



# Closing the Gap

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

## Supporting State Offices of Minority Health

By Houkje Ross

A large population of aging African American men in South Carolina makes prostate cancer a big problem for the state. A large influx of Asian Americans and Pacific Islanders makes culturally appropriate health care for this population a major issue in California. While each state faces unique challenges with minority health, some barriers are common to all.

One of the largest barriers facing states is a lack of minority health data. "What we really need is a full-time epidemiologist who can collect, analyze and track minority health data for our state," said Christine Patterson, director of Arkansas' Office of Minority Health. But like other state minority health offices, Patterson faces a limited budget and manpower. Health agencies with limited minority data have trouble identifying health disparities and in justifying the need for special initiatives targeted toward minority populations. "We are a small office with a large heart," said Barbara Pullen-Smith, director of North Carolina's Office of Minority Health. "But I can't do my job without the data," she added.

### OMH Funds First State Partnership Initiative

In an effort to strengthen the capacity of states to address minority health, the federal Office of Minority Health, U.S. Department of Health and Human Services (HHS), began a state partnership initiative in Fiscal Year 1998.

"We began the state partnership initiative because we wanted states to be able to focus on the minority health issues most important to them," said Gerrie Maccannon, special assistant to the director of OMH. States had the option of undertaking a special project that would address an emerging health-related issue or

a project in infrastructure development. Examples of special projects include asthma projects conducted in New York and New Jersey; and cultural competency projects in California, Georgia, and Oregon.

Infrastructure development projects could include improving communication technology, data collection and analysis; or developing partnerships with community-based and grassroots organizations. Many states chose to focus on data collection and analysis.

OMH gave \$733,000 to 25 state Offices of Minority Health for the initiative. "OMH would have liked to do the initiative earlier, but only recently obtained the necessary funds," said Maccannon.

### Initiatives Get Second Go-Around

This year OMH is funding a second round of state initiatives, principally for states that don't yet have established Offices of Minority Health, including Connecticut, Hawaii, Iowa, Mississippi, Montana, New Hampshire, North Carolina, Puerto Rico, the U.S. Virgin Islands, Wisconsin, and Wyoming.

The goal of the FY 2000 State Partnership Initiative is the same as the 1998 initiative: to enable states to develop and implement ways to eliminate minority health disparities.

Connecticut's Department of Public Health will be examining and analyzing its current data collection system's ability to set baseline standards for minority health status. Other states like Iowa and Wisconsin will focus on building networks of minority health coalitions. Puerto Rico and the U.S. Virgin Islands will

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### States Address Cross-Cutting Issues

According to HHS's Office of Minority Health, four cross-cutting issues that contribute to health disparities between whites and racial and ethnic minorities are:

- **Data Collection, Analysis, and Reporting.** Limited data on racial and ethnic minority health conditions can make it difficult for agencies to identify health disparities, justify the need for special initiatives targeted toward these populations, and measure progress made by state initiatives. Most states are attempting to improve data collection, however.
- **Cultural Competence.** Knowing how to serve patients from diverse backgrounds can be a challenge for states seeing an increase in racial and ethnic minority populations. Minority health agencies can provide diversity training to area health workers. Identifying cultural barriers, integrating culture-specific health strategies, and developing culturally appropriate health messages are all part of state efforts to serve minority communities.
- **Access to Health Care.** A limited availability of health care providers and institutions, lack of transportation or money, cultural barriers, or lack of linguistically appropriate services all create a barrier for minority communities seeking medical services. Access is both an urban and rural issue. Some states, like Wyoming, are assigning health department staff to Indian reservations where health providers are scarce.
- **Health Professions Development.** Underrepresentation of minorities in the health professions is a major concern affecting the delivery of health care services to racial and ethnic minorities. A number of programs at the federal and state level are working to increase the number of minorities in the health profession. For example, the Arkansas State Department of Health introduces adolescents to the health professions through a mentoring program; the University of Wyoming has a summer program for minority students who want to study medicine. ❖

### Conferences Provide Network Opportunities

In 1990, three years after it was established, the federal OMH began to encourage states to establish minority health offices to help reduce the disparities in minority health. At that time, only five states—Ohio, Indiana, Missouri, Michigan, and South Carolina—had already established offices. Now there are 37 states with Offices of Minority Health (SOMHs). Budgets range from \$64,000 to \$2.5 million and offices range from a one person operation, like Puerto Rico, to a 15-person operation, according to Gerrie Maccannon, special assistant to the director of OMH.

Traditionally OMH has supported state activities by sponsoring a bi-annual state minority health conference. "The conferences are a way the federal office can continue to build partnerships with the states and address issues like cultural competency and minority health data," Maccannon said.

State minority health directors reported that the conferences are a useful forum for sharing information. Mawuna Gardesey, director of Delaware's SOMH said the meet-

ings save time and money. "All the states are faced with the similar difficulties, and the conferences are a great way to hear how others have resolved the issues. The interchange is invaluable," he said. ❖

### States...from page 1

develop strategies to implement the federal government's Healthy People 2010 goals to eliminate health disparities.

