

# California Food Guide

## Health and Dietary Issues Affecting African Americans

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### What's New?

- Heart disease and cancer are the first and second leading causes of death for African-American adults 18 years and older in California<sup>1</sup> and nationally.<sup>2</sup>
- Diabetes was the fourth leading cause of death among African-American adults 18 years and older, accounting for 812 deaths in California<sup>2</sup> and 12,687 deaths nationally during 2002.<sup>3</sup>

### Public Health Implications

In an attempt to eliminate health disparities among minority populations, in 2002, the United States Department of Health and Human Services (HHS) created an educational campaign designed to help make good health an important issue among racial and ethnic minority populations. The campaign ***Closing the Health Gap*** supports HHS' efforts to eliminate racial and ethnic health disparities and promote the goals of Healthy People 2010. It also advances the HHS Steps to a Healthier U.S. program and the President's Healthier U.S. Initiative.<sup>4</sup>

### Introduction\*

Despite improvements in the overall health of Americans during the past few decades, minorities, primarily African Americans, American Indians, and persons of Hispanic origin, tend to have more chronic health problems, live in poverty, lack insurance coverage, and be unable to work because of a disability.<sup>5</sup> These disparities are multi-variant, complex, and rooted in an inequitable health care system. Contributing factors include lack of access to health care; barriers to care; biological, socioeconomic, ethnic, and family factors; cultural values and education; and culturally insensitive healthcare systems.<sup>6, 7</sup>

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\* African American, non-Hispanic black, and Black may be used in the text depending on the citation source. Similarly for White and Caucasian.

## **Definition**

African Americans, also known as Afro American or Black Americans, are an ethnic group in the United States whose ancestors were predominantly indigenous to sub-Saharan and West Africa. The majority of African Americans are of African, European and Native American ancestry.<sup>8</sup>

According to the 2004 U.S. Census figures, some 37.5 million African Americans lived in the U.S., comprising 12.9 percent of the total population. In 2000, 54.8 percent of African Americans lived in the South, 17.6 percent in the Northeast and 18.7 percent in the Midwest, while only 8.9 percent lived in the western states. Approximately 88 percent of African Americans lived in metropolitan areas in 2000. With over two million African-American residents, New York City had the largest Black urban population in the U.S. Among cities of 100,000 or more, Gary, Indiana, had the highest percentage of Black residents of any U.S. city, with 85 percent, followed closely by Detroit, Michigan, with 84.6 percent.<sup>9</sup>

African-American cuisine traditionally includes many nutritious items such as yellow and green leafy vegetables which are rich in vitamins and antioxidants; fish; poultry; and beans, which are naturally low in fat and excellent sources of protein. However, many of the traditional methods of cooking such as deep frying, seasoning with ham or ham hocks, or adding gravy are in conflict with the heart-healthy recommendations to reduce fat and sodium intake. Many African-American rites revolve around food. The popular term for African-American cooking is “soul-food.” Staples of soul food include fried chicken, fried pork chops, cornbread, and ribs. Many of these dishes use large amounts of pork fat, butter, and salt for flavor.<sup>10</sup>

When the African-American 5 a Day Campaign surveyed African Americans in California, they reported out-of-home eating weekly or less often (61 percent). Of these, only two percent never ate out and the remaining respondents dined out two or more times per week and ate significantly fewer daily servings of fruits and vegetables than those eating out less frequently (2.7 vs. 3.3 servings,  $p < .001$ ). These frequent diners tended not to meet the daily recommended number of fruit and vegetable servings (13 percent vs. 21 percent,  $p < .05$ ). In this survey, out-of-home eating was associated with lower fruit and vegetable intake.<sup>11</sup>

When dining out, fast food was the most popular restaurant choice among African Americans (29 percent), casual sit-down restaurants ranked second (26 percent), and soul food establishments came in third (22 percent). African Americans eating at fast food restaurants most often ate significantly fewer fruits and vegetables. However, there were no differences in fruit and vegetable intake when eating at other types of dining establishments.<sup>11</sup>

Fast food consumption is associated with a diet high in energy (calories), low in essential micronutrients. Frequent fast food consumption may contribute to weight gain,

because fast foods can provide more than one-third of the day's energy, total fat and saturated fat. Negligible amounts of milk and fruits and large amounts of non-diet carbonated soft drinks tend to be consumed at fast food places. Also, adults who report eating fast food regularly tend to have higher mean body mass index (BMI) values than those who did not eat fast food.<sup>12</sup>

## **Burden**

In 2003, health care spending in the U.S. reached \$1.7 trillion.<sup>13</sup> Despite this tremendous expenditure, it is well documented that ethnic and racial minorities are disproportionately affected by many health conditions that negatively impact their health in comparison to White Americans.

While the causes associated with disparities in health and health care are varied, it is important to understand the role socioeconomic status plays in health status. Lower socioeconomic status often results in inadequate housing; poor nutrition; bad social environments, and working conditions; poor access to or limited contact with the health care system; and fewer social amenities that directly or indirectly affect health. The impact of lower socioeconomic status on morbidity and mortality is especially pronounced among African Americans.<sup>14</sup> Unemployment due to disability was higher for non-Hispanic black men and women age 55-64 years than for other racial and ethnic groups. In 2001, 16 percent of disabled Medicare participants for age 45-64 years were Black adults, and they represented only 11 percent of the population in this age group.<sup>5</sup> Higher rates of unemployment due to disability for Black adults may be explained in part by a higher prevalence of heart, kidney, and other diseases and jobs that are physically demanding and less likely to accommodate a disabled or partially disabled worker. Also, African Americans tend to have higher rates of enrollment in the Medicare End-Stage Renal Disease Program, partially due to their higher prevalence of diabetes and hypertension.<sup>11</sup>

