, Age 35-64, 1994-1998

Disease	*Area Codes	East End Total Deaths	Allegheny Co. Total Deaths	East End % of Total Deaths in the County
Heart Disease	1, 2, 3, 5, 6, 7, 8	65	233	27.9%
Cancer	1, 2, 3, 5, 6, 7, 8	75	283	26.5%
-Lung cancer	1, 2, 3, 5, 6, 8	25	78	32.1%
-Colorectal Cancer	1, 2, 6, 8	6	16	37.5%
-Breast Cancer	1, 2, 3, 6, 8	17	69	24.6%
Stroke	3, 5, 6, 7, 8	14	59	23.7%
Unintentional Injuries	1, 3, 5, 6, 8	11	39	28.2%
Diabetes	1, 2, 3, 5, 6, 7, 8	18	56	32.1%
COPD	1, 3, 5, 6, 7, 8	10	28	35.7%
Influenza/Pneumonia	2, 3, 8	5	15	33.3%
Total		**246**	**876**	**28.1%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Table 21. White Female Deaths in the East End, Age 35-64, 1994-1998

Disease	*Area Codes	East End Total Deaths	Allegheny Co. Total Deaths	East End % of Total Deaths in the County
Heart Disease	6, 8	7	779	.90%
Cancer	2, 7, 8	24	1,753	1.4%
-Lung cancer	7, 8	7	456	1.5%
-Colorectal Cancer	7, 8	3	130	2.3%
-Breast Cancer	7, 8	6	420	1.4%
Stroke	4, 5, 7	3	169	1.8%
Unintentional Injuries	7, 8	3	145	2.1%
Diabetes	8	1	132	.76%
COPD	6, 8	2	131	1.5%
Influenza/Pneumonia	----	0	53	0%
Total		**56**	**4,148**	**1.4%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Area Codes:
1 = East Hills
2 = Homewood North
3 =Homewood South
4 = Homewood West
5 = Larimar
6 = Lincoln-Lemington-Belmar
7 = Point Breeze
8 = Wilkinsburg Borough

Table 22. Population By Race in the East End, Pittsburgh, and Allegheny County, 2000

Race	East End	Pittsburgh	Allegheny County
Black	*33,351	*93,902	159,058
White	11,604	226,258	1,080,800

*Note: Residents who marked "African American" as one of their races.

Table 23. Black Female Deaths in the McKeesport-Mon Valley Area, Age 35-64, 1994-1998

Disease	*Area Codes	McKeesport-Mon Valley Total Deaths	Allegheny Co. Total Deaths	McKeesport-Mon Valley % of Total Deaths in the County
Heart Disease	1, 2, 3, 5, 10, 12, 13, 15, 18	34	233	14.6%
Cancer	1, 2, 3, 5, 10, 12, 13, 15, 18	40	283	14.1%
-Lung cancer	1, 2, 3, 5, 10, 15	6	78	7.7%
-Colorectal Cancer	3, 15, 18	4	16	25.0%
-Breast Cancer	1, 2, 3, 5, 10	12	69	17.4%
Stroke	1, 2, 3, 5, 12, 18	8	59	13.6%
Unintentional Injuries	2, 3, 12	4	39	10.3%
Diabetes	1, 2, 5, 10, 12, 15	9	56	16.1%
COPD	2, 3, 5	3	28	10.7%
Influenza/Pneumonia	1	1	15	6.7%
Total		**121**	**876**	**13.8%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Table 24. White Female Deaths in the McKeesport-Mon Valley Area, Age 35-64, 1994-1998

Disease	*Area Codes	McKeesport-Mon Valley Total Deaths	Allegheny Co. Total Deaths	McKeesport-Mon Valley % of Total Deaths in the County
Heart Disease	1, 2, 3, 4, 6, 8, 9, 10, 11, 12, 13, 14, 15, 17, 19, 20, 21	116	779	14.9%
Cancer	1, 2, 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21	170	1,753	9.7%
-Lung cancer	1, 2, 3, 5, 8, 9, 10, 11, 12, 13, 14, 17, 19, 20, 21	49	456	10.7%
-Colorectal Cancer	1, 5, 12, 13, 15, 19, 20	11	130	8.5%
-Breast Cancer	1, 2, 3, 5, 8, 10, 11, 12, 13, 14, 19	22	420	5.2%
Stroke	1, 5, 13, 14, 17, 19	11	169	6.5%
Unintentional Injuries	1, 6, 8, 12, 13, 19, 20	8	145	5.5%
Diabetes	1, 6, 7, 9, 11, 13, 14, 19, 21	15	132	11.4%
COPD	1, 2, 4, 6, 8, 9, 13, 15, 17, 19, 20	20	131	15.3%
Influenza/Pneumonia	1, 8	4	53	7.5%
Total		**426**	**4,148**	**10.3%**

*Note: The areas listed are those with at least 1 death. Areas not listed had 0 deaths.

Area Codes:

McKeesport
1 = McKeesport City

Mon Valley
2 = Braddock Borough
3 = Clairton City
4 = Dravosburg Borough
5 = Duquesne City
6 = East McKeesport Borough
7 = Elizabeth Borough
8 = Elizabeth Township
9 = Glassport Borough
10 = Homestead Borough
11 = Liberty Borough
12 = North Braddock Borough
13 = North Versailles Township
14 = Port Vue Borough
15 = Rankin Borough
16 = Turtle Creek Borough
17 = Versailles Borough
18 = West Elizabeth Borough
19 = West Mifflin Borough
20 = White Oak Borough
21 = Wilmerding Borough

Table 25. Population By Race in McKeesport-Mon Valley, Pittsburgh, and Allegheny County, 2000

Race	McKeesport-Mon Valley	Pittsburgh	Allegheny County
Black	*24,984	*93,902	159,058
White	112,702	226,258	1,080,800

*Note: Residents who marked "African American" as one of their races.