North Carolina, which has an established Office of Minority of Health, will conduct two conferences to address the elimination of health disparities. In September 2000 the state held the first African American Health Summit, and in December 2000 it will hold the first statewide health disparities conference, called by the Secretary of the North Carolina Department of Health and Human Services.

For more information on the state initiatives, contact Gerrie Maccannon, federal Office of Minority Health, (301) 443-5084. ❖

# Minority Health Entities Impact State Health Disparities

Editorial by Nathan Stinson, Jr., PhD, MD, MPH  
 Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services

The United States is comprised of 59 states, districts, and territories—each uniquely defined by its topography, natural resources, and by the diversity of its people. The varying cultures, languages, races and ethnicities of individuals living in states across the nation pose equally unique challenges for health officials as they work to eliminate their own state's health disparities.

State minority health entities continue to serve as pivotal points for federal, state, tribal, and local efforts to improve the health status of minority populations. They have the ability to tackle head-on the cross-cutting issues in which the Office of Minority Health (OMH) is involved. Yet many states still lack sufficient resources to help them address minority health issues.

That is why OMH developed the State Partnership Initiative in 1998. We wanted to help individual state minority health entities develop or expand their existing infrastructure to address their specific public health needs, while at the same time helping us increase our involvement with the states. The one-year contracts also allowed some states to undertake special projects to address emerging health-related issues impacting minority communities.

Through the initiative, 25 state offices shared approximately \$733,000 to develop programs that impact state-wide racial and ethnic health disparities. Some state offices, such as Ohio and North Carolina, used the funding toward innovative programs that improve access to care and address data issues (see stories on pp. 6 and 7). Others directed the funds toward infrastructure development, like Tennessee's establishment of a Latino Network (see page 10).

In FY 2000 OMH awarded 12 new states—many of which do not have established state minority health

entities—with approximately \$285,000. For these states, the initiative provides an opportunity to reach minority populations with special projects they might not otherwise have been able to do.

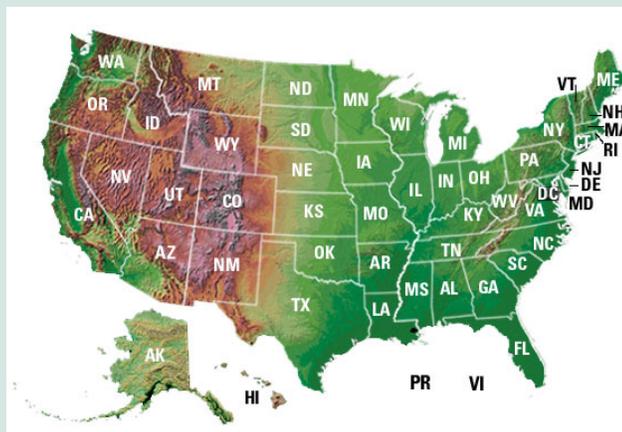
OMH recently completed an assessment of the minority health infrastructure in eight states and Puerto Rico. One of the important study questions of this assessment was whether the existence of state minority health entities made a difference in how/if states were addressing racial and ethnic health disparities. The study found that despite the many challenges facing the state minority health entities,

they are an organized and visible presence at the state policymaking level that provides numerous opportunities to shape and create initiatives that could affect the health status of minority populations. They also serve an important information dissemination function, providing information on minority health issues to policymakers, health professionals, community-based organizations, and the general public. State minority health entities also serve as important and visible points of contact in their states.

health entities also serve as important and visible points of contact in their states.

We know that improving the health of racial and ethnic minorities helps ensure the health of all Americans. We also know that state minority health entities can play an increasing role in the efforts to eliminate racial and ethnic disparities in health. Therefore, we must continue to urge our state health policymakers to put minority health on their agendas, especially if they are serious about closing the gaps in health in their states and the nation. Minority health is everyone's health.

*For more information on the OMH State Health Partnership Initiative, call Gerrie Maccannon at (301) 443-5084. ❖*



# Alabama Project Gives Medical Interpreters a Boost

By Michelle Meadows

It may seem convenient for a Spanish-speaking patient to bring along a bilingual family member or friend to handle medical interpreting. But the practice can wreck patient-provider relationships, threaten confidentiality, and damage health outcomes.

Unfortunately, the use of inappropriate medical interpreters is all too common. Many people who serve as interpreters are untrained and unskilled in interpreting health and cultural issues. They may not have the skills to create an environment in which the patient and provider feel like they are talking with each other. Or they may misunderstand medical terms, which could result in misdiagnosis or noncompliance with treatment instructions.