Data released by the U.S. Census Bureau shows that the number of uninsured Americans stood at 45.8 million in 2004, an increase of 800,000 people over the number of uninsured in 2003. Lack of insurance was much more common among those with low incomes. Some 24.3 percent of people with incomes below \$25,000 were uninsured; almost triple the rate of 8.4 percent for people with incomes over \$75,000. African Americans were much more likely to be uninsured than non-Hispanic whites (19.7 percent vs. 11.3 percent, respectively).<sup>15</sup>

The nation's official poverty rate rose from 11.7 percent to 12.1 percent, and median household income declined 1.1 percent or \$42,409 during 2001 to 2002 according to reports released from the U.S. Census Bureau.<sup>16</sup> Among people who identified solely as Black or African American in 2002, 24.1 percent were in poverty, higher than the 22.7 percent for those who reported Black or African American in 2001, compared to 8.0 percent for non-Hispanic single race white, 10.0 percent to 10.3 percent for Asian, and 21.8 percent for Hispanics.<sup>17</sup> More than 60 percent of Black and Hispanic children <18

years and more than half of the Black and Hispanic population ≥ 65 years were poor or near poor during 2003 (Table 1).<sup>18</sup>

**Table 1: Persons and Families Below Poverty Level, According to Selected Characteristics, Race, and Hispanic origin: United States, Selected Years 1973–2003**<sup>18</sup> (Data are based on household interviews of the civilian non-institutionalized population)

<i>Selected characteristics, race, Hispanic origin</i>	<i>1973</i>	<i>1980</i>	<i>1985</i>	<i>1990</i>	<i>1995</i>	<i>2000<sup>2</sup></i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
<b>All persons</b>									
	<b>% below poverty</b>								
All races	11.1	13.0	14.0	13.5	13.8	11.3	11.7	12.1	12.5
White only	8.4	10.2	11.4	10.7	11.2	9.5	9.9	10.2	10.5
<b>Black or African American only</b>	<b>31.4</b>	<b>32.5</b>	<b>31.3</b>	<b>31.9</b>	<b>29.3</b>	<b>22.5</b>	<b>22.7</b>	<b>24.1</b>	<b>24.4</b>
Asian only	---	---	---	12.2	14.6	9.9	10.2	10.1	11.8
Hispanic or Latino	21.9	25.7	29.0	28.1	30.3	21.5	21.4	21.8	22.5
Mexican	---	---	28.8	28.1	31.2	22.9	22.8	---	---
Puerto Rican	---	---	43.3	40.6	38.1	25.6	26.1	---	---
White only, not Hispanic or Latino	7.5	9.1	9.7	8.8	8.5	7.4	7.8	8.0	8.2
<b>Related children under 18 years of age in families</b>									
All races	14.2	17.9	20.1	19.9	20.2	15.6	15.8	16.3	17.2
White only	9.7	13.4	15.6	15.1	15.5	12.4	12.8	13.1	13.9
<b>Black or African American only</b>	<b>40.6</b>	<b>42.1</b>	<b>43.1</b>	<b>44.2</b>	<b>41.5</b>	<b>30.9</b>	<b>30.0</b>	<b>32.1</b>	<b>33.6</b>
Asian only	---	---	---	17.0	18.6	12.5	11.1	11.4	12.1
Hispanic or Latino	27.8	33.0	39.6	37.7	39.3	27.6	27.4	28.2	29.5
Mexican	---	---	37.4	35.5	39.3	29.5	28.8	---	---
Puerto Rican	---	---	58.6	56.7	53.2	32.1	33.0	---	---
White only, not Hispanic or Latino	---	11.3	12.3	11.6	10.6	8.5	8.9	8.9	9.3

Source: Centers for Disease Control and Prevention website. [www.cdc.gov/nchs/data/hus/hus05/pdf#053](http://www.cdc.gov/nchs/data/hus/hus05/pdf#053) Accessed August 25, 2006.

Persons with incomes below or near the poverty level were at least three times as likely to have no health insurance coverage as those with incomes twice the poverty level or higher.

In 2003, persons living below the poverty level reporting fair or poor health were three times more than those with a family income more than twice the poverty level (20 percent and 6 percent, age adjusted). Fair or poor health among Hispanic persons and non-Hispanic black persons was twice as high as non-Hispanic white persons (see Table 1 and 2).<sup>5</sup>

**Table 2: Respondent-assessed Health Status According to Selected Characteristics: United States, Selected Years 1991–2003<sup>18</sup>**

(Data are based on household interviews of a sample of the civilian non-institutionalized population)

<i>Characteristic</i>	<i>1991</i>	<i>1995</i>	<i>1997</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
<b>% of persons with fair or poor health</b>								
Total	10.4	10.6	9.2	8.9	9.0	9.2	9.3	9.2
<b>Age</b>								
Under 6 years	2.7	2.7	1.9	1.4	1.5	1.6	1.6	1.4
6–17 years	2.6	2.5	2.1	1.8	1.8	1.9	2.1	2.0
18–24 years	4.8	4.5	3.4	3.4	3.3	3.3	3.6	3.8
25–44 years	6.4	7.2	5.9	5.6	5.7	6.0	6.2	6.3
45–54 years	13.4	13.4	11.7	11.5	11.9	11.8	12.7	12.1
55–64 years	20.7	21.4	18.2	18.5	17.9	19.1	17.9	18.9
65 years and over	29.0	28.3	26.7	26.1	26.9	26.5	26.3	25.5
65–74 years	26.0	25.6	23.1	22.7	22.5	22.9	22.0	22.3
75 years and over	33.6	32.2	31.5	30.2	32.1	30.7	31.3	29.2
<b>Race</b>								
White only	9.6	9.7	8.3	8.0	8.2	8.2	8.5	8.5
<b>Black or African American only</b>	<b>16.8</b>	<b>17.2</b>	<b>15.8</b>	<b>14.6</b>	<b>14.6</b>	<b>15.4</b>	<b>14.1</b>	<b>14.7</b>
American Indian and Alaska Native only	18.3	18.7	17.3	14.7	17.2	14.5	13.2	16.3
Asian only	7.8	9.3	7.8	8.6	7.4	8.1	6.7	7.4
Hispanic or Latino	15.6	15.1	13.0	11.9	12.8	12.6	13.1	13.9
Mexican	17.0	16.7	13.1	12.3	12.8	12.4	13.3	13.7

