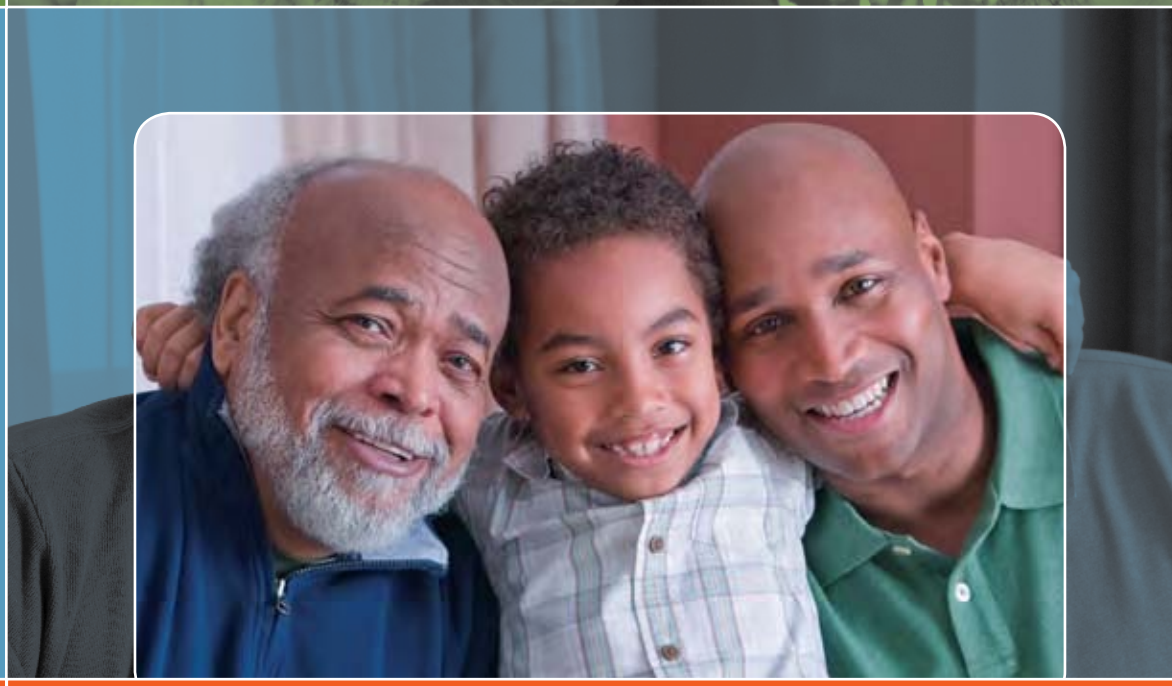


A Review of Psychosocial Factors and Systems-Level Interventions

A Closer Look at African American Men and High Blood Pressure Control – Executive Summary

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Suggested Citation:

Centers for Disease Control and Prevention. *A Closer Look at African American Men and High Blood Pressure Control: A Review of Psychosocial Factors and Systems-Level Interventions.* Atlanta: U.S. Department of Health and Human Services; 2010.

Photos:

The photographs used in this publication are for illustration purposes only. They show African American men from various age groups. They are not intended to depict people who have high blood pressure or who had a heart attack or stroke.

For Free Copies or Additional Information:

E-mail: cdcinfo@cdc.gov

Write: Division for Heart Disease and Stroke Prevention, NCCDPHP
Centers for Disease Control and Prevention
4770 Buford Highway, NE, Mailstop K-47
Atlanta, GA 30341

Phone: 1-800-CDC-INFO (232-4636)

TTY: 1-888-232-6348

Online: http://www.cdc.gov/dhdsp

Table of Contents

Acknowledgments

This project was supported by a task order contract (200-2001-00123) between RTI International and the Division for Heart Disease and Stroke Prevention (DHDSP), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC). This document is a continuation of previous work performed by the Program Development and Services Branch in DHDSP. We would like to thank the following people for their participation in making this document a reality:

Contributors:

Bernadette Ford Lattimore, MPH[1]; Nancy D. Berkman, PhD[2]; Andrea Yuen, BS[2]; Suzanne M. Randolph, PhD[3]; Erika Willacy, MPH[2]; Linda Lux, MPH[2]; Ben Beatty, MPH[2]; Shelly Harris, MPH[2]; Rosanne Farris, PhD[1]; Belinda Minta, MPH, MBA[1]; Adrienne Rooks, BA[2]; Sheree Marshall Williams, PhD[1]; Sarah O'Leary, MPH, MA[1]; Nora Keenan, PhD[1]; Robert Merritt, MA[1]; Cathleen Gillespie, MS[1]; Kathryn Gallagher, MA[1]; Yuling Hong, MD, MSc, PhD, FAHA[1]; Michael Schooley, MPH[1]; Julie Will, PhD[1]; Angela Soyemi, BA[1] and Darwin Labarthe, MD, MPH, PhD[1].

[1]Centers for Disease Control and Prevention, [2]RTI International, [3]The MayaTech Corporation

We extend many thanks to the project's expert panel for their guidance in the development and content of this guide. Their contributions and participation in the process were key in bringing together the document. The expert panel consisted of: Jean J.E. Bonhomme, MD, MPH; Jules Harrell, PhD; B. Waine Kong, PhD, JD; George Mensah, MD, FACP, FACC; Alan Richmond, MSW; and Herman A. Taylor, Jr., MD, MPH, FACC, FAHA.

Special thanks to the key informants for providing us with the information necessary to produce this document. They are as follows: Shauntice Allen, MA; Karen Boone, RN, MN, MPH; Jeanne Charleston, RN; Akilah Heggs, MA; Devon Love; James Plumb, MD, MPH; Sara Eve Sarliker, MPH; Berenice Tow, MS; and Ronald Victor, MD.

Recommendations

Top 10 Considerations for Public Health Programs When Planning Systems-Level Interventions for African American Men to Control High Blood Pressure

Because public health programs share the Division for Heart Disease and Stroke Prevention's mission of "…eliminating disparities in the burden of heart disease and stroke," this document provides a tool that can be used to develop or fund systems-level interventions, particularly addressing African American men and high blood pressure control. Below is a list of considerations as public health programs plan, develop, and implement systems-level interventions for this underserved population:

1. Review and become familiar with the national prevalence data on hypertension in African American men, as well as factors related to awareness, treatment, and control. Gather and analyze state and local data on this population; determine priority groups or localities if appropriate.
2. Become familiar with the psychosocial factors (e.g., effects of racism, social support, access to care) related to high blood pressure control among African American men.
3. Identify and share data with stakeholders that public health programs might partner with when developing interventions related to high blood pressure control in African American men.
4. Collaborate with nontraditional partners (e.g., faith-based organizations, sororities and fraternities, barbershops) to develop and implement interventions for this population.
5. Before implementing an intervention, examine the history and politics of the community. Be sure to include members of the community during the initial planning stages of an intervention or activity. Not only does this build trust, but it can also increase the chances that the intervention or activity will be successful.
6. Identify settings or mechanisms for possible intervention, which may include conducting community needs assessments or environmental scans of potential sites and how the priority group could best be reached.
7. Identify reviewed projects and interventions that have been evaluated for possible pilot programs; determine characteristics of programs that are most compatible with potential pilot program setting.
8. Consider reviewing information on similar interventions and programs dealing with men's health concerns to discover promising or best practices regardless of topic area, such as prostate cancer or diabetes.
9. Review the *Lessons Learned* from interviewed programs and *Key Findings* from literature reviews to use as tools to develop interventions or similar activities for your target population.
10. Develop evaluation plans for proposed interventions.

1 Introduction

Heart disease and stroke impact the U.S. population in epidemic proportions. According to the American Heart Association, these conditions have led to direct and indirect costs of an estimated $475 billion in 2009. With heart disease and stroke being the first and third leading causes of death and major causes of disability, national and international experts agree that now is the time to take action in addressing these conditions and their risk factors.

Disease burden and growing disparities among certain populations are characteristics of the heart disease and stroke epidemic. One of the populations greatly affected by this epidemic is African American men. African American men suffer disproportionately from high blood pressure, a known risk factor for heart disease and stroke. Because of this, the Centers for Disease Control and Prevention's Division for Heart Disease and Stroke Prevention (DHDSP) began to focus attention and resources to developing materials that provide answers.

DHDSP contracted with RTI International, with assistance from the MayaTech Corporation, to create a document addressing high blood pressure control in African American men. The purpose of the book is to highlight resources and systems-level interventions regarding high blood pressure control of African American men to stakeholders (such as state and local government agencies, health care organizations, non-profit organizations, and others) to facilitate positive changes in their states and communities. A systems-level intervention is defined as a change in policy, legislation, training, or environmental supports that impacts individual and community-level outcomes. Systems-level interventions can focus on organizations, providers, patients, and the health care system as a whole, and can also include media campaigns. Information for the review was gathered through input from an expert panel, key informant interviews with individuals conducting interventions, and a search of the literature.

This executive summary (abridged version) of the book was created to use as a quick reference guide. It contains an overview and summaries of the more in-depth information and findings presented in the unabridged version including:

- A list of recommendations to guide state programs as they create systems-level interventions to serve African American men;
- Key statistics on burden data pertaining to African American men and high blood pressure;
- A summary of psychosocial factors that have been found to be related to disproportionately high blood pressure rates among African American men;
- An overview of effective and culturally appropriate promising practices and interventions;
- A list of men's health informational resources.