Last year, the Alabama Health Access by Language Advocacy (ALHABLA) project set out to address these issues, said Gwendolyn Lipscomb, director of the Minority Health Section of the Office of Primary Care and Rural Health, Alabama Department of Public Health. With funding from the federal Office of Minority Health's state partnership initiative, Lipscomb's office partnered with Troy State University's College of Health and Human Services to come up with ALHABLA, an English-to-Spanish Medical Interpreter Training Program. The program is an adaptation of the Colorado Migrant Health Program's Medical Interpreters Training Curriculum.

Through ALHABLA, 29 people sharpened skills in medical terminology, ethics, management of interviews, and Hispanic

culture. Project training, which took place at two training sites in the Spring of 1999, consisted of 25 hours of classroom work over five days and a three-four hour testing and evaluation period. The first site, selected to serve the southern part of Alabama, was Baldwin County Public Health Department in Robertsedale. The second site, selected to serve the northern part of the state, was the Cullman County Public Health in Cullman.

Some participants received a certificate of attendance and others earned a full certificate of completion, which indicates that the participant obtained full, supervised experience providing interpretation services in a medical setting. Lipscomb said she considers the ALHABLA a success, pointing out that before this training, most of the participants worked in medical interpreting on an informal, volunteer basis.

"After this program," Lipscomb said, "more than 20 are now employed as interpreters. Either they have a position or a contract."

Lipscomb would like to see the program expanded and repeated, especially because many community members showed interest and enthusiasm in ALHABLA.

"But what we haven't been able to do is generate much interest from institutions of higher education," said Lipscomb, who believes such a program should be worked into college interpreting classes.

The Alabama Department of Public Health recently sent out materials to several colleges and universities, but hasn't

received any responses. It's disappointing, Lipscomb said, but her office will continue looking for ways to promote and improve medical interpreting and cross-cultural communication in the state, especially because of the growing Hispanic population in Alabama.

*For more information on the Alabama Health Access by Language Advocacy (ALHABLA) project, contact Gwendolyn Lipscomb at 334-206-5396. ❖*

*Many people who serve as interpreters are untrained and unskilled in interpreting health and cultural issues*

## Medical Interpreter Resources

- **Resources for Cross Cultural Health Care** has a resource guide for medical interpretation services on its website. Go to [http:// www.DiversityRx.org](http://www.DiversityRx.org) or call (301) 588-6051.
- **The National Council on Interpretation in Health Care (NCIHC)** has an email discussion group. Participants can raise issues, ask questions, share information and resources and network with each other around topics related to medical interpretation and access to health-care services for limited English proficient persons. NCIHC-list is open to anyone with an interest in these issues. To subscribe to the NCIHC-list, send an email to: [NCIHC-list@diversityRx.org](mailto:NCIHC-list@diversityRx.org). ❖

# Are We Culturally Competent?

## *California Takes a Critical Look at its Health Department*

By Houkje Ross

California is one of the most diverse states in the nation. Twenty-five percent of the state's residents are foreign born. During the 1990s, more than 3.5 million new immigrants came to California: 32 percent from Mexico, 12 percent from the Philippines, and 7 percent from Vietnam. By 2040, it is estimated that almost half of the State's population will be Latino.

To find out just how capable the California Department of Health Services (DHS) is at providing services to such a diverse population, the state Office of Multicultural Health (OMH) conducted a cultural competency needs assessment. The assessment was funded by the federal Office of Minority Health.

The spring 1999 survey assessed strengths, weaknesses, and attitudes toward cultural competency among DHS branches and programs. "We wanted to find out where we are and what we need to do to achieve a culturally competent organization," said Gregory Franklin, chief of the California OMH. Approximately 88 percent of program personnel responded to the survey, which looked at disparities in health status, access to service, linguistic resources, community input, cultural beliefs and practices, outreach, and program resources.

### Useful Information Hard to Find

Most programs reported a lack of useful information on the cultural beliefs and attitudes of the multiple ethnic groups living in California, according to the executive summary of the survey. "Substantive information in a 'user friendly' format which could be distributed to subcontractors and service providers was the most frequently requested item in the survey. In addition to requests for specific information (e.g., cultural attitudes related to

sexual and reproductive practices, beliefs about physical activity and 'folk' medicine practices), information about health-seeking behaviors and the best outreach methods to use with different groups was also a priority," said the authors of the summary.

Having a lack of useful information on cultural competency and working with ethnic and minority groups isn't a problem unique to California, however. For example, Oregon's Office of Multicultural Health reported in its 1999 Strategies in Collaboration study that "research studies specific to testing and improving collaboration across ethnic groups were not readily apparent." The Oregon study searched a large number of databases and reviewed over 100 journals, half of which were specific to health care issues. Terms such as collaboration, ethnic, intercultural, communication, multicultural, or health services were searched.

### Enforcement and Policy Needed

Information may be lacking, but Franklin says a larger problem is a lack of enforcement of provisions that create a culturally competent health care system. "California's larger programs like WIC and Medi-Cal (the state Medicaid program) are definitely better equipped to deal with cultural competency issues," said Franklin. This is partly due to the fact that these are well-established programs, with the resources to ensure cultural competency. Being in tune with their stakeholders, providing publications in different languages, and consulting with outside organizations enable these organizations to be more culturally competent, according to Franklin.