Source: Centers for Disease Control and Prevention website. [www.cdc.gov/nchs/data/hus/05/pdf#053](http://www.cdc.gov/nchs/data/hus/05/pdf#053) Accessed August 25, 2006.

Evidence suggests that African Americans suffer increasing health disparities in the incidence, prevalence, mortality, and burden of diseases and adverse outcomes in comparison to other populations. They have greater rates of heart disease, diabetes, cancer, stroke, and obesity. In 1999–2002, 50 percent of non-Hispanic black women were obese compared with nearly one-third of non-Hispanic white women. The prevalence of obesity among men differed little by race and ethnicity (28–29 percent).<sup>19</sup>

Overall mortality was 30 percent higher for Black Americans than for White Americans in 2003, and age-adjusted death rates for the Black population exceeded those for the white population by 43 percent for stroke, 31 percent for heart disease, 23 percent for cancer, and almost 750 percent for HIV disease.<sup>20</sup>

Mortality from cancer for males, the second leading cause of death, was most frequently diagnosed as prostate, followed by lung and bronchus, and colon and rectum. Cancer incidence at these sites is higher for Black males than for males of other racial and ethnic groups. In 2001 age-adjusted cancer incidence rates for Black males exceeded those for White males by 50 percent for prostate, 49 percent for lung and bronchus, and 16 percent for colon and rectum (see Table 2).<sup>20</sup>

The most frequently diagnosed cancer site in females is breast cancer and incidence is highest for non-Hispanic white. However, breast cancer mortality was 37 percent higher

for Black females than for White females in 2003. Cervical cancer rates were higher for Black women than the average for all women and experienced the highest death rates in 1997–2001, 5.6 deaths per 100,000 despite their high Pap smear screening rates.<sup>21</sup>

**Table 3: Age-adjusted Cancer Incidence Rates, 1990–2002<sup>18</sup>**

(Data: Surveillance, Epidemiology, and End Results [SEER] Program’s 13 population-based cancer registries)

	1990	1995	1999	2000	2002	1990–2002
<b>All sites, sex, race</b>						
<b>Number of new cases per 100,000 population</b>						
All persons	475.7	470.3	477.6	469.3	458.2	–0.5
White	483.2	476.4	496.5	480.4	466.9	–0.4
<b>Black or African American</b>	<b>512.7</b>	<b>532.2</b>	<b>527.7</b>	<b>511.8</b>	<b>504.3</b>	<b>–0.6</b>
American Indian or Alaska Native	265.1	272.1	269.4	224.1	199.7	–2.0
Asian or Pacific Islander	335.7	337.7	340.5	331.4	334.0	–0.3
Hispanic or Latino	341.1	358.7	362.4	349.8	346.7	–0.1
White, not Hispanic or Latino	490.0	484.4	497.4	492.3	478.4	–0.3
<b>Prostate</b>						
Male	166.7	165.7	178.3	175.9	171.5	–1.5
White	168.2	160.4	172.8	171.1	166.3	–1.8
<b>Black or African American</b>	<b>218.3</b>	<b>271.6</b>	<b>280.0</b>	<b>281.3</b>	<b>265.1</b>	<b>–0.7</b>
American Indian or Alaska Native	84.8	66.4	67.3	36.8	46.6	–5.9
Asian or Pacific Islander	88.8	103.2	105.8	104.8	98.7	–0.9
Hispanic or Latino	114.7	138.4	143.9	142.2	141.0	0.2
White, not Hispanic or Latino	169.2	160.0	171.4	170.3	166.0	–1.8
<b>Breast</b>						
Female	129.2	130.6	137.6	133.1	129.9	0.4
White	134.3	136.2	144.3	140.1	135.8	0.5
Black or African American	116.6	121.8	122.8	118.8	119.3	0.1
American Indian or Alaska Native	46.7	66.1	58.1	55.4	47.9	–1.3
Asian or Pacific Islander	86.9	86.6	97.1	91.6	97.4	1.4
Hispanic or Latino	84.5	88.8	92.0	92.6	88.5	0.5
<b>White, not Hispanic or Latino</b>	<b>138.4</b>	<b>142.2</b>	<b>153.0</b>	<b>147.7</b>	<b>144.2</b>	<b>0.7</b>

Source: Centers for Disease Control and Prevention website. [www.cdc.gov/nchs/data/hus/05/pdf#053](http://www.cdc.gov/nchs/data/hus/05/pdf#053) Accessed August 25, 2006.