2 The Burden of High Blood Pressure

Overview

In this chapter, we summarize the burden of high blood pressure in African American men and include comparisons with other groups. According to the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC VII report), the classification for hypertension, or high blood pressure, measures greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic.[1] We include statistics at the national level on morbidity and mortality related to hypertension and the associated conditions of heart disease and stroke.

Morbidity

Elevated Blood Pressure

Table 1 reports the percentage of African American, white, and Mexican American men and African American women with elevated blood pressure. Elevated blood pressure is defined as having systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg.

The data are collapsed into three time spans on the basis of data availability: 1988–1994, 1999–2002, and 2003–2006. In all periods, a larger percentage of African American men had elevated blood pressure than did white or Mexican American men. However, compared with the 1988–1994 period, the percentage of men in each race or ethnicity group with elevated blood pressure had declined by the 2003–2006 period. The percentage of African American women with elevated blood pressure fluctuated over the three periods, but by the 2003–2006 period was smaller than that of African American men.

Table 1. Percentage of Persons with Elevated Blood Pressure by Race/Ethnicity and Sex, 20–74 Years of Age, for Selected Years

Race/Sex	1988–1994	1999–2002	2003–2006
African American men	30.3	28.2	26.5
White men	19.7	17.6	17.4
Mexican American men	22.2	21.5	15.3
African American women	26.4	28.8	23.9

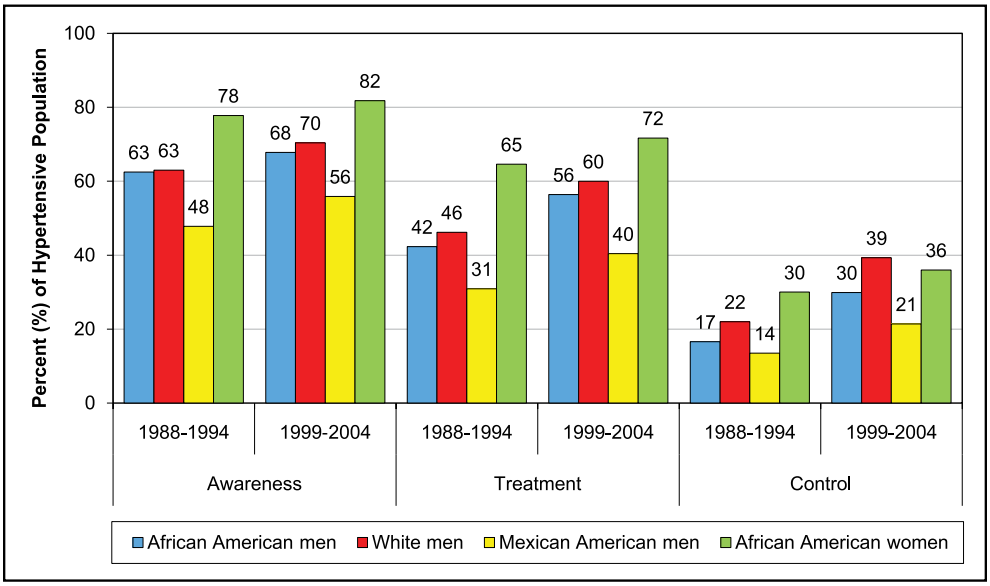
Note: Percentages are age adjusted. Elevated blood pressure is defined as having systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg. Those with elevated blood pressure may be taking prescribed medicine for high blood pressure.

Source: National Center for Health Statistics (2008). Table 71. Hypertension and elevated blood pressure among persons 20 years of age and over, by selected characteristics: United States, 1988–1994, 1999–2002, and 2003–2006. Health, United States, 2008. With chartbook on trends in the health of Americans. Hyattsville, MD, 312–313.

Hypertension Awareness, Treatment, and Control

Figure 1 shows that among African American men with high blood pressure, awareness (told by physician that they have high blood pressure or hypertension), treatment (taking prescribed medication) and control (maintaining their blood pressure within normal limits) has been increasing over time. Still, during the 1999 to 2004 period, while more than half of African American men were aware that they had high blood pressure, 56% were receiving medications, and only 30% had their high blood pressure under control. The percentage of African American men who were aware of their hypertension was similar to that of white men, larger than that of Mexican American men but smaller than that of African American women. Regarding hypertension treatment and control, percentages among African American men were larger compared to Mexican American men but smaller than that of white men and African American women. These trends were consistent during both the 1988–1994 and the 1999–2004 time periods. A significant predictor of greater awareness, treatment, and control of the disease in African American men is increasing age.[2]

Figure 1.
Hypertension Awareness, Treatment, and Control Percentages (%) in the U.S. Adult Hypertensive Population by Race; 1988–1994 and 1999–2004



Note: The U.S. adult hypertensive population consists of National Health and Nutrition Examination Survey (NHANES) respondents with an average systolic blood pressure greater or equal to 140 mm Hg and diastolic blood pressure greater or equal to 90 mm Hg or a reported current use of antihypertensive medication. Awareness is defined as hypertensive respondents having been told at least once by a health professional that they have high blood pressure. Treatment is defined as hypertensive respondents reporting use of a prescribed medication for hypertension. Control is defined as hypertensive respondents with a systolic blood pressure less than 140 mm Hg and a diastolic blood pressure less than 90 mm Hg. African American men, white men, and African American women are from the non-Hispanic population.

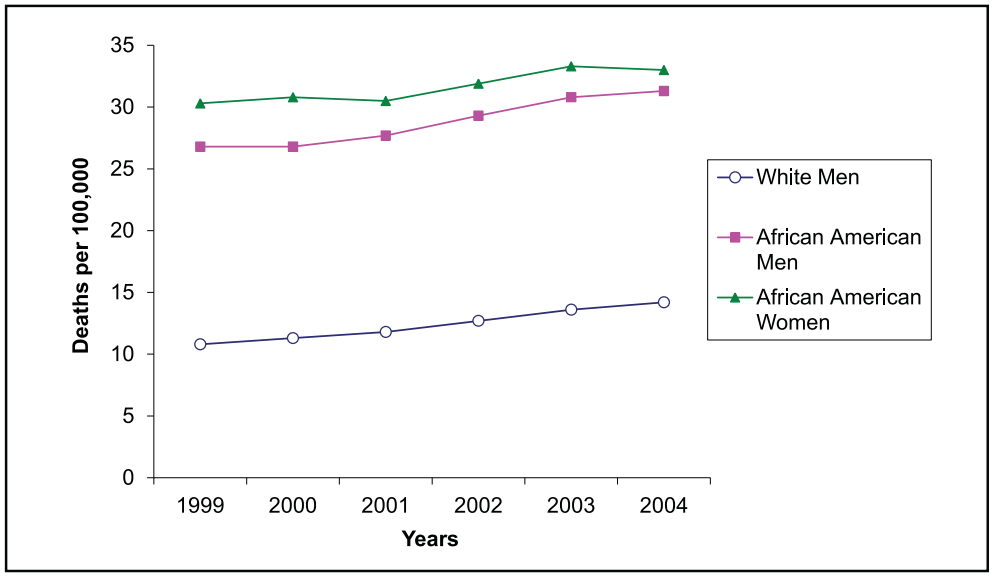
Source: Cutler JA, Sorlie PD, Wolz, M, Thorn T, Fields LE, Rocella, E J. Trends in hypertension prevalence, awareness, treatment, and control rates in United States adults between 1988–1994 and 1999–2004. Hypertension 2008; 52: 818–827.

Mortality

Death Rates from Hypertensive Disease

Hypertensive disease includes: (1) essential (primary) hypertension, (2) hypertensive heart disease, (3) hypertensive renal disease, and (4) hypertensive heart and renal disease. While death rates from hypertensive disease increased among African American men, white men, and African American women from 1999 to 2004, the increase was largest among African American men. Death rates from hypertensive disease (*Figure 2*) in both African American men and women, throughout the period, were more than double those of white men.

Figure 2.
Death Rates Due to Hypertensive Disease by Race and Sex, 1999–2004



Note: Rates are per 100,000 of the population. Data collected through the National Health Interview Survey, 2006.

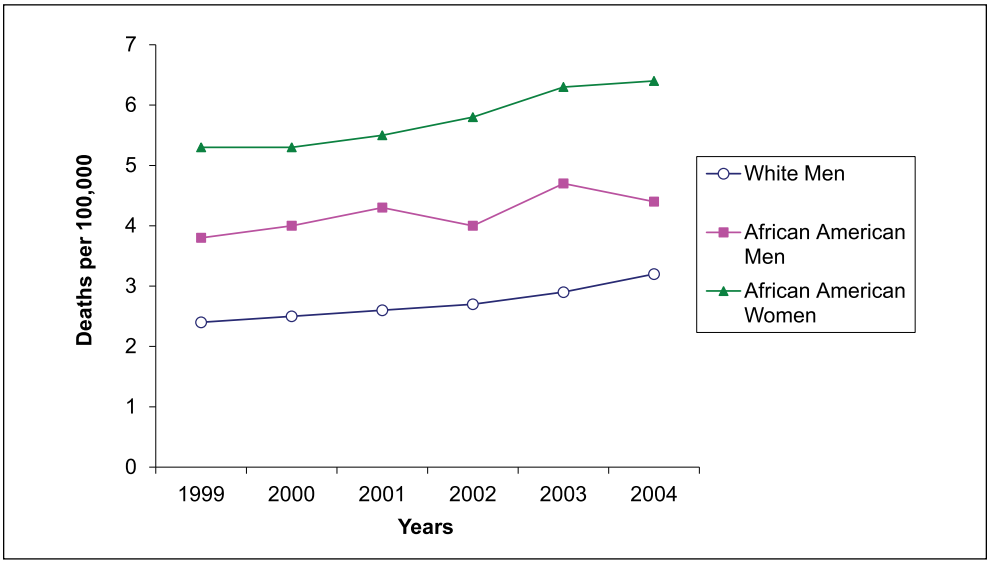
Note: Hypertensive disease includes essential (primary) hypertension (ICD-9 code: 401), hypertensive heart disease (ICD-9 code: 402), hypertensive renal disease (ICD-9 code: 403), and hypertensive heart and renal disease (ICD-9 code: 404). It does not include complications from childbirth, pulmonary hypertension, neonatal hypertension, and hypertension involving coronary vessels.