Although the survey found that some agencies—like the Medi-Cal Managed Care Division and the Office of AIDS—do

a good job of providing translations in various languages, other programs lag in this area. And enforcement of provisions to do so are also absent from the picture. The Medi-Cal Managed Care Policy letter on Linguistic Services requires health plans to develop and implement specific policies for ensuring competent, 24-hour-a-day interpreter services for plan members with limited English proficiency, but enforcement rarely occurs.

Budget size is a big determinant in ensuring cultural competency, said Franklin. "But we have to get programs to think beyond money and towards policy." One thing policy can do is target already available resources, he said.

The executive report of California's survey includes several recommendations to ensure that its DHS is culturally competent. Some of these include: producing effective training materials to educate providers and public health staff about the various cultural groups residing in California, their health care beliefs, practices, and needs; supporting efforts to recruit racial and ethnic students into health professions; actively monitoring and reporting on compliance with linguistic competency requirements in service programs funded or operated by DHS; and developing guidelines for translating DHS-produced materials.

But Franklin is waiting to see what happens with the Federal Culturally and Linguistically Appropriate Standards (see *CTG*, January 2000 issue) before he implements certain recommendations. "When the standards hit the street they will give us a place to start from, a clearer picture of what needs to be done in order to have a culturally competent organization," he said.

*For more information on the California DHS survey, contact: Gregory Franklin, (916) 322-1519. ♦*

# Ohio Turns to Hispanic Community to Develop Data Publication

By Houkje Ross

Hispanics are the second largest minority population in Ohio, but in 1998 there were no statistical data reflective of the needs of the community, said Cheryl Boyce, director of the Ohio Commission on Minority Health. “This has been particularly frustrating for providers and consumers in Ohio,” added Boyce.

So Boyce turned to the Hispanic community to develop the much needed information. She armed herself with as many statistics as she could find from the National Council of La Raza, the State Data Center and the Ohio Bureau of Employment Service. And she hired Lydia Alejandro—a well-respected member of the community and current director of prevention services at Adelante Inc., a Substance Abuse Prevention Agency in Toledo—as her program consultant for the project.

Alejandro and an advisory committee of nine members from Latino communities came together to develop a publication based on the U.S. Census Bureau series, *We the People*. The committee consisted of Hispanic professionals, including a marketing consultant, city council member, director of Hispanic social services agency, farm labor relations worker, and the president of a Hispanic Awareness Organization.

The publication includes an introduction on the history of how Latinos came to Ohio, the types of jobs they currently and historically have held, and their countries of origin.

“We wanted to personalize it and clear up the myth that all Latinos in the state are from Mexico,” said Alejandro. Although Mexicans comprise the largest group of Hispanics living in Ohio, Puerto Ricans and Central and South Americans also reside in the state.

The publication also includes information on population growth; popula-

tion in selected counties; median age; educational attainment; educational attainment by ethnic group; types of jobs held; marriage status; median income; poverty rates; and most prevalent diseases.

There is also a one page narrative section on farm labor and four “historical clips,” from individuals who have lived in Ohio for their entire lives.

“We have really built a model for developing an information base with a community partnership,” Boyce added. “It created an approach for the Commission to follow for integrating the talents of minority communities with federal and state government efforts to close the gap in data needs.”

For more information on the Ohio Commission initiative, contact: Cheryl Boyce, Ohio Commission on Minority Health, (614) 466-4000.



## We... The Ohioans of Latino/Hispanic Heritage

The excerpt below is from a publication produced by the Ohio Commission's Minority Health. *We... Ohioans of Latino/Hispanic Heritage* is a statistical report produced as part of the state partnership initiative, funded by the federal OMH in 1998.

*“We, the Latino Ohioans find that our birthplace in Ohio began with our fathers and grandfathers who came to this State for improved opportunities—the opportunity to work hard and earn a decent living to support our families as other immigrants have done in the past.*

*“Some of our ancestors were recruited to Ohio from Mexico and Puerto Rico to build railroads in Toledo and Cleveland as early as the 1920s. For others, coming to Ohio meant steady employment in the steel mills, farm labor and auto industry. And in the past 15 to 20 years, many other Latinos have come to Ohio to begin or continue their professional careers as engineers, doctors, professors at universities, and other careers.*

*“For whatever reason we have come to live in Ohio, Latinos have contributed significantly to enrich the economy of this State, not only through our agricultural labor or the auto or steel mill industries, but also in education, medicine, social services, sports, arts and culture, science, and the military.”*

# North Carolina OMH Improves Availability of Health Data

By Houkje Ross

North Carolina's Office of Minority Health improved its ability to distribute health data and statistics to its partners, thanks to funding from the federal Office of Minority Health's State Partnership Initiative. Now, important data on racial and ethnic groups in the state are more easily distributed to local health departments, community-based organizations, the state department of health and human services, colleges and universities, and advocacy groups.