Infant mortality, the risk of death during the first year of life, is related to the health of the mother, public health practices, socioeconomic conditions, and availability and use of appropriate health care for infants and pregnant women. During 2000–2002, the infant mortality rate was highest for infants of non-Hispanic black mothers. Rates were also high among infants of American Indian or Alaska Native mothers, Puerto Rican mothers, and Hawaiian mothers.<sup>22</sup>

**Incidence and Prevalence**

African Americans have one of the highest levels of obesity in the U.S. Fifty-eight percent of African American men and 69 percent of African American women are either overweight or obese.<sup>23</sup> Among African American children at 6-11 years of age, 17 percent of boys and 22 percent of girls are overweight. Among African American

adolescents at 12-19 years of age, 21 percent of boys and 27 percent of girls are overweight. Studies have shown that overweight adolescents have a 70 percent chance of becoming obese adults, increasing to 80 percent if one or more parent is overweight or obese.<sup>24</sup>

Increasing numbers of African Americans suffer from health problems associated with obesity, such as high cholesterol, stroke, hypertension, asthma, sleep apnea, polycystic ovarian syndrome, and orthopedic problems.<sup>25</sup>

Obesity and overweight contribute to the high prevalence of type 2 diabetes in the African American community. Approximately 2.8 million or 13 percent of African Americans have diabetes and are twice as likely to suffer from type 2 diabetes as whites, and 25 percent of African Americans between the ages of 65-74 have diabetes.<sup>25</sup>

The highest rates of diabetes are found among black women—one in four women over 55 years of age has diabetes. African Americans also have higher rates of complications from diabetes, such as blindness, cardiovascular disease, end stage renal disease (kidney disease) and amputation.<sup>25</sup>

Within California, the statistics are just as startling. According to the California Department of Health Services, 27 percent of adults are obese, while in total, 65 percent are overweight and obese, and heart disease and cancer account for (52.2 percent) of deaths among African Americans in California. Diabetes was the fifth leading causing of death among African-American adults 18 years and older accounting for 704 deaths in California during 2001.<sup>25</sup>

According to the American Heart Association, cardiovascular disease (CVD) ranks as the number one killer of African Americans, claiming the lives of 36 percent of the more than 290,000 African Americans who die each year. It was also reported that the rate of high blood pressure in African Americans in the U.S. is among the highest in the world.<sup>26</sup>

Based on an American Cancer Society report, it was noted that African Americans are less likely to survive for five years after being diagnosed with cancer than whites at all stages of diagnosis. This may be due to reduced access to medical care; being diagnosed at a later stage, when the disease has spread to regional or distant tissue; and/or disparities in treatment. Although cancer death rates decreased for African Americans in the 1990s, African Americans still have a higher death rate from all causes of cancer compared to whites.<sup>27</sup>

## **Trends/Contributing Factors**

Poor dietary choices and limited access to healthy foods, inactive lifestyles, cultural norms and beliefs, and low socio-economic status all contribute to the high prevalence of obesity and overweight among African Americans. Fewer than half of all African

Americans meet the minimum recommended servings of fruits and vegetables and do not consume enough fiber.<sup>28</sup>

African Americans tend to consume processed and fast foods that are higher in fat and calories and lower in nutrients. Larger meal portions consumed also contribute to increased fat and calories. Scientists estimate that as many as 50 to 70 percent of cancer deaths in the U.S. are caused by human behaviors such as smoking and dietary choices. Some important steps in preventing cancer include maintaining a healthy weight, being physically active, avoiding tobacco use, and eating a low-fat diet that is high in fruits and vegetables.<sup>29</sup>

In a 2004 survey, the majority of the African Americans surveyed reported out-of-home eating weekly or less often (61 percent). Of these, only two percent never ate out. The remaining respondents dined out two or more times per week and were classified as regular diners. When dining out, a fast food restaurant was the most popular choice among African Americans (29 percent). Casual sit-down restaurants ranked second (26 percent) and soul food restaurants came in third (22 percent). African Americans who reported eating at fast food restaurants most often ate fewer servings of fruits and vegetables (2.5 vs. 3.3 servings) and were less likely to reach the daily recommended number of fruit and vegetable servings (8 percent vs. 21 percent).<sup>30</sup>

With respect to physical activity, when surveyed, more than half of African Americans reported that they did not participate in the recommended levels of physical activity (30 minutes of moderate or vigorous physical activity, five days a week).<sup>31</sup>

Within California, 18 percent of African Americans reported that they did not participate in any leisure time physical activity in the past month.<sup>32</sup>

Although African American men get less physical activity than White men, the greatest disparity in physical activity is seen among African American women. Various barriers have been cited, such as: a lack of time; physical and emotional exhaustion; lack of motivation to be physically active; living in a high crime area; inclement weather; lack of recreational facilities; and an absence of social support.<sup>33</sup>

### **Barriers to Implementation/Myths**

African American culture may play a role in the prevalence of overweight and obesity. Cultural factors have historically affected dietary choices, physical activity levels, and body weight acceptance.

Historically, African Americans lived an extremely active lifestyle that may have provided protection from the unhealthy effects of a high-fat diet. Unfortunately, sedentary lifestyles have caused health problems related to their diets to surface.

Ethnic disparities in prevalence of overweight highlight the importance of examining cultural differences among children from different racial and ethnic backgrounds and their

effects on adiposity. For example, several studies have shown that African American girls and women experience less social pressure about their weight. Thus, they tend to be more satisfied with their bodies, and have less negative attitudes about being overweight compared to white girls and women. These cultural differences have been hypothesized to account, in part, for the higher prevalence of obesity observed among African American girls and women.<sup>34</sup>

The correlation between body image size and ethnic and gender background for Americans, especially for standards of attractiveness, is a primary determinant of body size. Black women are more satisfied with a larger body size than White women because African-American men consider a large buttock and wide hips as features of attractiveness.<sup>35</sup> As a result, most black women are not only comfortable with a large body size but maintain large bodies to increase acceptance by Black males.