Source: National Center for Health Statistics (2007). Death rates from 358 selected causes, by 10-year age groups, race and sex: United States 1999–2004 (Worktable No. 12). National Vital Statistics System.

Death Rates from Heart Disease and Cerebrovascular Disease

Death rates related to both heart disease and cerebrovascular disease (stroke) declined steadily for African American men and women as well as for white men from 1990 to 2004, but rates remained the highest among African American men in each of the years. *Figure 3* reflects this trend for death rate from heart disease.

Figure 3.
Death Rates Due to Diseases of the Heart by Race and Sex, 1990–2004



Note: Rates are per 100,000 population, all rates are age adjusted.

Source: National Center for Health Statistics (2008). Table 35. Death rates for diseases of the heart, by sex, race, Hispanic origin, and age. Health, United States, 2008. With chartbook on trends in the health of Americans. Hyattsville, MD. 229-232.

Psychosocial Aspects of Blood Pressure Control among African American Men

3

We examined the results from studies concerning the effects of racism, attitudes towards hypertension, socioeconomic status, access to care, health insurance, quality of care, and comorbidities on hypertension rates among African American men.

Several studies found an association between racism and higher blood pressure levels in African American men.[3–6] Perceived racism contributes to stress and low self esteem, which can ultimately negatively affect blood pressure levels.[3,4,5,7] The relationship between exposure to discrimination and blood pressure levels among African American men differs based on socioeconomic status. Greater social and economic resources and the resulting increased ability to name and challenge discrimination have been found to be protective factors among professional African American men.[8] John Henryism is described as behaviors used to deal with psychosocial and environmental stressors that are often exhibited by African Americans determined to succeed in the face of obstacles.[9,10] Among African American workers of lower socioeconomic status, those with high John Henryism were found to have higher blood pressure levels than those with low John Henryism.[11]

Knowledge, beliefs, and attitudes about hypertension among African Americans can affect health behaviors, perceptions of susceptibility to hypertension, and adherence to treatment.[12] Those who are older, of lower socioeconomic status, or lower educational attainment are more likely to have non-clinically based beliefs about hypertension and have greater difficulty believing they have hypertension when they do not have symptoms.[13]

Low socioeconomic status is a stronger predictor of hypertension among African Americans compared to whites.[14,15] Low socioeconomic status coupled with lack of health insurance can make it particularly difficult for this population to obtain adequate health care, resulting in African American men being diagnosed at later disease stages or after a serious event, and having greater difficulty keeping their blood pressure under control, once diagnosed.[16–18] Those who reside in racially isolated neighborhoods are especially at risk for poor health.[19] Although socioeconomic status is a strong contributor to health status in African Americans, even after controlling for this factor, hypertension rates are still significantly higher than in other groups.[14,20]

Less use of medical care services and medications among African Americans compared to whites has been found to be related to mistrust of the medical system.[21–23] Mistrust can negatively affect communication between providers and African American patients[22,24,25] as can lack of cultural competence among health care providers.[26]

Health insurance coverage can influence the successful control of hypertension. Based on 2006 Current Population Survey data, African American males were more likely to be uninsured than white males (23% compared to 17%) and less likely to have private insurance coverage (54% compared to 70%).[27] Successful control of hypertension among African Americans is significantly related to health insurance coverage.[28] Lack of prescription drug coverage and access to hypertensive drugs may play a role in this relationship.[29]

Quality care helps to ensure that hypertensive patients adhere to their medication regimen. Seeing the same provider has been found to be positively correlated to successful hypertension control. Hypertensive African Americans are significantly less likely than hypertensive whites to consistently see the same provider.[28] Among African American patients, adherent patients were more likely to report a trusting, honest relationship with their clinician, and that their clinician worked with them to manage their treatment.[12] Elements of quality care that are important for treating African Americans with hypertension include establishing good doctor-patient communication and trust,[12, 30] addressing possible racial disparities,[31] and creating patient-centered interventions.[32] African American patients with African American physicians were more likely than those with non-African American physicians to rate their physicians as excellent.[33]

Obesity has been strongly and positively linked to elevated blood pressure.[34–41] Approximately two-thirds of African American men are overweight and, of these, close to half are obese.[42] In the African American community, cultural dietary patterns and fear of social stigmatization deter significant changes in diet or exercise lifestyle modification.[43–47]

The relationship between standards of masculinity in African American men and hypertension care and treatment has not been studied extensively. Traditionally, men have had poorer health outcomes compared with women, in part because of a belief that masculinity is associated with strength, independence, a reluctance to seek help, and denial of vulnerability.[48] Health-seeking behaviors such as regular visits to health care providers and treatment for illness are often seen as expressions of helplessness or weakness. These concerns may be exacerbated in African American men as a result of a history of slavery, segregation, racism, and discrimination.[49] They may be less likely to seek preventive care and secondary preventive treatment due to a personal perception of strength and virility by virtue of being male that is in contrast to the inferior role placed upon them by society.

Although each of the aforementioned factors has had a demonstrated effect on hypertension rates in African Americans, it is also clear that there is no single factor or consistent combination of factors that explains the difference in hypertension rates between African Americans and whites.[50] Additional research is needed to more fully understand the role and level of influence of psychosocial factors that affect health disparities.

4 Programs with Systems-Level Interventions

Overview

To obtain information on systems-level interventions related to high blood pressure control in African American men, we interviewed key informants at nine programs with the intent to disseminate successful practices to stakeholders. Information obtained from interviews was supplemented by program evaluations, Web sites, and journal articles. An independent evaluation of program quality was not conducted.

We explored the peer reviewed literature and found 11 relevant systems-level interventions. We located programs in the peer-reviewed literature by using the search engine MEDLINE®, which indexes articles concerning medical and health services research and also located programs in the practice literature through searches of Web sites and other relevant information on the Internet.

In this chapter, we present lessons learned and descriptions of the 9 interviewed programs and the 11 interventions from the peer-reviewed literature.

Summary of Lessons Learned

Presented below is a synthesis of lessons learned that emerged across the interviewed programs and journal articles. We have divided lessons into the following three categories: overall lessons, lessons on program participation by African American men, and lessons on cultural competency.

Overall Lessons

- Having high visibility is important for building trust with program participants and the community. Repeat visibility can be achieved through radio, television, posters, or through faith-based organizations or community events.
- If a program involves members of the community, such as barbers, stylists, community members affiliated with faith organizations, or health educators, providing incentives to these providers increases participation. Also, providing incentives for program participants is an effective means for garnering and maintaining participation.
- It is necessary to go into the field to learn about the needs of the community and shape program interventions around those needs. For example, if a program promotes eating healthier foods, it is essential to identify places where specific healthier foods can be purchased in the community.

- Continuously evaluating program interventions (through focus groups, surveys, or interviews) is necessary for making improvements and ensuring that the program is continuing to meet the needs of the community.
- Programs should not only identify health problems in program participants but also provide resources for them to obtain needed services. Programs need to provide referrals so participants can obtain follow-up care.
- Workplace programs that blend behavioral and environmental interventions to complement and reinforce each other should support the health outcome shared by the employer and employees. The blending of these approaches may promote behavioral change by enhancing workplace awareness.
- Issues of privacy/confidentiality and liability are critical barriers to more effective follow-up. Providing screening organizations with a confidentiality agreement before the screening may be helpful, or alternatively, adding a tear off section to the screening form where screeners would record the participant's screening results and then detach it for the participant to have for future reference.
- Using volunteers has its assets and liabilities. Volunteers are often recruited because of their interest and availability without giving consideration to their talents and skills. For example, in one faith-based program, the pastor may have assumed that all registered nurses and faith leaders had the requisite skills and talents to implement the faith-based organization's high blood pressure program. Based on members' self-assessments, this was not always true.
- Hypertension is often not an isolated condition. Collaborating with programs focusing on other diseases such as diabetes or obesity may increase effectiveness since many of these programs have overlapping aims.
- Forming partnerships that engage and consistently involve the community is essential for program sustainability. For example, community screening events are more likely to be successful and sustainable when they are institutionalized and supported by the community.
  - The following is a list of nontraditional partnerships:
    - Barbershops: They offer a racial, ethnic, and gender-specific environment effective for fostering a systems-level change.
    - Faith-based organizations: These offer access to participants, volunteers to provide services, venues for events, and leadership in the community.
    - Black fraternities and sororities: These organizations are well-organized and willing to serve and partner with health programs. An increasing number identify health as a major area of focus.
    - Historically Black Colleges and Universities (HBCUs): HBCUs often have research and community-based programs centered on health disparities.