A critical part of this strategy was setting up a database of partner addresses and other contact information that could be easily used for sending out reports and other notification of state health data.

"Facts speak for themselves," said Barbara Pullen-Smith, director of the North Carolina OMH. "And when our partners have statistical information, they are better able to pinpoint the types of

programs they need and justify them."

Pullen-Smith cites the fact that North Carolina has one of the highest infant mortality rates in the nation as an example of critical health data that should be considered in state health activities. Data indicate that American Indian mothers may have a high incidence of risk factors associated with infant mortality. And while 31 percent of the state's children are minorities, 44 percent of child deaths occurred in minority children. Sixty-four percent of those deaths were in infants under one year old.

The goal, said Pullen-Smith, was to give its partners "information, resources, the ability to access those resources, and an understanding of how they can influence policy at the local level."

Pullen-Smith said she worked closely with North Carolina's Center for Health Statistics, along with her office research

associate, her assistant director, and a project consultant to collect minority health data and produce new publications.

Through the state partnership initiative, the office developed and updated African American, American Indian, and Hispanic/Latino fact sheets, the Latina Reproductive Health Report, and the African American Health Assessment.

It's not only distributing the data that's important, Pullen-Smith added. "A big part of our job is to act as interpreters of data related to minority health," she said. "It has to be understandable. It's one thing for a researcher at Duke to be able to look at numbers and know what they mean, but I want my aunt to be able to understand it too."

*For more information, contact Barbara Pullen-Smith, 919-715-0992. ❖*

## How to Establish a Database

The development of North Carolina's Office of Minority Health's (NC-OMH) database involved three phases: planning and designing, database implementation, and data entry and report development. Here's a general idea of how NC-OMH approached the project.

**1. Planning and Designing:** In the first phase OMH staff met with the project consultant in a series of meetings to clearly layout and define the purpose and scope of the database. Discussion at this stage surrounded the types of data that would be stored in the database, who would be the main users of the data, how the database would enhance the work of the office in meeting the needs of minorities in the state, and what demands the database would create for the Office in terms of

data entry, maintenance, and upgrades. The project consultant also met with a representative from the North Carolina State Center for Health Statistics. This person provided technical assistance in the planning phase.

**2. Database Implementation:** This is the technical phase, which involves translating the information gathered by the project consultant into a database format. The project consultant developed a flow chart of the database, which indicated the types of tables and reports available and how they could be linked. NC-OMH used in-house staff for support and guidance. Staff members talked with the consultant about what they would like the database to be able to do and developed a timeline for the project.

**3. Data Entry and Report Development:** NC-OMH hired a data entry person to enter addresses of its partners. The database holds more than 5,500 names and addresses of colleges, individuals, churches, minority radio stations and newspapers, legislators, community-based organizations, ministers, interpreters, and conference attendees. The database also includes a complete listing of NC-OMH publications. Pullen-Smith suggests developing a long-term plan for updating and maintaining the database and publications. Other suggestions include documenting the process for developing and implementing the project and providing training to staff for using the database. ❖

# Helping New Jersey Residents Breathe Easier

By Jean Oxendine

Asthma was the primary diagnosis for 13 percent of African American children hospitalized in New Jersey in 1997, according to the National Center for Health Statistics (NCHS). During the same period, seven percent of Latino children of the same age group (1-14 years) were hospitalized with asthma.

The problem is not limited to New Jersey. Asthma is the most common chronic illness of childhood, afflicting more than 4.4 million American children, and is generally managed via outpatient care and, occasionally, emergency room visits. Hospitalization for asthma indicates severe disease and may suggest that the child hasn't had adequate care from a physician who can help control asthma. Children who live in poorer neighborhoods continue to have higher rates of hospitalization for asthma than others. Statistics also show that between 1989 and 1991, African American children had higher rates of asthma than White children did at every level of socioeconomic status.

In 1998 the state of New Jersey decided to begin combating asthma in minority communities. With a \$30,000 grant from the federal Office of Minority Health, the New Jersey Office of Minority Health (NJOMH) was able to develop and implement a community-based asthma project. The asthma initiative—conducted from August 1998 to July 1999—aimed to increase awareness through outreach, education, and training racial and ethnic minorities in three cities in New Jersey.

"The program was very popular," said Gilbert Ongwenyi, a research scientist with the NJOMH. "Even though the funding has ended, we continue to help the community with questions and concerns about asthma," he said.

## Churches Lend Support

In an effort to increase the community involvement for the asthma project, NJOMH formed a partnership with Metropolitan Ecumenical Ministry (MEM), a statewide, faith-based coalition of religious organizations that foster health promotion ministries among underserved communities in New Jersey.

MEM gathered local religious organizations to serve as health information centers where community health promoters provided outreach and support services to individuals. (See *CTG*, August 2000, p. 4, Lay Health Workers)

The asthma outreach project consisted of 21 community health promoters and health coordinators from local churches. Participants received in-depth training in asthma education

and prevention. Community health promoters conducted 42 presentations in the three targeted cities—Newark, New Brunswick, and Trenton. Nearly 800 individuals were reached.