Although obesity and overweight affect African Americans from all socioeconomic levels, poverty appears to play a major role in the prevalence of obesity. Low socioeconomic status and the resulting stress and difficulties can contribute to poor choices and high rates of obesity. More African Americans with higher and middle incomes meet minimum dietary recommendations than do those with lower incomes.<sup>36</sup>

Among African Americans who think they should eat more fruits and vegetables, over 75 percent listed difficulty purchasing fruits and vegetables at fast food restaurants as the leading barrier to eating more fruits and vegetables. The reasons stated for not eating more fruits and vegetables was they are hard to get at work and hard to buy in restaurants.<sup>37</sup>

### **Common Concerns/Strategies**

Access to safe, affordable, nutritionally adequate foods determines a community's food security. Limited access to healthy and inexpensive foods in poor neighborhoods is a major barrier for weight control and good health. Studies have shown that there are fewer grocery stores with affordable fruits and vegetables, and other healthy low-fat items close to low-income neighborhoods.<sup>36</sup>

In most low-income neighborhoods, fast food and processed foods are cheaper and more convenient to purchase than healthier produce and whole grains.<sup>30</sup>

Another factor affecting African Americans is limited or no access to physical fitness programs and facilities in low-income neighborhoods. In most low-income communities, there are limited numbers of parks, open spaces, and biking or walking trails. Also, after-school sports and recreational programs are non-existent or limited, and many parents do not allow their children to play outside because of high crime rates.<sup>31</sup>

In addition to poverty, other factors can contribute to difficulties in controlling weight and improving one's health status. These include disparities in education and awareness about prevention and treatment of overweight and obesity. Also, because there is a

lack of negative social pressure to lose weight within the African American community, individuals engage in weight loss only for a short period of time.<sup>32</sup>

Obesity is curable and its complications are often reversible. However, a combination of diet, exercise, social support, medical treatment, and community involvement is needed to effectively treat obesity. Unfortunately, treatment options for poor African Americans are limited because black people have a long history of economic deprivation and inadequate health care.<sup>33</sup> High poverty rates and lack of health insurance are barriers to appropriate health care in the African American community.

Although African Americans are more likely to report chronic disease than Whites, they are less likely to see a physician on a regular basis or consult with a registered dietitian. African-American patients without a regular physician are less likely to receive preventive services and culturally appropriate care for diseases related to obesity such as diabetes and hypertension. Also, African Americans are more likely to report negative health care experiences and treatment with disrespect during health care visits in comparison to White Americans.<sup>34</sup>

Despite the barriers, there are several programs nationwide that are aimed at improving the health of African Americans. Below is a sample of a few of those programs:

Randy Klebanoff, MSPH, MPH, and Naoko Muramatsu, Ph.D., developed ***Lively Ladies***, a community-based physical education and activity intervention targeted at low-income, preadolescent, African American girls in community-based youth services organizations in Chicago. The goal of the program is to incorporate healthful habits in an enjoyable way. The program is successful because it takes advantage of existing community-based youth programs, obtains the support of the organization, and involves parents.<sup>36</sup>

***Sisters Together: Move More, Eat Better***

(<http://win.niddk.nih.gov/notes/summerfall03notes/sisters.htm>) is based on a pilot program conducted in Boston from 1994-1998. The program was based on research which showed that Black women preferred receiving information from trusted family and community sources, as well as from the media. Based on these findings, community partnerships were created with churches, barber and beauty shops, health centers, newspapers, and radio stations with a high number of African-American listeners. A culturally sensitive intervention campaign resulted in successful weight loss for many of the women involved.<sup>37</sup>

***Steps to Soulful Living*** tested the effects of a culturally adapted weight loss program on African Americans. Black women participated for six months and achieved relatively large weight loss, thus demonstrating that interventions which were tailored specifically to the African American community can be effective.<sup>38</sup>

Within California, the California Department of Health Services, Cancer Prevention and Nutrition Section has developed the ***African American 5 a Day Campaign (Campaign)***. The *Campaign* is a public health initiative designed to improve the health of the low-income

African American community by offering education, advocacy, and policy development on healthy eating and physical activity. Its purpose is to empower African American adult women, ages 18-54, and their families to consume the recommended levels of fruits and vegetables and be physically active every day. The *Campaign* is also charged to encourage food secure households by promoting participation in nutrition assistance programs.

The *Campaign* works with communities throughout California to create environments where healthy eating and physical activity are socially supported and easy to do. Through the work of 16 Faith-Based Community Projects and six *Regional Nutrition Network Agencies*, the *Campaign* provides services to the nearly 40 percent of African Americans in California who are low-income individuals.

In partnership with the American Cancer Society and the National Cancer Institute, the *Campaign* Faith-based Community Projects implement *Body & Soul: A Celebration of Healthy Living* (<http://www.bodyandsoul.nih.gov/>). *Body & Soul* is a model program that has been proven to increase fruit and vegetable consumption among African Americans. The Faith-Based Community Projects also work with local congregations and faith-community leaders to create safe communities for physical activity and increase access to healthy foods to uplift and support the quality of life for African American families.<sup>39</sup>

## **Opportunities for Improvement**

### ***Closing Gaps in Health Disparities:***

In order to help improve the health status of African Americans, the gap in racial and ethnic disparities in health care must be addressed. The Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care*, provides compelling evidence that racial and ethnic disparities persist in medical care for a number of health conditions and services. These disparities exist even when comparing individuals of similar income and insurance coverage.<sup>40</sup>

A review of studies from 1984 to 2001 investigating racial and ethnic differences in cardiac care provides evidence of lower rates in diagnostic and revascularization procedures for at least one of the minority groups under study. Evidence of racial and ethnic disparities among patients with comparable insurance and the same illness has been the most troubling since insurance coverage is widely considered as the “great equalizer” in the health care system.<sup>41</sup>

In 1999, the U.S. Department of Health and Human Services (DHHS) established a national goal of eliminating health disparities by the end of this decade. The decision to have one set of goals for all Americans, rather than a set for Whites and another set for minority populations has helped to focus public and private sector attention on racial and ethnic disparities in health and the health care system.<sup>42</sup>