A more detailed description of these kinds of partnerships can be found in the General Health Resources chapter.

Lessons on Program Participation by African American Men

- Involving family members can help in encouraging men to take charge of their own health.
- Many African Americans do not trust the health care system. It can be helpful to have prominent community members, such as faith leaders, local celebrities, barbers, and trustworthy health educators participate in and represent programs.
- A peer-to-peer approach sets a good example and encourages African American men to participate in health interventions.
- African American men may be more likely to talk about their health or get a blood pressure screening as a group than individually.
- Programs must be considerate of participants and lower barriers to participation by making programs as convenient as possible. For example, health events should be held at a time when men are not working. Also, if a community or screening event requires waiting time, it could be used as an opportunity to provide health education so that participants do not feel like they are wasting their time.
- Messages need to be tailored to different African American male audiences. For example, places of worship may be effective for reaching older men, while Web-based education campaigns are more likely to reach younger men.
- Cultural beliefs should not simply be tolerated but understood. Social, religious, and other beliefs influence the role of fatalism in the African American community.
- Younger men (aged 18–49 years) or men newly diagnosed with high blood pressure are more difficult to recruit and retain. These groups are more at risk for inadequate education about high blood pressure.
- It is feasible to identify, recruit, and follow-up on young, inner-city African American men; however, the process is very labor intensive. An enthusiastic, energetic, committed, and persistent minority staff is essential to recruitment and retention. Staff can bring to the study knowledge, experience, nonjudgmental concern about the health of the population, and an ability to establish contacts and rapport with the men. It is important that the workers are comfortable in the community, but they do not need to be from the community.

Lessons on Cultural Competency

- Program materials need to be culturally relevant and use language familiar to members of the community.
- Visual materials need to be aimed at and include representations of African American men.

Interviewed Programs

Programs were located across seven states and varied in longevity, ranging from 1 to 34 years. Interventions include blood pressure screening and monitoring, referral to providers, patient education and media campaigns, outreach, follow-up, and training of community members or professionals. Examples of successful, sustainable practices include implementing interventions in a venue such as a barbershop primarily serving African American men, forming partnerships with community organizations, using the "peer-to-peer" approach to reach out to the target population, and ensuring that program materials are presented in a culturally competent manner.

We present a matrix with details about selected characteristics of each program, a detailed summary of two model programs, and contact information of key personnel from the interviewed programs.

Interviewed Programs Matrix

Selected Characteristics	1 Can Barbers Cut Dallas, TX	2 CHAMP Baltimore, MD	3 Magic City Birming-ham, AL	4 Power to Live Smart Seattle, WA	5 REACH Atlanta, GA	6 REACH Chicago, IL	7 SHAPE-IT Phila-delphia, PA	8 SHAPP GA	9 Sound Heart Seattle, WA
Sponsoring organization type									
Community-based				●					●
Government					●	●		●	
University	●	●	●				●		
Program maturity (years)	9	29	4	1	8	7	2.5	34	29
Funding									
Federal: CDC		●		●		●	●		●
Federal: other	●		●						
State	●	●					●	●	
County/local					●			●	●
Private	●	●		●					
Setting									
Faith-based organization		●	●		●	●	●		●
Barber shops/beauty salons	●	●		●	●	●	●		
Community centers		●	●			●			
Clinics						●	●	●	
Community events		●	●			●	●		
Service delivery									
Barbers	●	●		●	●			●	
Staff coordinators	●	●	●	●	●	●		●	
Staff nurses	●			●				●	
Staff health educators		●				●	●		●
Community health/outreach workers		●			●	●			●
Service recipient focus									
Low-income/underserved					●			●	●
African Americans	●	●	●	●		●	●		●
Men only	●						●		
Program activities									
Blood pressure screening/monitoring	●	●	●	●	●			●	●
Referral to providers	●			●		●		●	●
Patient education/media campaign	●	●	●	●	●	●	●	●	●
Outreach			●	●	●	●	●	●	
Follow-up					●			●	●
Training community members/ professionals		●		●	●	●		●	
Grants to local orgs			●						
Partners	●		●	●	●		●		
Evaluation	●			●	●	●	●	●	

Model Program Examples for States

The following two programs are highlighted because they focus on African American men and have been evaluated. These programs increased awareness about high blood pressure, use of medical care, and adoption of behavior change to support blood pres¬sure reduction. The programs are examples of how to work with health care providers to address systems issues in serving African American men.

Can Barbers Cut Blood Pressure Too?

The goal of this program was to train barbers in the African American community to become community blood pressure specialists. The barbershop plays an important role in the lives of African American men, and the program provides both training and support to barbers about blood pressure. The barbers measure and record blood pressure readings of customers, provide information about high blood pressure, and make referrals to providers. The barbers are supported by a nurse and research assistants. The program has been evaluated through two non-randomized studies. African American men receiving service through the intervention were found to have a decrease in blood pressure and an increase in treatment and control.

Key characteristics:

- Increased awareness of and knowledge about screening for high blood pressure
- Increased follow-up with medical providers
- Engaged a nontraditional population to improve high blood pressure awareness in the community
- Required an incentive structure to encourage barbers to participate

Stroke, Hypertension, and Prostate Education Intervention Team (SHAPE-IT)

The goal of this program was to increase community partnerships that can develop methods to address prostate cancer and stroke among African American men. The program had two phases. The first phase established an advisory council, developed a community action plan, and conducted a community assessment through focus groups. The second phase identified African American men to participate in program interventions, developed community contacts to host activities, and conducted small and large group educational presentations on prostate cancer, hypertension, and stroke. Evaluation of the program found that participants had increased knowledge about high blood pressure, increased ability to discuss high blood pressure with family and health care providers, and increased medical care seeking and lifestyle changes supportive of reducing high blood pressure.

Key characteristics:

- Fostered partnerships between health care providers, community-based organizations, and community members to develop strategies to reduce high blood pressure
- Demonstrated integration of services for education about two diseases affecting the population
- Increased knowledge about high blood pressure
- Increased behavior changes to reduce high blood pressure

Contact Information and Websites for Interviewed Programs

The following table includes the contact information of program administrators as well as link(s) to Web sites with detailed information regarding the program intervention:

Program Name	Contact Information/Website
1. Can Barbers Cut Blood Pressure Too?	Ronald G. Victor, MD, Cedars-Sinai Medical Center (Los Angeles, CA) Phone: (310) 248-7641, Assistant Julie Groth E-mail: julie.groth@cshs.org Website: http://www8.utsouthwestern.edu/utsw/cda/dept100467/files/138990.html
2. Church/ Community Health Awareness & Monitoring Program (CHAMP)	Ina Glenn-Smith, C.H.A.M.P. (Baltimore, MD) Phone: (410) 669-6340, Email: ismith9576@aol.com Jeanne Charleston Phone: (443) 802-5161, Email: jeannebc@comcast.net Website: http://medschool.umaryland.edu/champ/
3. Magic City Stroke Prevention Project	Shauntice Allen, MA, Magic City Stroke Prevention Project (Birmingham, AL) Phone: (205) 975-5429, Email: sallen1@uab.edu Website: http://www.magiccitystroke.com/page.asp?id=19
4. Power to Live Smart program	Sara Eve Sarliker, MPH, Heart Disease and Stroke Prevention Program Washington State Department of Health (Olympia, WA) Phone: (360) 236-3781, Email: sara.eve.sarliker@doh.wa.gov Website: http://www.americanheart.org/presenter.jhtml?identifier=3047257
5. Racial and Ethnic Approaches to Community Health (REACH) Cardiovascular Wellness Centers	Association of Black Cardiologists, Inc. (Atlanta, GA) Phone: (404) 201-6643, Email: abcardio@abcardio.org Website: http://www.abcardio.org/reach.htm
6. Chicago REACH 2010/Lawndale Health Promotion Project	Berenice Tow, MS, Chicago Department of Health (Chicago, IL) Phone: (312) 745-0590, Email: Tow_Berenice@cdph.org Websites: http://www.uic.edu/cuppa/gci/uicni/partnerships/current%20projects/REACH%20 2010%20Lawndale%20Health%20Promotion%20Project.htm http://www.cdc.gov/reach/pdf/IL_Lawndale.pdf http://apha.confex.com/apha/130am/techprogram/paper_45984.htm http://apha.confex.com/apha/132am/techprogram/paper_78793.htm
7. Stroke, Hypertension, and Prostate Education Intervention Team (SHAPE-IT)	James Plumb, MD, MPH, Thomas Jefferson University (Philadelphia, PA) Phone: (215) 955-0535, Email: James.Plumb@jefferson.edu Website: http://apha.confex.com/apha/135am/techprogram/paper_162962.htm
8. Stroke and Heart Attack Prevention Program (SHAPP)	Karen Boone, RN, MN, MPH, Georgia Department of Human Resources (Atlanta, GA) Phone: (404) 657-6638, Email: kaboone@dhr.state.ga.us Websites: http://health.state.ga.us/programs/cardio/shapp.asp http://northcentralhealthdistrict.com/content.asp?pid=104&id=162
9. Sound Heart Program	Devon Love, Center for MultiCultural Health (Seattle, WA) Phone: (206) 461-6910 (ext. 210), Email: devon.love@cschc.org Website: http://www.multi-culturalhealth.org/programs_svcs/sound_heart.htm

Literature Search Results

We present information on 11 programs described in 12 publications from the peer-reviewed literature. We primarily focus on programs that would be directly applicable to the goals of this document, namely, presenting systems-level programs concerning blood pressure control in populations comprised solely or predominantly of African American men. We also include programs focusing on other diseases, because they include lessons learned on recruiting African American men into health care programs. We present a matrix highlighting key characteristics of the interventions, similar to the matrix for the interviewed programs. We also list references to full articles describing the study interventions.