## Other activities

The NJOMH asthma project had other accomplishments, including:

- Developing a partnership with faith-based organizations to promote community outreach and education in African American and Latino communities in the three targeted cities;
- Training and presenting 21 community health promoters and coordinators with their certificates of achievement to document the "train the trainer" asthma intervention project;
- Establishing the first New Jersey Minority Health Network on Asthma committed to the treatment, education, and prevention of asthma in New Jersey;
- Developing a bilingual (English and Spanish) Asthma Resource Directory; producing an Asthma Fact Sheet and an Asthma Training Manual for use in this asthma prevention project; and
- Providing recommendations to the New Jersey Department of Health and Senior Services Commissioner to establish the Asthma Network as a permanent committee in order to sustain activities related to asthma and to incorporate asthma in the Healthy New Jersey 2010 initiatives.

The Asthma Resource directory is free of charge and provides information on organizations that offer asthma services in Newark, New Brunswick, Trenton, and their surrounding communities. Information is provided on each individual organization, including the type of organization and specific asthma outreach and education services.

"The Resource Directory is very popular. We have recently made additional copies of the Spanish version, due to great interest," said Ongwenyi. NJOMH also distributes copies of the directory to consumers.

As part of an Asthma Forum held at a church in New Brunswick, community health promoters and members of church leadership determined that the asthma health promotion effort enhanced the community health and wellness in each target

*continued on page 11...*

*Asthma is the most common chronic illness of childhood, afflicting more than 4.4 million American children...*

# Prostate Cancer: “Real Men” are Checking it Out in South Carolina

By Houkje Ross

**G**ardenia Ruff is on a mission to improve the health status of minorities in South Carolina. As the director of South Carolina’s Office of Minority Health, she is excited about the attention minority health issues are receiving across the state. Ruff continues to work on many issues, and decided to tackle prostate cancer because of a lack of emphasis in general on male health issues and the limited number of initiatives that are culturally competent.

In 1998, funding from the federal Office of Minority Health enabled Ruff to develop the Prostate Cancer Health Communication and Education Initiative for African American males in South Carolina. Within the last decade, prostate cancer has become a major health problem in South Carolina. Statistics from the Centers of Disease Control and Prevention and the American Cancer Society, hospital discharge data, and death certificates show that the state has one of the highest rates of prostate cancer mortality in the nation.

Several organizations in South Carolina have set out to educate and screen African American men for prostate cancer but, “they have not taken into consideration the need to seek community involvement in the development and implementation of acceptable educational programs for the target population,” according to a summary of the initiative.

Ruff’s project, which did seek community involvement, developed a health education guide poster and other educational materials that work for African American communities in her state. The message, “Real Men Get It Checked,” confronts masculinity issues while encouraging men to get prostate screenings.

## Success Comes from Listening to the Community

The initiative has been highly successful, in part because Ruff and her staff made a point of gaining an understanding of African American attitudes, beliefs, and knowledge about health and prostate cancer. Outreach materials, tools, and methods were all developed based on what the African American community told the South Carolina team.

With one urban and one rural county represented, the initiative used focus groups to gather information on definitions of health, early exposure to health messages, sources of health information, and knowledge of prostate cancer and screening methods.

Focus group participants, who included both men and women, were asked to develop messages that would encourage men to participate in early screening. Initially, the community resisted participation in the focus groups. Many African Americans are tentative when it comes to discussing cancer and sexuality. But once a well-respected community member facilitated the process of recruiting members and word spread, participation was no longer a problem.

The focus groups determined that clear, to-the-point messages should be used when conducting outreach to African American males. A trusted messenger and a comfortable and familiar setting also play a large part in how well African American males respond to outreach. Threats to masculinity, denial, fear of impotence, death, and rectal exams all were cited as barriers to screening. The focus group results revealed:

- African American males had no clear definition of health. Being pain free, however, was associated with good health.
- Media sensationalism, hysteria, and mixed messages about health contribute to a lack of trust in the African American community.
- Unnatural food production (i.e. steroid injections, food additives) and preparation was associated with cancer.
- Rural respondents were more likely to perceive a correlation between soil, ground water, air pollution and cancer. Lack of consumption of home-grown vegetables was also associated with the increase in cancer.
- Cancer is not discussed because cancer always means death.
- Doctor and hospital visits were not a part of early family rituals.
- Women expressed frustration in men’s lack of cooperation in scheduling and following through with doctor’s visits, and over men’s unwillingness to learn about diseases that can have a devastating effect on the individual as well as the entire family.
- A lack of knowledge of the location and function of the prostate was evident, particularly in the rural male group ages 21-39.