While attention to racial and ethnic disparities in health and the health care system has increased among policy makers, there is little agreement on what can or should be done to reduce these disparities. The U.S. Congress provided leadership on this issue by legislatively mandating the IOM study on health care disparities and creating in statute, the National Center on Minority Health and Health Disparities at the National Institutes of Health. Congress also required DHHS to produce an annual report, starting in 2003, on the nation's progress in reducing health care disparities which has provided an important first step for addressing health and health care disparities.<sup>43</sup>

The IOM study committee for *Unequal Treatment* recommended the use of a comprehensive, multi-level strategy to address potential causes of racial and ethnic disparities in care that arise at the patient, provider, and health care system level. The recommendations pointed to five broad areas of policy challenges:

- Raising public and provider awareness of racial and ethnic disparities;
- Expanding health insurance coverage;
- Increase the number and improve the capacity of providers in underserved communities;
- Improving the quality of care;
- Adopting communication practices that promote behavior change; and
- Increasing the knowledge base of causes and interventions to reduce disparities.<sup>43</sup>

### ***Improving Supermarket Access in Low-Income Communities:***

Research shows that there are fewer supermarkets in low-income communities than in middle class or upper middle class communities. In 1995, the University of Connecticut's Food Marketing Policy Center examined census and grocery store information for 21 major metropolitan areas across the United States. Findings determined that there were 30 percent fewer supermarkets in low-income areas than in higher income area. It also found that low-income consumers were less likely to possess cars, thereby further limiting their access to food choices.<sup>44</sup>

Due to a lack of supermarkets in low-income communities, residents often shop at smaller neighborhood stores. Small stores provide fewer food choices at higher prices than supermarkets. The reasons for differences in price, quality, and selection are varied, but are often tied to the economies of scale. Smaller stores that cannot buy in volume have limited access to large-scale wholesale produce, and often do not have the space or equipment needed to offer fresh produce on a daily basis.

Prices at neighborhood stores can exceed those at chain supermarkets by as much as 76 percent. In a 1993 study in Eastern Pennsylvania, researchers found that the average full-service supermarket offered 19 kinds of fruit, 29 kinds of vegetables, and 18 kinds of meat, while the average small store only carried 6 kinds of fruit, 5 kinds of vegetables, and 2 kinds of meat. The study also showed that the produce and other foods offered in smaller stores were often lower in quality.<sup>42</sup>

By having fewer supermarkets in urban, low-income communities, residents have less access to healthy foods. Not only are low-income residents' food purchases limited by their financial constraints, they also do not have access to fresh, healthy, high quality, affordable food. Limited supermarkets make it harder for individuals to meet their dietary needs, and therefore contribute to ever increasing rates of chronic disease in low-income communities.

Many cities have begun to explore public/private partnership as ways of meeting the public's need for infrastructure, community facilities, and services. Public/private partnerships are agreements between government and private sector organizations that feature shared investment, risk, responsibility, and reward.<sup>43</sup>

Below are examples of two successful public/private partnerships:

In Harlem, two community organizations the Community Association of East Harlem Abyssinian Triangle (EHAT) and the Abyssinian Development Corporation, worked for ten years to bring a supermarket to the community. The supermarket, which opened in 1999, faced many challenges along the way, particularly from small local grocers concerned about their own businesses. The store has proven to be very successful. Data from a 1999 report revealed that supermarkets are meeting or exceeding industry averages in almost every category.<sup>45</sup>

The last full-service grocery store in West Oakland, California, a low-income African-American community, closed its doors in 1993. In 2001, a group of concerned citizens, community-based organizations, and social services agencies formed the West Oakland Food Collaborative to increase access to nutritious food while stimulating community economic development. The cornerstone of their efforts was the Mandela Farmers' Market, which opened in April 2003. The market is doing well and turnout is increasing, with approximately 200 customers a week.<sup>46</sup>

### **Opportunities to Change Attitudes Within the African-American Community:**

In order to improve their health, African Americans must develop a new attitude when it comes to eating, physical activity habits, and acceptable body size. While it is refreshing to know that African Americans are less apt to belittle an overweight woman or girl, it is important to understand the huge impact weight, particularly excess weight, has on health.

The African-American community is traditionally based on family, sharing, and cooperation. Many of the traditional ways of sharing and interacting center on food which are typically high in fat and high in calories. African Americans tend to focus less on the health consequences of what is being eaten and more on simply enjoying the company and emotional support of friends and family.

During times of crisis, African Americans often pull together by way of food. If someone in the community falls on hard times, they can count on neighbors to bring over a plate

of food or dish to see them through. While no one is expecting African Americans to give up the tradition of sharing and caring for one another or stop eating foods that are important to them and their families. However, if African Americans are to be successful in losing weight and keeping it off, they must rethink what to eat, how much to eat, and healthier ways of preparing their favorite foods.