Journal Article Projects Matrix

Selected Characteristics	Edwards et al. (2007) OH	Hill et al. (1999) Baltimore, MD	Hill et al. (2003) & Dennison et al. (2007) Baltimore, MD	Fouad et al. (1997) Birmingham, AL	Graham et al. (2006) Various locations	Keys (1999) Various locations	Smith et al. (1997) Chicago, IL	Becker et al. (2005) Baltimore, MD	Abernethy et al. (2005) Los Angeles, CA	Dickson et al. (2004) NC	Vetter et al. (2004) Baltimore, MD
Study design											
Descriptive	●				●	●			●	●	
Randomized controlled trial		●	●					●			●
Quasi-experimental				●			●				
Study length	1 time	1 year	5 years	1 year	6 months	1 year	3 months	1 year	unknown	ongoing	2 years
Target health condition											
Hypertension	●	●	●	●	●	●	●				
Cardiovascular disease						●		●			
Diabetes					●					●	●
Prostate cancer									●		
Setting											
Faith-based organizations					●	●	●		●		
Community	●				●	●		●			
Medical/clinics		●	●								●
Workplace				●							
Government	●									●	
Service delivery											
Project staff	●			●		●				●	
Physicians			●			●					
Nurses/nurse practitioners		●	●			●	●	●			●
Health educators							●				
Community health/ outreach workers		●	●					●			●
Community organization leaders/ staff					●		●		●		
Study population											
Low-income/ underserved				●						●	
African American only	●	●	●		●	●	●	●	●		●
Men only	●	●	●						●		
Study/program activities											
Blood pressure screening/ monitoring		●	●	●	●	●	●	●			●
Participant education/ media campaign	●	●	●	●		●	●	●	●	●	●
Free medications			●					●			
Referral to providers		●									
Home visits		●	●				●				●
Training community members							●				
Forming partnerships					●	●	●		●	●	

Blood pressure control programs focusing on African American men

Article 1 - Addressing health disparities within Ohio's African American male population: Ohio Department of Health, Heart Disease and Stroke Prevention Program's focus groups, 2007 summary report and recommendations.

Lessons Learned

- Future studies should investigate approaches for obtaining family health history.
- Health messages should be created that encourage young African American men to make health a priority in their lives.
- Further exploration of better marketing of alternative food-based nutrition interventions is needed including community gardens and farmers markets accessible to the African American community.
- Aspects of religion or spirituality should be included in health messages; places of worship should be considered as means of disseminating health messages to older audiences.
- The perception that health care providers are not being honest impedes the development of relationships.
- Messages need to be tailored to various African American male audiences.
- Web-based health education campaigns should be directed at younger men.
- Trusted female figures should be used in educational campaigns.
- In designing communication plans, educational campaigns should partner with trusted local businesses.
- Traditional media sources should be used to disseminate health messages.
- The entertainment factor should be considered when creating a campaign for younger men.

Reference: Edwards J, Greene E, Pryor B. Addressing health disparities within Ohio's African American male population: Ohio Department of Health, Heart Disease and Stroke Prevention Program's focus groups 2007 summary report and recommendations. Columbus, OH; 2007: Office of Health Ohio, Ohio Department of Health.

Article 2 - A research study to improve high blood pressure care in young urban African American men: recruitment, follow-up, and outcomes.

Lessons Learned

- It is feasible to identify, recruit, and follow-up on men with these characteristics; however, the process is very labor intensive.
- The Emergency Department is an important recruitment site in underserved urban areas.
- Men who were currently or had been in care for their high blood pressure were more likely to participate than those who had not previously been diagnosed.
- Word-of-mouth is a valuable approach for recruiting participants.
- The likelihood of reaching men was enhanced by identifying three, rather than two verified contacts.

- For many, the provision of transportation, minimal financial assistance with medical visit fees, and medication were not sufficient incentives to overcome negative prior experiences and the perceived absence of benefit.
- Modest financial and tangible incentives, such as sunglasses and squeeze bottles with the study logo, were useful.
- An enthusiastic, energetic, committed, and persistent minority staff was essential to recruitment and retention. Staff members brought to the study knowledge, experience, nonjudgmental concern about the health of the population, and an ability to establish rapport with the men and contacts. It was important that the workers were comfortable in the community, but they did not need to be from the community.

Reference: Hill MN, Bone LR, Hilton SC, Roary MC, Kelen GD, Levine DM. A clinical trial to improve high blood pressure care in young urban black men: recruitment, follow-up, and outcomes. Am J Hypertension 1999;12(6):548–54.

Article 3 - Hypertension care and control in underserved urban African American men: behavioral and physiologic outcomes at 36 months and hypertension study outcomes and mortality results at 5 years.

Lessons Learned

- It is possible to recruit, track, and follow a cohort of inner city young African American men with hypertension.
- High rates of obesity, smoking, and illicit drug use emphasize the need to better incorporate lifestyle modification therapies within BP control programs.
- The multi-faceted, individually tailored, multi-disciplinary team approach with free medications appears to have effectively reduced barriers to BP control among these men.
- Assistance with life priorities (e.g., job training and housing) appeared to help the men better focus on their health problem.
- Even the less intensive intervention (telephone calls every 6 months, annual evaluation, appropriate referrals for health conditions and social needs, and attention from a culturally competent and motivated staff) helped high-risk patients lower their blood pressure.
- Integrating assessment, counseling, and referral for substance abuse is useful.
- The physician visit needs to be supplemented by home visits from community health workers, free BP management, and medication.

Individual interactions influenced the number of nurse practitioner visits. A decrease in visits in years 4 and 5 may have been related to participant fatigue as the uniqueness wore off. A modified or intensified intervention may have been useful in the last years of the study.

References: Hill MN, Han HR, Dennison CR, Kim MT, Roary MC, Blumenthal RS, et al. Hypertension care and control in underserved urban African American men: Behavioral and physiologic outcomes at 36 months. Am J Hypertension 2003;16:906–913.

Dennison CR, Post WS, Kim MT, Bone LR, Cohen D, Blumenthal RS, et al. Underserved urban African American men: hypertension trial outcomes and mortality during 5 years. Am J Hypertension 2007;20:164–171.

Blood pressure control/coronary heart disease prevention programs focusing on the African American community

Article 4 - A hypertension control program tailored to unskilled and minority workers.

Lessons Learned

- Several barriers to participation became apparent:
  - High rate of illiteracy
  - Lack of understanding of concept of delayed gratification (preventive measure to avoid heart disease in future)
  - Significant variability in health priorities
  - Inaccurate health beliefs about cardiovascular risk factors
  - Inadequate support from supervisors
  - Lack of time for participation
  - Adverse peer group pressure
- Involving employees in the creation of the intervention program might have improved participation rates.
- Because this study was part of a larger health intervention, it is difficult to isolate the impact of the hypertension program from that of the larger health intervention project.
- Workplace programs blending behavioral and environmental interventions to complement and reinforce each other cause the health outcome to be shared by employer and employee. The blending of these approaches may promote behavioral change by enhancing workplace awareness.

Reference: Fouad MN, Kiefe CI, Bartolucci AA, Burst NM, Ulene V, Harvey MR. A hypertension control program tailored to unskilled and minority workers. Ethn Dis 1997;7(3):191–199.

Article 5 - Development of a standardized screening form that can be used at community-based screening events conducted by community organizations in the African American community.

Lessons Learned

- Collaborative models can be successfully created between OMH and national African American organizations.
- Community organizations that are not health oriented may require more technical assistance when using screening tools and selecting appropriate personnel to conduct health screenings.
- Additional appropriate personnel may ease the time pressures that could lead to incomplete completion of the forms.

- Issues of privacy/confidentiality and liability are critical barriers to more effective follow-up. Providing screeners with a confidentiality agreement before the screening with additional language for handling this situation with participants may be helpful, or adding a tear-off section to the forms where the screeners would record the participant's screening results and then detach if from the screening form for the participant to use for future reference may also be helpful.

Reference: Graham GN, Kim S, James B, Reynolds G, Buggs G, Hunter M, et al. Benefits of standardized diabetes and hypertension screening forms at community screening events. Health Promot Pract 2006;7(1):26–33.

Article 6 - Take It To Heart: a national health screening and educational project in African American communities.

Lessons Learned

- Results of screening tests demonstrated the need for more community-based programs designed to increase awareness of the importance of regular check-ups and health information regarding hypertension.
- The program was well received and has expanded so that the partnership between the National Medical Association and the Bayer Corporation has expanded to include the National Black Nurse's Association. This will provide participants with greater access to African American health care providers.
- In light of a high percentage of abnormal results, a follow-up program is being developed. Several new activities are being explored including educational mailing to participants' homes and phone calls from local National Medical Association physicians.

