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Disparities in the Health Care Status of Women: Implications for Research

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Even a cursory review of data on the health status of women reveals striking differences by race. According to data from the National Center for Health Statistics, death rates among Black women from the three leading causes of death (cardiac disease, cancer and cerebrovascular disease) exceed those of white, Asian, Native American and Latina women for each age category from 45–84. With the exception of Black women, the death rates among white women from these diseases exceed those of other ethnic groups of women.[1] Data on two of the risk factors for cardiac and cerebrovascular diseases (hypertension and obesity), show that rates among Black women exceed those of white women by a ratio of 2:1. Overall, the age-adjusted obesity rate between 1976–1980 was 44% among Black women and 24% among white women between the ages 20–74.[2] The 1988–1991 obesity rates for Black and white women were 50% and 34% respectively.

While the disparity is not as great, a similar pattern is reflected in the data on hypertension. From 1976–1980, the overall age-adjusted hypertension rate among Black females 20–74 was 48% while that for white females was 32%. The 1988–1991 hypertension rates for Black and white women were 31% and 19% respectively.[3] Even when we move from mortality statistics and the prevalence of selected risk factors to another end of the age spectrum, the data show that low birth weight births among Black females are alarmingly higher than those of white females and other groups of women of color.[4] The statistics illustrate that Black women are at a disproportionately higher risk of disease, disability, and death than white women and other groups of women of color; and when socioeconomic status is taken into account, these disparities become even greater.

Based on data from the National Center for Health Statistics, 33% of the Black population, 29% of the population of Hispanic origin, and 12% of the white population reported incomes below the poverty level. In addition, 57.2% of Black families, 57.4% of Hispanic families, and 39% of white families were female-headed with children under the age of 18.[5] Poverty is not unidimensional, rather it is poverty and its sequelae, both direct and indirect, that explain much of racial disparities in the health status of women, and clearly any discussion on health care reform must address issues of access to health care for the uninsured and the underinsured, as part of a multi-pronged strategy to decrease the gaps in health status.

Public policy clearly has a role in addressing these disparities through expanded quality health services for marginalized groups who have not had access to such services and care. Health educators and practitioners can play an effective role by providing some voice to the voiceless regarding this situation. In addition to advocacy through public policy, there is a need for new models for health promotion. The disparities in the health status of women suggest that traditional models of health promotion and disease prevention have been unsuccessful in significantly improving the health status of Black women. As pointed out in the *Report of the Secretary's Task Force on Black and Minority Health*, "it will take health education and behavioral change to close the gap between the health status of whites, African Americans, and other ethnic groups."[6]

A multi-faceted strategy is required to reduce the gaps in health status between Black and white women. A significant piece of the strategy involves the creation of effective community-based health promotion models that can be adapted to one's culture, rather than perpetuating models and concepts that are based on the assumptions, theories, and frameworks of the dominant culture. Failure to develop a health promotion model that encompasses the cultural meaning and significance of health behaviors can be linked to the glaring disparities in health care status.

Effective health promotion strategies include three components: program planning, implementation, and evaluation. The effectiveness of health promotion programs is measured by the degree of success in meeting a prescribed goal, of course, but there is another basic question that must be answered. Prior to measuring the effectiveness of a health promotion initiative, we need to ensure that the information reaches the intended audience.

Too often and too quickly, health promotion initiatives focusing on communities of color may be judged ineffective or anecdotally successful, but careful analysis would reveal that the necessary program information never even reached the intended audience. Failure of health promotion programs to reach an intended audience, particularly communities of color, is frequently linked to the development of health information and distribution strategies that are conceptually and methodologically flawed.[7]

When the failure is conceptual, the information may be presented in a manner that fails to attract the attention of the intended audience because the audience is not reflected in the message. Yet when the failure is methodological, information may not reach the intended audience due to patterns of information distribution. Our current health promotion models often require one to enter a health care facility to receive the information, and often the motivation for entering a health care facility is an episodic event or periodic health maintenance matter. Access to group-specific health information needs to be integrated into the ordinary activities of daily living. Health promotional information should be placed in laundry mats, beauty salons, and grocery stores, for example. These are examples of health promotional information that is accessible, and available through the ordinary activities of daily living for members of the intended audience. The development of a culturally-appropriate paradigm is critical. Dr. Collin Airhihenbua, Professor of Health Education at Penn State University, has developed a health education model that addresses issues of cultural sensitivity and appropriateness in health promotion program development. His "Pen-3" model was originally developed as a framework for health promotion and disease prevention in African countries. The model consists of three dimensions: health education, educational diagnosis of health behavior, and cultural appropriateness of health behavior. These dimensions are interdependent. Each dimension consists of three concepts designated by each letter of the acronym PEN: P-person; E-extended family; N-neighborhood and community.[8]

In order to meet the first condition of effectiveness, the information regarding a health promotion initiative must penetrate each of these levels. Too often the failure of health promotion initiatives can be linked to a failure to implement a strategy that penetrates each of these levels.

A health promotion intervention must include a methodology that not only locates the specific intervention in the community, but also assures that the socio-political realities of the residents of a specific community are reflected in the methodology. Lack of attention to this level of detail is not only naive but will also result in program failure. In addition, health promotion program planners should understand that the implementation methodology may not fit into a Monday–Friday, 9 a.m.–5 p.m. schedule. It may be necessary to attend community meetings, or a weekend community event.