In the spring of 2005, the U.S. Department of Agriculture released a new food guide pyramid called MyPyramid. The new pyramid contains a rainbow of colored, vertical strips which represents the five food groups plus fats and oil. Although the recently released MyPyramid does not specifically address foods traditionally consumed by African Americans; based on previous editions of the Food Guide Pyramid, a Soul Food Pyramid was developed to categorize foods important to African Americans within the six major food groups, as well as offer serving guidelines for a well balanced, healthy diet.<sup>47</sup>

In addition to the Soul Food Pyramid, various recipe books are available in bookstores and via the internet that bring together many African American favorite recipes, prepared in a heart healthy way such as the National Institutes of Health's *Heart Healthy Home Cooking: African American Style*.<sup>48</sup>

## **Resources/Web Sites**

[www.ca5aday.com](http://www.ca5aday.com)

[www.9aday.cancer.gov](http://www.9aday.cancer.gov)

[www.hschange.org](http://www.hschange.org)

[www.nih.gov](http://www.nih.gov)

[www.americanheart.org](http://www.americanheart.org)

[www.census.gov](http://www.census.gov)

[www.soulfoodpyramid.org](http://www.soulfoodpyramid.org)

[www.nhlbi.nih.gov/health/public/heart/other/chdblack/cooking](http://www.nhlbi.nih.gov/health/public/heart/other/chdblack/cooking)

## **References**

1 California Health Interview Survey. CHIS 2003. Available at:  
<http://www.chis.ucla.edu>. Accessed August 24, 2006.

2 California Department of Health Services, Center for Health Statistics. Vital Statistics of California 2002. Available at:  
<http://www.dhs.ca.gov/hisp/chs/OHIR/reports/vitalstatisticsocalifornia/vsofca2002.pdf>. Accessed August 24, 2006.

3 Anderson, R.N., Smith, B.L. National Vital Statistics Reports: Deaths: Leading Causes for 2002. Available at:  
[http://www.cdc.gov/nchs/data/nvsr/nsvr53/msvr53\\_17.pdf](http://www.cdc.gov/nchs/data/nvsr/nsvr53/msvr53_17.pdf). Accessed August 24, 2006.

---

4 US Department of Health and Human Services, *Closing the Health Gap*, Fact Sheet. 2006. Available at <http://www.omhrc.gov/healthgap/2006factsheet.aspx>. Accessed on August 24, 2006.

5 National Center for Health Statistics. *United States with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2005. Page 5.

6 Jackson, S.J., Camacho, D., Freund, K.M., et al. Women's health centers and minority women: Addressing barriers to care. *Journal of Women's Health and Gender Based Medicine*. 2001;24:551-559.

7 Smedley, B.D., Stith, A.Y., and Nelson, A.R. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal treatment: Confronting racial and ethnic disparities in healthcare*. Washington, DC: National Academies Press; 2003.

8 Word I.Q. Definition of African American. Available at: [http://www.wordiq.com/definition/African\\_American](http://www.wordiq.com/definition/African_American). Accessed on February 10, 2006.

9 US Census Bureau, Fact Finder. 2000. Available at: <http://www.factfinder.census.gov>. Accessed on February 10, 2006.

10 Ajose, Toyin. The dark side of soul food. *Journal of the Student National Medical Association*. Spring 1998;4(1):2-3.

11 California 5 A Day website. <http://www.dhs.ca.gov/ps/cdic/cpns/aa/research.htm>. Accessed on August 25, 2006.

12 Journal of the American College of Nutrition. <http://www.jacn.org/cqi/content/abstract>. Accessed on August 29, 2006.

13 National Coalition on Healthcare. 2003. Available at: <http://www.nchc.org/facts/cost.shtml>. Accessed on February 10, 2006.

14 Office of Minority Health, Office of the Director, CDC. Health disparities experienced by Black or African Americans—United States. *MMWR*. January 14, 2005;54(01):1-3.

15 US Census Bureau. Income, Poverty, and Health Insurance in the US: 2003. Available at: <http://www.census.gov/hhes/www/income.html>. Accessed on February 10, 2006.

16 US Census Bureau. 2002 Income and Poverty Statistics. 2003. Available at: [http://www.policyalmanac.org/social\\_welfare/archive/poverty\\_statistics2002.shtml](http://www.policyalmanac.org/social_welfare/archive/poverty_statistics2002.shtml). Accessed on February 10, 2006.

17 US Census Bureau, Fact Finder, People: Poverty. 2002. Available at: <http://www.factfinder.census.gov>. Accessed on February 10, 2006.

18 Centers for Disease Control and Prevention. [www.cdc.gov/nchs/data/05/0505/pdf#053](http://www.cdc.gov/nchs/data/hus/05/0505.pdf). Accessed on August 25, 2006.

19 National Center for Health Statistics. *United States with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2005. Page 61.

20 National Center for Health Statistics. *United States with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2005. Pages 30-31.

21 National Center for Health Statistics. *United States with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2005. Page 75.

22 National Center for Health Statistics. *United States with Chartbook on Trends in the Health of Americans*. Hyattsville, Maryland: 2005. Page 85.

23 Prevalence of Overweight and Obesity among Adults 1999-2000. Healthy weight, overweight, and obesity among persons 20 years of age and over, according to sex, age, race, and Hispanic origin: United States, 1960-62, 1971-74, 1976-80, 1988-94, and 1999-2000, Table 70. *NCHS*. Hyattsville, MD: National Center for Health and Statistics, 2002.

24 Overweight children and adolescents 6-19 years of age, according to sex, age, race, and Hispanic origin: United States, selected years 1963-65 through 1999-2000, Table 71. *NCHS*. Hyattsville, MD: National Center for Health and Statistics, 2003.

25 Statistics Related to Overweight and Obesity. NIDDK. Available at: <http://win.niddk.nih.gov/statistics/index.htm> and <http://www.diabetes.org>. Accessed on February 10, 2006.

26 American Heart Association. Heart Facts 2005: All Americans/African Americans. Assessed from <http://www.americanheart.org/downloadable/heart.pdf>.

27 American Cancer Society. Cancer Facts and Figures for African Americans 2005-2006. Assessed from: <http://cancer.org/downloadables.pdf>.

28 Produce for Better Health. 5 A Day the Color Way. Available at: <http://www.5aday.com>. Accessed on February 10, 2006.

29 Harris, E. and Bronner, Y. *Food Counts in the African American Community: Chartbook*. Baltimore, MD: Morgan State University; 2001.