Reference: Keys R. Take It To Heart: a national health screening and educational project in African American communities. J Natl Med Assoc 1999;19(12):649–652.

Article 7 - Faith-based education: an outreach program for African Americans with hypertension.

Lessons Learned

- Men and individuals who were younger or newly diagnosed with high blood pressure were more difficult to recruit and retain. These groups were more at risk for inadequate education about high blood pressure.
- Low participation by African American men may be related to a belief that it is the woman's role to direct the management of the men's high blood pressure treatment regimen, as well as a fear of disclosing feelings about the impact of high blood pressure and high blood pressure drugs on their sexuality.
- Using volunteers has its assets and liabilities. Volunteers are often recruited because of their interest and availability without giving consideration to their talents and skills. The pastor may have assumed that all RNs and leaders had the requisite talents and skills to organize and implement the high blood pressure education program in their faith-based organizations. From members' self-assessments, this was not always true. This may partially explain why some

leaders did not implement the high blood pressure education program at their faith-based organization.

Reference: Smith ED, Merritt SL, Patel MK. Church-based education: an outreach program for African Americans with hypertension. Ethnic Health 1997;2(3):243–253.

Article 8 - Impact of a community-based multiple risk factor intervention on cardiovascular risk in African American families with a history of premature coronary disease.

Lessons Learned

- While the CBC intervention was superior, the EPC group demonstrated a smaller improvement in risk factors, suggesting that barrier-reducing enhancements to primary care may moderately improve individual risk factors.
- Even in the best-case scenario in which the major well-known risk barriers have been reduced, risk factor goals were not attained by a relatively large number of individuals in both groups.
- The superior results of the CBC group may be due in large part to the community health worker, who served as a culturally sensitive navigator through the systems of care including filling prescriptions, shopping for and preparing healthier foods, and accessing exercise facilities. Also, assistance of the nurse practitioner to the CBC group may have helped individuals' ability to manage pharmacotherapy effectively, as evidenced by more frequent use of the pharmacy card.
- Unexpectedly, the small exercise room at the CBC was a strong incentive because individuals could use it for a short period of time at their convenience.

Reference: Becker DM, Yanek LR, Johnson WR, Garrett P, Moy TF, Reynolds SS, et al. Impact of a community-based multiple risk factor intervention on cardiovascular risk in black families with a history of premature coronary disease. Circulation 2005;111:1298–1304.

Other relevant systems-level health care programs focusing on the African American community

Article 9 - Recruiting African American Men for cancer screening studies: applying a culturally based model.

Lessons Learned

- Efforts to recruit African American men for cancer prevention studies are enhanced by the application of culturally based models that provide a framework for understanding the unique concerns of African American men in cancer prevention research.

- Cultural beliefs should not simply be tolerated but understood. Social, religious, and other factors may influence the role of fatalism in the African American community.
- Cultural tailoring in recruitment is also an important strategy. Giving consideration to racial, gender, socioeconomic, educational, and religious characteristics of the proposed sample is key to maximizing participant recruitment.
- Viewing prevention efforts from a collective rather than exclusively an individualistic perspective, as well as identifying the specific concerns of African Americans regarding PCS, may be an important element in maximizing the recruitment of African American men and other cultural groups where the community has a primary role.

Reference: Abernethy AD, Magat MM, Houston TR, Arnold HL, Bjorck JP, & Gorsuch RL. Recruiting African American men for cancer screening studies: applying a culturally based model. Health Educ Behav 2005;32(4):441–451.

Article 10 - Systems-level and community-based interventions for diabetes control.

Lessons Learned

- The Partnership is addressing the lack of multimedia campaigns by launching a major social marketing campaign aimed at diabetes prevention. Funding will be provided through a recent appropriation of the state legislature to establish "public health incubators" across the state. Social marketing campaigns aimed at heart disease, stroke, and HIV/AIDS prevention will be developed in subsequent years. The major social marketing campaign aimed at diabetes has the potential for great impact with a limited amount of new resources.
- The Partnership is attempting to convince state legislators and state public health leaders to make an ongoing funding commitment to the region to tackle not only the diabetes, heart disease, stroke, and HIV/AIDS health issues of pressing concern, but also to strengthen the local public health infrastructure and improve its ability to assess, address, and assure the public's health.

Reference: Dickson CW, Alexander JG, Earley, BH, Riddle, EKR. Northeastern North Carolina partnership for public health and health disparities in Northeastern North Carolina. N C Med J 2004;65(6):377–380.

Article 11 - A model for home care clinician and home health aide collaboration: diabetes care by nurse case managers (NCM) and community health workers (CHW).

Lessons Learned

- The findings suggest the importance of nonprofessional community health workers on the diabetes care team. Many issues with which the CHW assisted patients—including finances, family responsibilities, and insurance—went beyond the traditional diabetes care provided in outpatient primary care settings.
- In light of a high percentage of abnormal results, it has been recommended that a follow-up program be developed. Several programs are being explored including educational mailings to participants' homes and phone calls from local National Medical Association physicians.

- The integration of NCMs and CHWs into the primary care setting can produce improvements in diabetic control and reduce the excess burden of diabetes-related complications in African Americans.
- Additional outcome improvements might have occurred if study personnel had provided the amount of interventions typically provided to home care patients with diabetes. In this study, improved outcomes occurred despite a lower than planned number of interventions. The number of face-to-face visits conducted by both the NCM and CHW was very modest compared with the number of home visits typically provided to home care patients with diabetes. Insufficient staff time and patient noncompliance were barriers to achieving this goal.

Reference: Vetter MJ, Bristow L, Ahrens J. A model for home care clinician and home health aide collaboration: diabetes care by nurse case managers and community health workers. Home Healthc Nurse 2004;22(9):645–648.

5

This chapter presents organizations that programs can potentially partner with to design or implement program interventions. We included associations for African American health professionals; African American men's health organizations; multicultural health programs at the federal, state, and local levels; and cardiovascular health organizations. Also included are nontraditional resources such as Historically Black Colleges and Universities, and African American fraternities and sororities. While local faith-based organizations and churches are often used as a resource by programs, since these organizations lack central contact information at the national level, they are not included in this chapter.

Professional Health Associations of African Americans

Resource	Aims and Description	Contact Information/Web site
Association of Black Cardiologists, Inc. (ABC)	International membership of over 600 health care professionals to eliminate disparities related to cardiovascular disease in all people of color. Produces publications on reducing cardiovascular risks for people of color and sponsors community health programs.	5355 Hunter Road Atlanta, GA 30329 Phone: (404) 201-6600 Email: abcardio@abcardio.org Website: http://www.abcardio.org/
The Association of Black Psychologists, Inc. (ABPsi)	To have a positive impact on the mental health of the African American community through planning, programs, services, training, and advocacy.	P.O. Box 55999 Washington, DC 20040-5999 Phone: (202) 722-0808 Email: abpsi_office@abpsi.org Website: http://www.abpsi.org
Black Caucus of Health Workers (BCHW)	Improve the health of African Americans through relevant database development, professional development, policy analysis, research, and legislative review. Provides an entry point for African American public health workers to the American Public Health Association (APHA) and provides programs that explore public health problems facing people of color in the US.	c/o University of Illinois at Chicago School of Public Health 2121 W. Taylor, Rm. 208 Chicago, IL 60612 Phone: (312) 355-2951 Website: http://www.saaphi.org/bchwmissionf.doc
The Black Young Professionals' Public Health Network, Inc. (The Network)	Promotes networking opportunities for junior-level public health professionals and enhances awareness of African American health issues. Strives to increase communication between traditional Schools of Public Health and the newly forming Masters of Public Health programs at Historically Black Colleges and Universities.	P.O. Box 1954 Mount Pleasant, SC 29465-1954 Phone: (843) 819-4388 Email: bypphn@yahoo.com Website: www.bypphn.org
National Black Nurses Association, Inc. (NBNA)	Provides a forum for African American nurses to investigate, define, and advocate for the health care needs of African Americans. Chapters provide screening and health education activities related to cardiovascular disease, hypertension screening and referral; smoking-cessation intervention programs; cholesterol screening and referral; CPR training; and education regarding heart attack prevention and early treatment.	8630 Fenton St., Suite 330 Silver Spring, MD 20910-3803 Phone: (800) 575-6298 Email: NBNA@erols.com Website: http://www.nbna.org
National Medical Association (NMA)	Advance medicine for people of African descent through education, advocacy, and health policy. Provides the public with information about various conditions and interventions. Conducts an annual meeting and colloquiums, and consensus panels concerning issues related to health disparities, and publishes a journal.	1012 Tenth St., NW Washington, DC 20001 Executive Offices Phone: (202) 347-1895 Website: http://www.nmanet.org/