Another component of a health promotion initiative is program evaluation. According to James Mason, former Assistant Secretary for Health and Human Services, research in the 1990's increasingly focuses on those that experience a disproportionate burden of disease, disability, and death. This focus in minority communities is justified and essential for achieving national health objectives.[9] Many of the behavioral factors that explain the disparities in health status can be changed. However, progress toward reaching national goals and objectives will require greater research into the behavior, motivation, and relationship of people at the grassroots level.[10] But, as a precondition for obtaining this insight, researchers must also understand that there is a distrust of research in the Black community, due to negative experiences with researchers.

Collaboration and cooperation between the medical and health sectors and community groups could alleviate some of this suspicion.

In an article titled, "A Legacy of Distrust: African-Americans and Medical Research," Dr. Vanessa Northington Gamble suggests that "a historical analysis of racism and American medicine illuminates the ways in which the profession has been used to support racist social institutions, and has in turn been influenced by them."[11] The Tuskegee Syphilis Study is highlighted to illustrate this point. This study was conducted from 1932–1972 by the United States Public Health Service (USPHS). The experimental group consisted of 400 poor Black sharecroppers from Macon County, Alabama with latent Syphilis, and the control group consisted of 200 men without the disease. Treatment was denied to the experimental group in order to document the natural development and history of the disease. Numerous reports on the study were published in prominent medical journals and the study had received much notoriety throughout the medical community. After reviewing the study in 1969, a committee from the Centers for Disease Control (CDC) decided to continue it. The study was eventually terminated because a USPHS worker leaked the information to the press. The media disclosure and public outrage not only led to the termination of the study, but ultimately to the National Research Act of 1974, which mandated institutional review board approval of all federally-funded projects involving human subjects.[12]

The specter of suspicion has been raised once again as the numbers of Blacks infected with HIV and AIDS increases. Concerns about genocide and conspiratorial schemes are real, and researchers must willingly engage in dialogue around these concerns and not merely dismiss them as "much ado about nothing." Collaboration and cooperation between the medical and health sectors and community groups could alleviate some of this suspicion. But, the lack of a collaborative effort too often results in the formation of false hypotheses about observed behavior, by those who are from different cultures than

the clients. The benefits of collaboration are symbiotic. This is precisely why guidelines from National Institutes of Health (NIH) call for the inclusion of women and non-white subjects in studies, and if they are omitted from a study, a compelling reason for their exclusion should be provided. Researchers will be unable to recruit people of color for inclusion in NIH-funded studies without first addressing this issue of distrust. As one safeguard, I recommend the establishment of community review boards to approve and monitor community research projects.

In an article titled, "Community Research: Partnership in Black Communities," J. Hatch et al. suggest that finding a common ground between researchers and a particular community is the goal of collaborative research. Collaboration is possible when each party has a stake in the design of studies and the interpretation of research findings.[13] In his book *The Disturbed Subject: Epistemological and Ethical Implications of Reactivity in Videotape Research*, Jeffrey Roth suggests that collaboration between researchers and subjects actually enhances the internal validity of a study because alternative explanations for the findings would be identified and discussed.[14] In addition, a collaborative research model ought also to ensure the continuation of the health promotion intervention when the research project is concluded. The withdrawal of resources at the conclusion of a project only adds to the prevailing distrust.[15]

New models for health promotion intervention and new models for community-based collaborative research are required as a partial strategy to address the disparities in the health care status of women. These models are necessarily similar because community involvement and cultural awareness are integral to both. The challenge for the researcher and the community is to find the common ground where each has a stake in the process and the product, thus creating a win-win situation. If institutions continue to seek NIH-supported funding for research, a dialogue about issues of trust must occur between institutions and communities of color as a first step to gaining access to a study population. Creating an effective model for community-based health promotion program intervention, combined with strong advocacy for access to health care will, over time, change the statistics and decrease the racial disparities in health status for women. To be sure, the challenge is formidable, but new approaches to health promotion are required to move beyond the rhetoric on achieving the surgeon general's objectives for the year 2000.

Notes

[1] National Center for Health Statistics, *Health United States, 1993* (Hyattsville, Maryland: Public Health Service, 1994.)

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] U.S. Department of Health and Human Services, *Report of the Secretary's Task Force on Black and Minority Health*, Vol. 1, Executive Summary (Washington, D.C.: Government Printing Office, 1985).

[7] C.O. Airhihenbua, "Health Promotion and Disease Prevention Strategies for African Americans: A Conceptual Model." In R. Braithwaite & S. Taylor (Eds.), *Health Issues in the Black Community.* (San Francisco: Jossey-Bass, 1992).

[8] Ibid.

[9] J. Hatch, et al., "Community Research: Partnership in Black Communities." In D. Rowley & H. Tosteson (Eds.), *Racial Differences in Preterm Delivery. American Journal of Preventive Medicine*, Supplement 9(6), (1993), 27-31.

[10] Ibid.

[11] V. Gamble, "A Legacy of Distrust: African American and Medical Research." In D. Rowley & H. Tosteson (Eds.), *Racial Differences in Preterm Delivery. American Journal of Preventive Medicine*, Supplement 9(6), (1993), 35-38.

[12] Ibid.

[13] Hatch, et al., "Community Research."

[14] J. Roth, *The Disturbed Subject: Epistemological and Ethical Implications of Reactivity in Videotape Research.* (New York: Peter Lang, 1990).

[15] Hatch, et al., "Community Research."

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