- 
- 30 Keihner, A, Adkins, S., and Scruggs, V. Out of Home Eating Relates to Fruit and Vegetable Consumption Among African American. California Department of Health Services, Sacramento, CA: June 2004. Available at: <http://www.dhs.ca.gov/ps/cdic/cpns/aa/researchbriefs.htm> Accessed on August 25, 2006.
- 31 California Dietary Practices Survey (data file). Cancer Prevention and Nutrition Section, California Department of Health Services.
- 32 California Behavioral Risk Factor Survey (data file). Cancer Prevention and Nutrition Section, California Department of Health Services.
- 33 Henderson, Karla A, Ainsworth, Barbara E. A synthesis of perceptions about physical activity among older African American and American Indian women. *American Journal of Public Health*. February 2003;93:2.
- 34 Becker, DM, Yanek, LR, Koffman, DM, Bronner, YC. Body image preference among urban African Americans and whites from low-income communities. *Ethn. Dis*. 1999;9: 377-386.
- 35 Body-type preferences among Whites and African Americans, Wikipedia, the free encyclopedia. Available at: [http://en.wikipedia.org/wiki/Body-type\\_preferences\\_among\\_Whites\\_and\\_African\\_Americans#Factors\\_Influencing\\_Body-Type\\_Preference](http://en.wikipedia.org/wiki/Body-type_preferences_among_Whites_and_African_Americans#Factors_Influencing_Body-Type_Preference) Accessed on August 30, 2006.
- 36 Harris, E. and Bronner, Y. *Food Counts in the African American Community: Chartbook*. Baltimore, MD: Morgan State University; 2001.
- 37 California Dietary Practices Survey: 2003 (data file). Sacramento, CA. Cancer Prevention and Nutrition Section, California Department of Health Services.
- 38 Karanja, Njeri. Cultural competence in the prevention and treatment of obesity: African American. *The Permanente Journal*. Spring 2003;7(2). <http://www.kpcmi.org/>. Accessed March 9, 2006.
- 39 Mencimer, Stephanie. Hiding in Plain Sight. *Washington City Paper* [online] June 16, 2000; A1. Available from: <http://www.washingtoncitypaper.com>. Accessed February 10, 2006.
- 40 Collins, Karen Scott, Tenney, Katie, Hughes, Dora L. Quality of Health Care for African Americans from the Commonwealth Fund 2001 Health Care Quality Survey. *The Commonwealth Fund*. March 2002.

- 
- 41 Klebanoff, Randi, Muramatsu, Naoko. A community based physical education and activity intervention for African American preadolescent girls: a strategy to reduce racial disparities in health. *Health Promotion Practice*. April 2002;3(2):276-285.
- 42 Weight-Control Information Network. Sisters Together. Available at: <http://win.niddk.nih.gov/sisters>. Accessed on February 10, 2006.
- 43 Karanja, N., Stevens VJ., Hollis, JF, Kumanyika, SK. Steps to Soulful Living (Steps): a weight loss program for African American women. *Ethn Dis*. Summer 2002;12(3): 363-71.
- 44 Klebanoff, R., Muranmatsu, N. A Community Based Physical Education and Activity Intervention For African American Pre-Adolescents. *Health Promo. Pract.* 2002;3:276-285.
- 45 California Department of Health Services, Cancer Prevention and Nutrition Section. California African American 5 A Day Campaign webpage. Available at: <http://www.dhs.ca.gov/ps/cdic/cpns/aa/>. Accessed on February 10, 2006.
- 46 Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Heath Care*. Washington, DC: The National Academic press; 2002.
- 47 Kaiser Family Foundation, American College of Cardiology Foundation. Racial/Ethnic Differences in Cardiac Care; The Weight of the Evidence. 2002.
- 48 US Department of Health and Human Services. *Healthy People 2010*. Washington, DC: US Government Printing Office, 1999: 11-16.
- 49 US Department of Health and Human Services. *2003 National Healthcare Disparities Report*. Rockville, MD: Agency for Health Care Research and Quality; 2003.
- 50 Cotterill, RW, Franklin, AW. The Urban Grocery Store Gap. *Food Marketing Policy Issue Paper No. 8*. University of Connecticut, CT: Food Marketing Policy Center; 1995.
- 51 Hoats, K. *The Cost of Being Poor in the City: A Comparison of Cost and Availability of Food in the Lehigh Valley*. Lehigh, PA: Community Action Committee of the Lehigh Valley;1993.
- 52 British Columbia Ministry of Municipal Affairs. Public Private Partnerships: A Guide for Local Government. Government of British Columbia website. May 1999. Available at: [http://www.cserv.gov.bc.ca/lgd/pol\\_research/MAR/PPP](http://www.cserv.gov.bc.ca/lgd/pol_research/MAR/PPP). Accessed on February 10, 2006.
- 53 Healthy Food, Healthy Communities: Improving Access and Opportunities Through Food Retailing, Fall 2005. Available at: <http://www.policylink.org/pdfs/HealthyFoodHealthyCommunities>. Page 23.

54 Healthy Food, Healthy Communities: Improving Access and Opportunities Through Food Retailing, Fall 2005. Available at:

<http://www.policylink.org/pdfs/HealthyFoodHealthyCommunities>. Page 37.

55 HEBNI Nutrition Consultants, Inc. Good Health Begins with Good Nutrition.

Available at: <http://www.soulfoodpyramid.org>. Accessed on February 10, 2006.

56 National Institute of Health. Heart Healthy Home Cooking: African American Style. National Heart, Lung, and Blood Institute website. Available at:

<http://www.nhlbi.nih.gov/health/public/heart/other/chdblack/cooking.pdf>. Accessed on February 10, 2006.