Health Programs Targeting African American Men

Resource	Aims and Description	Contact Information/Web site
100 Black Men of America, Inc.	Aims: to improve the quality of life and enhance educational and economic opportunities for all African Americans. A Health and Wellness Initiative, in partnership with other non-profit organizations promotes preventative health strategies, delivers screenings and provides education on prevalent diseases.	141 Auburn Ave. Atlanta, GA 30303 Phone: (404) 688-5100 Website: http://www.100blackmen.org
Black Men's Health Initiative (BMHI)	Educates African American men about the risks and complications of chronic disease, makes presentations, holds discussions, and provides blood pressure screenings through men's groups at churches in counties/towns with high prevalence of cardiovascular disease.	4800 University Drive #4B Durham, NC 27707 Phone: (919) 237-2617 Email: BlackMHI@aol.com Website: http://www.bmhi.org/
The National Black Men's Health Network	Educates and raises public awareness about the excessive morbidity and mortality rates in the African American community and among African American males in particular.	250 Georgia Ave., Suite 321, Atlanta, GA 30312 Phone: (404) 524-7237 Email: info@nbmhn.net Website: http://www.nbmhn.net/
Project Brotherhood Black Men's Clinic	Provides medical and social services to improve the health and well-being of African American men in Chicago by providing primary, holistic health care and improving health awareness through a culturally and gender-specific environment. Innovative strategies, taking into account the disenfranchisement of African American men are used to recruit and retain them into primary care.	6337 S. Woodlawn Ave., Chicago, IL 60637 Phone: (773) 753-5500 Email: ProjectBrotherhood@hotmail.com Website: http://www.projectbrotherhood.net/

Programs Targeting African Americans

Resource	Aims and Description	Contact Information/Web site
Congressional Black Caucus Foundation, Inc. (CBCF)	Focuses on leadership education, public health and economic development to be the catalyst that educates future leaders and promotes collaboration among legislators, business leaders, minority-focused organizational leaders, and organized labor to effect positive and sustainable change in the African American community. .	1720 Massachusetts Ave., NW, Washington, DC 20036 Phone: (202) 263-2800: Email: info@cbcfinc.org Website: http://www.cbcfinc.org
National Association for the Advancement of Colored People (NAACP)	To ensure the political, educational, social, and economic equality of rights of all persons. Health related aims include: national health education initiatives; expanding community outreach; and sponsoring collaborative programs with other health organizations. Target areas include reducing disparities in obesity and related diseases such as diabetes, hypertension, and heart disease.	4805 Mt. Hope Drive, Baltimore, MD 21215 Phone: (877) NAACP-98 Website: http://www.naacp.org/ home/index.htm
National Caucus and Center on Black Aged, Inc. (NCBA)	To improve the quality of life for elderly African American and low-income minorities. Sponsors The Health and Wellness Program which focuses on prevention and control of chronic diseases, emphasizing cancer, diabetes, cardiovascular disease, hypertension, substance abuse, and HIV/AIDS	1220 L St., NW, Suite 800 Washington, DC 20005 Phone: (202) 637-8400 Email: info@ncba-aged.org: Website: http://www.ncba-aged.org
National Urban League	To enable African Americans to secure economic self-reliance, parity, power, and civil rights. Has worked with various other organizations, to address prevention strategies concerning diabetes, cancer, Alzheimer's, and depression..	120 Wall St., 8th Floor New York, NY 10005 Phone: (212) 558-5300 Website: http://www.nul.org/

Minority/Multicultural Health Organizations and Programs (Federal)

Resource	Aims and Description	Contact Information/Web site
National Center on Minority Health and Health Disparities (NCMHD)	As part of the NIH, NCMHD promotes minority health and leads, coordinates, supports, and assesses NIH efforts to reduce and ultimately eliminate health disparities. Conducts and supports research; promotes research infrastructure and training; fosters emerging programs; disseminates information; and reaches out to minority and other health disparity communities.	6707 Democracy Blvd., Suite 800 Bethesda, MD 20892-5465 Phone: (301) 402-1366 Website: http://nchmd.nih.gov/
Office of Minority Health (OMH)	Within DHHS, OMH develops health policies and programs to eliminate health disparities, including initiatives geared toward African Americans. State Offices of Minority and Multicultural Health Liaisons: http://www.omhrc.gov/images/stateliaisons.htm	The Tower Building, 1101 Wootton Parkway, Suite 600 Rockville, MD 20852 Phone: (240) 453-2882 Email: info@omhrc.gov Website: http://www.omhrc.gov/
Project EXPORT: Excellence in Partnerships for Community Outreach and Research on Disparities in Health and Training	Sponsored by NCHMD to build research capacity at designated institutions enrolling a significant number of students from health disparity populations and to promote participation and training in biomedical and behavioral research among such populations. Grantees are HBCUs and other health disparities centers including the Hopkins-Morgan Center for Health Disparities Solutions and the University of Pittsburgh EXPORT Center and Center for Minority Health.	Web site: http://ncmhd.nih.gov/our_programs/centerOfExcellence.asp

Minority/Multicultural Health Organizations and Programs (National)

Resource	Aims and Description	Contact Information/Web site
Community Voices: Health Care for the Underserved	A national health initiative aimed at eliminating men's health disparities through community-based demonstration projects dedicated to providing greater access to quality health care to the underserved and uninsured. Program founded first US Men's Health Clinic in Baltimore, MD.	Melva B. Robertson, Health Communications Specialist National Center For Primary Care Morehouse School of Medicine, 720 Westview Drive S.W., Atlanta, GA 30310 Phone: (404) 752-1977 Email: mrobertson@msm.edu Website: http://www.communityvoices.org/Default.aspx
Health Power for Minorities	To eliminate racial and ethnic health disparities by promoting multicultural health improvement. Provides a Website with culturally relevant health information, printed materials, consultative and training services, and collaboration with other organizations. Website includes a "Men's Health Channel" and "African American Channel".	Norma J. Goodwin, M.D. 3020 Glenwood Road Brooklyn, NY 11210 Phone: (718) 434-8103 Email: njgoodwin@healthpowerforminorities.org Website: http://www.healthpowerforminorities.org
National Minority Quality Forum (NMQF)	Strengthens national and local efforts to eliminate premature death and preventable illness in minorities. Activities include research, fostering cultural competency among health care providers, and evaluating policy initiatives. Includes a Healthy Heart Initiative.	1200 New Hampshire Ave., NW, Suite 575 Washington, DC 20036 Phone: (202) 223-7560 Website: http://www.nmqf.org

Cardiovascular Health Organizations

Resource	Aims and Description	Contact Information/Web site
American Heart Association (AHA)	Funds research and educational programs to reduce the burden of cardiovascular disease. Focuses on cardiovascular science, education and community programs, and fund-raising.	7272 Greenville Ave., Dallas, TX 75231 Phone: 1-800-242-8721 Website: http://www.american heart.org/presenter.jhtml?identifier=1200000
American Stroke Association (ASA)	To reduce risk, disability, and death from stroke through research, education, fund-raising, and advocacy. (Division of AHA)	Website: http://www.strokeassociation.org/presenter.jhtml?identifier=1200037
American Society of Hypertension, Inc. (ASH)	Strengthens national and local efforts to eliminate premature death and preventable illness in minorities. Activities include research, fostering cultural competency among health care providers, and evaluating policy initiatives. Includes a Healthy Heart Initiative.	148 Madison Ave., 5th floor, New York, NY 10016 Phone: (212) 696-9099 Email: ash@ash-us.org Website: http://www.ash-us.org/
International Society on Hypertension in Blacks (ISHIB)	To eliminate cardiovascular health disparities. Sponsors accredited professional educational programs; participates in patient and community education, publishes ***Ethnicity & Disease***, and hosts an annual International Interdisciplinary Conference..	157 Summit View Dr. , McDonough, GA 30253 Phone: (404) 880-0343 Email: inforequest@ishib.org Website: http://www.ishib.org/

Other Nontraditional Resources

Historically Black Colleges and Universities (HBCUs)

A complete list of HBCUs is located on the National Association for Equal Opportunity in Higher Education Web site: http://www.nafeo.org/fullmemberlist.php

African American Fraternities

Web sites of national organizations may provide contact information for local affiliates

Fraternity Name	Web Site of National Headquarters
Alpha Phi Alpha	http://www.alpha-phi-alpha.org/
Iota Phi Theta	http://www.iotaphitheta.org/index.html
Kappa Alpha Psi	http://www.kappaalphapsi1911.com/index.asp
Omega Psi Phi	http://www.omegapsiphifraternity.org/generalpublic.asp
Phi Beta Sigma	http://www.pbs1914.org/default.asp
Program guide for the health initiative, "Living Well Brother to Brother": http://www.pbs1914programs.org/9.html	

African American Sororities

Web sites of national organizations may provide contact information for local affiliates

Sorority Name	Web Site of National Headquarters
Alpha Kappa Alpha	www.aka1908.com
Chi Eta Phi (African American Nurses' Sorority)	http://www.chietaphi.com/
Delta Sigma Theta	www.deltasigmatheta.org
Sigma Gamma Rho	http://www.sgrho1922.org/
Zeta Phi Beta	www.zphib1920.org

Masons

Web site of the national organization may provide contact information for local affiliates

Lodge Name	Web Site of National Headquarters
Most Worshipful Prince Hall Grand Lodges	http://www.princehall.org/

Abbreviations: CDC: Centers for Disease Control and Prevention; DHHS: Department of Health and Human Services; NIH: National Institutes of Health.