“We have had an overwhelmingly positive response from those who participated in the prostate education. Both the men and women found it to be very useful. Ten years ago this would not have happened,” said Ruff. “We accomplished what we set out to do; we reached our target population,” she said. Palmetto Baptist Hospital, one of the largest teaching hospitals in the state, has adopted the

*continued on page 11...*

# Tennessee Creates Latino Network

By Houkje Ross

An increase in phone calls about Hispanic health to her office and in the number of Hispanic faces she saw on the street were enough to convince Patricia Totty that something was changing in Tennessee.

Tennessee's Latino population has grown tremendously over the last 18 years. Traditionally a state comprising African Americans and whites, Tennessee now has more than 63,000 Latinos, up from 14,000 in 1980. "Even without the data to back it up, you could see the changes," said Totty, assistant director of the Tennessee Office of Minority Health (OMH).

With the changing demographics came more and more Hispanic-serving community-based organizations around the state. They were all working to address the concerns of the growing Latino population. "We also began to receive calls and questions from health care workers," Totty said. "They were asking for data on Hispanics and looking for physicians who could serve this population."

At the same time state OMH was receiving calls, it noticed that many community organizations were unaware of each other. "As a result, services were sometimes overlapping," said Totty.

## Network promotes information sharing

To bring organizations and individuals together, Tennessee's OMH, with funding from the federal OMH, initiated a collaborative partnership in 1998 called the Hispanic Coalition Network. The Network aims to gather information on the socio-cultural characteristics of Latinos in Tennessee and to disseminate statistical data among agencies and organizations

that work with Latinos.

The Network will also work to increase partnerships and collaborative efforts between Latinos and non-Latinos of Tennessee and serve as a clearinghouse for appropriate information and resources.

Once a month, members of the Hispanic Coalition Network meet with staff of Tennessee's OMH. "It's really about information sharing," said Totty. Members of the network include churches, police departments, educators, individuals who work with migrants, and other community organizations. An average of 15 members come to the meetings, said Totty.

"With this population, we found that the best way to provide services is by word of mouth," said Totty. Recently, BellSouth gave the Network space on the Web for a listserv where members can post information. The state also developed a bilingual resource directory of Hispanic and Latino services throughout the state.

"For about eight months now, we have also had a presenter come to speak with Network members on current topics of interest," said Totty. An agent for the Immigration and Naturalization Service has come to discuss immigration laws and documentation guidelines, and several state health representatives came to talk about the state managed care, maternal and child health, and breast and cervical cancer programs, according to the summary report of the Network. (See box on this page.) "The response has been very positive," said Totty.

Totty notes that the Network is not expensive to run—only about \$200 per month. "The most expensive and time consuming part of developing the Network was the initial set-up. I spent a lot of

*"With this population, we found that the best way to provide services is by word of mouth."*

## Keeping up with Emerging State Issues

The Tennessee Office of Minority Health arranged several presentations for members of the Hispanic Coalition Network. Examples of presenters and topics included:

- The Immigration and Naturalization Service gave a presentation on immigration laws, documentation guidelines, establishment of full service offices, and deportation policies.
- A legislative lobbyist discussed how to access legislators to support general diversity and specific interest issues in the state's General Assembly.
- A community organizer discussed how to develop community needs assessments for public service awareness programs for new populations.
- Legal aide representatives and public defense attorneys discussed legal issues impacting Hispanics in Tennessee and how to access criminal justice resources.
- Representatives from the Tennessee Department of Health talked about the state managed care program (TennCare), maternal and child health programs, and breast and cervical cancer programs.

time searching for a consultant who could help me establish a strategic plan for the Network," she said. Totty added that she chose a Hispanic consultant to gain credibility with the Hispanic population.

*For more information on the Hispanic Coalition Network, contact Patricia Totty, (615) 741-9443. ❖*

**Association of State and Territorial Health Officials**

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Washington, D.C. 20005-4006  
<http://www.astho.org>  
(202) 371-9090

**American Public Health Association**

800 I Street NW  
Washington, DC 20001-3710  
<http://www.apha.org>  
(202) 777-APHA

**Association of Schools of Public Health**

1101 15th Street NW Suite 910  
Washington DC, 20005  
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**National Alliance of State & Territorial AIDS Directors**

444 North Capitol Street NW, Suite 339  
Washington, D.C. 20001  
<http://www.nastad.org>  
(202) 434-8090

**National Association of County and City Health Officials**

1100 17th Street, Second Floor  
Washington, DC 20036  
<http://www.naccho.org>  
(202) 783-5550

**National Association of Local Boards of Health**

1840 East Gypsy Lane Road  
Bowling Green, OH 43402  
<http://www.nalboh.org>  
(419) 353-7714

**National Association of State Alcohol/Drug Abuse Directors**

808-17th Street NW, Suite 410  
Washington, DC 20006  
<http://www.nasadad.org>  
(202) 293-0090

**National Conference of State Legislatures (NCSL)**

444 North Capitol St. NW Suite 515  
Washington, D.C. 20001  
<http://www.ncsl.org>  
(202) 624-5400

city. The Forum allowed community members who had participated in the project to present their impressions of the project and community receptiveness to the program, said Ongwenyi. Giving one-on-one information on asthma was a key part of the project, according to forum members. Attendees also said the project was well received by Latino and African American communities in the three cities. Community leaders encouraged the continuation of the project.