References

1. Chobanian AV, Bakris GL, Black HR, Cushman WC, Green LA, Izzo JL Jr, et al. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Hypertension 2003; Dec 42(6):1206–52.
2. Wyatt SB, Akylbekova EL, Wofford MR, Coady SA, Walker ER, Andrew ME, et al. Prevalence, awareness, treatment, and control of hypertension in the Jackson Heart Study. *Hypertension 2008; 51*: 650–656.
3. Davis SK, Liu Y, Quarells RC, Dim-Dzietham R. Stress-related racial discrimination and hypertension likelihood in a population-based sample of African Americans: The metro Atlanta heart disease study. *Ethn Dis 2005;15*:585–593.
4. Din-Dzietham R, Nembhard WN, Collins R, Davis SK. Perceived stress following race-based discrimination at work is associated with hypertension in African-Americans. The metro Atlanta heart disease study, 1999-2001. *Soc Sci Med 2004;58*:449–461.
5. James K, Lovato C, Khoo G. Social identity correlates of minority workers' health. *Acad Manage J 1994;37*(2):383–396.
6. Krieger N, Sidney S. Racial discrimination and blood pressure: The CARDIA Study of young black and white adults. *Am J Public Health 1996;86*(10):1370–1378.
7. Paradies Y. A systematic review of empirical research on self-reported racism and health. *Int J Epidemiol 2006;35*:888–901.
8. Williams DR, Neighbors H. Racism, discrimination and hypertension: evidence and needed research. *Ethn Dis 2001;11*(4):800–816.
9. James SA. John Henryism and the health of African-Americans. *Cult Med Psychiatry 1994;18*(2):163–182.
10. James SA, LaCroix AZ, Kleinbaum PG, Strogatz DS. John Henryism and blood pressure differences among black men. II. The role of occupational stressors. *J Behav Med 1984;7*(3):259–275.
11. James SA, Keenan NL, Strogatz DS, Browning SR,Garrett JM. Socioeconomic status, John Henryism, and blood pressure in black adults: The Pitt County Study. *Am J Epidemiol 1992;135*(1):59–67.
12. Lukoschek P. African Americans' beliefs and attitudes regarding hypertension and its treatment: a qualitative study. *J Health Care Poor Underserved 2003;14*:566–587.
13. Wilson RP, Freeman A, Kazda MJ, Andrews TC, Berry L, Vaeth, PA, et al. Lay beliefs about high blood pressure in a low- to middle-income urban African-American community: an opportunity for improving hypertension control. *Am J Med 2002; 112*(1):26–30.
14. Bell AC, Adair LS, Popkin BM. Understanding the role of mediating risk factors and proxy effects in the association between socio-economic status and untreated hypertension. *Soc Sci Med 2004; 59*(2):275–283.
15. Sharma S, Malarcher AM, Giles WH, Myers G. Racial, ethnic, and socioeconomic disparities in the clustering of cardiovascular risk disease factors. *Ethn Dis 2004;14*(1):43–48.
16. Grumbach K. Insuring the uninsured: time to end the aura of invisibility. *J Am Med Assoc 2000;284*:2114–2116.
17. James SA, Van Hoewyk J, Belli RF, Strogatz DS, Williams DR, Raghunathan TE. Life-course socioeconomic position and hypertension in African-American men: The Pitt County Study. *Am J Public Health 2006;96*(5):812–817.
18. Shulman NB, Martinez B, Brogan D, Carr AA, Miles CG. Financial cost as an obstacle to hypertension therapy. *Am J Public Health 1986;76*:1105–1108.
19. LaVeist TA (2005) Minority populations and health: An introduction to health disparities in the United States. San Francisco (CA): Jossey-Bass; 2005.
20. Kingston RS, Smith JP. Socioeconomic status and racial and ethnic differences in functional status associated with chronic diseases. *Am J Public Health 1997;87*:805–810.
21. Fillenbaum GG, Hanlon JT, Corder EH, Ziqubu-Page T, Wall WE, Brock D. Prescription and nonprescription drug use among black and white community-residing elderly. *Am J Public Health 1993;83*:1577–1582.
22. LaVeist TA, Nickerson K, Bowie J. Attitudes about racism, medical mistrust, and satisfaction with care among African American and White cardiac patients. *Med Care Res Rev 2000; 57* Suppl 1:146–161.
23. Lee AJ, Gehlbach S, Hosmer D, Reti M, Baker CS. Medicare treatment differences for Black and Whites. *Med Care 1997;35*:1173–1189.

24. Collins KS, Tenney K, Hughes DL. Quality of health care for African Americans: findings from the Commonwealth Fund 2001 health care quality survey. New York (NY): The Commonwealth Fund; 2002.

25. van Ryn M, Burke J. The effect of patient race and socioeconomic status on physicians' perceptions of patients. *Soc Sci Med 2000;50*:813–828.

26. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep 2003;118*(4):293–302.

27. Bureau of the Census, Current Population Survey, Annual Social and Economic (ASEC) Supplement, http://pubdb3.census.gov/macro/032007/health/h01_000.htm.

28. He J, Mutner P, Chen J, Roccella EJ, Streiffer RH, & Whelton PK. Factors associated with hypertension control in the general population of the United States. *Arch Intern Med 2002; 162*(9):1051–1058.

29. Briesacher B, Limcangco R, Gaskin D. Racial and ethnic disparities in prescription coverage and medication use. *Health Care Financ Rev 2003;25(*2):63–76.

30. Ogedegbe G, Harrison M, Robbins L, Mancuso CA, Allegrante JP. Barriers and facilitators of medication adherence in hypertensive African Americans: a qualitative study. *Ethn Dis 2004a;14*(1):3–12.

31. Ogedegbe G, Mancuso CA, Allegrante JP. Expectations of blood pressure management in hypertensive African-American patients: a qualitative study. *J Natl Med Assoc 2004b; 96*(4):442–449.

32. Rawaf MM, Kressin NR. Exploring racial and sociodemographic trends in physician behavior, physician trust and their association with blood pressure control. *J Natl Med Assoc 2007; 99*(11):1248–1254.

33. Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. *Arch Intl Med 1999;159*:997–1004.

34. Heyden S, Schneider KA. Obesity and hypertension: Epidemiological aspects of the relationship. *J Hum Hypertens 1990;4*(4):431–435.

35. Higgins M, Agostino R, Kannel W, Cobb J. Benefits and adverse effects of weight loss: observations from the Framingham Study. *Ann Intern Med 1993;119*(7 Pt 2):758–763.

36. Hu G, Tuomilehto J, Silventoinen K, Barengo N, Jousilahti P. Joint effects of physical activity, body mass index, waist circumference and waist-to-hip ratio with the risk of cardiovascular disease among middle-aged Finnish men and women. *Eur Heart J 2004;25*(24):2212–2219.

37. Jonsson S, Hedblad B, Engstrom G, Nilsson P, Berglund G, Janzon L . Influence of obesity on cardiovascular risk. Twenty-three-year follow up of 22,025 men from an urban Swedish population. *Int J Obes Relat Metab Disord 2002;26*(8):1046–1053.

38. Jousilahti P, Tuomilehto J, Vartiainen E, Pekkanen J, Puska P. Body weight, cardiovascular risk factors, and coronary mortality: 15-year follow-up of middle-aged men and women in eastern Finland. *Circulation 1996;93*(7):1372–1379.

39. Kannel WB, et al. Regional obesity and risk of cardiovascular disease; The Framingham Study. *J Clin Epidemiol 1991;44*(2):183–190.

40. Kannel WB. Hazards, risks, and threats of heart disease from the early stages to symptomatic coronary heart disease and cardiac failure. *Cardiovasc Drugs Ther 1997;11*(Suppl 1):199–212.

41. Rosengren A, Wedel H, Wilhelmsen L. Body weight and weight gain during adult life in men in relation to coronary heart disease and mortality. A prospective population study. *Eur Heart J 1999;20*(4):269–277.

42. National Center for Health Statistics. *Health, United States: with chartbook on trends in the health of Americans.* Hyattsville, MD: U.S. Centers for Disease Control and Prevention, 2006; 2068:304–306.

43. Adrogue HJ, Wesson DE. Role of dietary factors in the hypertension of African Americans. *Semin Nephrol 1996;16*(2):94–101.

44. Bediako SM, Kwate NO, Rucker R. Dietary behavior among African Americans: assessing cultural identity and health consciousness. *Ethn Dis 2004;14*(4):527–532.

45. Peters RM, Aroian KJ, Flack JM (2006). African American culture and hypertension prevention. *West J Nurs Res 2006;28*(7):831–863.

46. Reusser ME, DiRienzo D, Miller G, McCarron D. Adequate nutrient intake can reduce cardiovascular disease risk in African Americans. *J Natl Med Assoc 2003;95*(3):188–195.

47. Tucker K. Dietary patterns and blood pressure in African Americans. *Nutr Rev 1999;57*(11):356–358.

48. de Souza P, Ciclitira KE. Men and dieting: a qualitative analysis. *J Health Psychol 2005;10*:793–804.

49. Welch, M. Care of Blacks and African Americans. In J.A. Bigby (Ed.) *Cross-Cultural Medicine*. Philadelphia (PA): American College of Physicians; 2003. p. 29–60.

50. Dimsdale JE. Stalked by the past: the influence of ethnicity on health. *Psychosom Med 2000;62*: 161–170.

211234-B

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease & Stroke Prevention
Mail Stop K–47 · 4770 Buford Highway, NE · Atlanta, Georgia 30341
800-CDC-INFO · cdcinfo@cdc.gov · www.cdc.gov/DHDSP