The Forum allowed community health promoters to share first-hand their involvement with the project. Ongwenyi said, as a result of the project, community members became interested in other asthma resources, such as where to go for help and what to do about problems with asthma.

After funding for this project ended, the NJOMH asked the Division of Family

Health Services of the New Jersey Department of Health to continue the asthma project. The NJOMH asked that the Division of Family Health Services continue to involve community members who were involved in the Minority Health Network on Asthma from the start. "We wanted to ensure that there should be a community presence," said Ongwenyi.

To ensure that minorities who are most in need of asthma services are not left by the wayside, the NJOMH wanted key people from this project to go on to the next phase. "We know that the focus is going to be on a larger scale, but we don't want to completely dilute the minority presence," said Ongwenyi.

*For more information, contact the New Jersey Office of Minority Health at (609) 292-6962. The Resource Directory is available on line at: <http://www.state.nj.us/health/commis/omb/asthma/>.* ❖

**Health Data for US Counties Now Available on Web**

HRSA, the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, and the Public Health Foundation, recently unveiled a new Web site on health data for all 3,082 U.S. counties.

The Community Health Status Indicators Project has compiled pre-existing data from a variety of sources and created a report for each county. The reports offer data on population characteristics, leading causes of death, vulnerable populations, environmental health, and access to care.

To access reports, users can either enter a county or search for a county by selecting a state and/or population range. Searches can also be limited to those counties with the highest percentage of non-white or Hispanic inhabitants. Reports can be downloaded and data can be compared to that of "peer" counties, which share similar demographics. The site also provides supplemental material to make the reports more understandable and usable.

*For more information, go to <http://www.communityhealth.hrsa.gov/>.* ❖

**Prostate...from page 9**

model Ruff and her staff developed.

The hospital gave grants to 30 churches throughout the state, which will use the "Real Men Get it Checked" prostate cancer information materials. Many organizations have expressed an interest in using the posters and materials Ruff's office developed; other organizations want to adapt the materials for colorectal screening. "I would estimate that as many as 12,000 people could be reached through the church grants," said Ruff.

Other states can use South Carolina's model, but Ruff says they should still conduct focus groups to fine-tune the model to their target population.

*For more information, contact: Gardenia Ruff, South Carolina Office of Minority of Health, (803) 898-3344.* ❖

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# Closing the Gap

## Conferences: Year 2000-2001

**Oct 11-14:** Strategy and Action for Communities, Providers, and a Changing Health Care System. The Second Annual Conference on Quality Health Care for Culturally Diverse Populations. Sponsored by DiversityRX. Wilshire Grand Hotel and Centre, Los Angeles, CA. Contact Diversity RX or call (718) 270-7727.

**Oct 27-28:** Treatment and Adherence Research in Racial and Ethnic Minority Communities: Opportunities for Minority Investigator's Treatment and Adherence Research. Crystal City Marriott, Arlington, VA. Sponsored by the Office of AIDS Research, National Institutes of Health. Contact: Elaine or Lolita Ellis (301) 402-2932; <http://www.nih.gov/od/oar>.

**Nov 1-3:** Preparing for the Future Dynamic Border. The University of Texas-Mexico Border Health Coordination Office's 6th Biennial Health Symposium. Contact: Texas-Mexico Border Health Coordination Office, (956) 381-3687; <http://www.panam.edu/dept/tmbhco>.

**Nov 2-5:** Building Personal and Professional Competence in a Multicultural Society Conference held at the Wyndham Washington, DC. Sponsored by the National Multicultural Institute. Contact the National Multicultural Institute at (202) 483-0700; or go to <http://www.nmci.org>.

**Nov 29-Dec 1:** Living Healthier, Living Longer: The Will and the Way. The 15th National Conference on Chronic Disease Prevention and Control. Washington Hilton and Towers, Washington, DC. Sponsored by the Centers for Disease Control and Prevention and the Association of State and Territorial Chronic Disease Program Directors. Call (202) 797-5782.

**Dec 13-15:** Eliminating Health Disparities: A Challenge for the Decade. Texas' Eighth Minority Health Conference. Hyatt Regency in Dallas, TX. Sponsored by the Texas Department of Health, Office of Minority Health and the Texas Health Foundation. Contact Eva Holguin, (512) 458-7629.

**Feb 10-13, 2001:** National Association of State Mental Health Program Directors Research Institute, Inc. 11th Annual Conference on State Mental Health Agency Services Research, Program Evaluation and Policy, Washington, DC. Visit <http://www.nasmhpd.org/nri>; or call Vera Hollen 703-739-9333; [vera.hollen@nasmhpd.org](mailto:vera.hollen@nasmhpd.org).

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