The Importance of Analyzing Health Disparities among Ethnic and Racial Groups

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Measures of health status highlight disparities in the health of ethnic minorities compared to white Americans in the United States. For example, African-American, American Indian and Puerto Rican infants have higher mortality rates than those reported for white infants. African-Americans have higher rates of heart disease, stroke and diabetes.[1] African-Americans and Hispanics represented only 26 percent of the U.S. population in 2001, yet they accounted for 66 percent of adult AIDS cases.[2] Despite progress made in reducing the burden of cancer in the United States, disparities persist in how cancer affects different racial and ethnic groups.[3]

The effective use of socially and culturally appropriate public health interventions is an important step in health disparity reduction. Interventions that address culture and social context facilitate increased knowledge and the ability to act on this knowledge for several preventive health behaviors: nutrition; physical activity; smoking cessation; screening; vaccination; and immunization. While there is widespread agreement that communication materials, programs and interventions will be more effective when they are "culturally appropriate" for the populations they serve,[4,5] little is known about when and how best to select health promotion and intervention strategies, what works and for whom when cultural and social appropriateness are at issue.

The call for evidence-based public health (EBPH) presents dilemmas for proponents of cultural appropriateness due to the still limited data available on interventions for the populations most affected by health disparities. As noted in a previous article in this series,[6] EBPH requires the use of evidence to guide the selection of interventions. However, *The Community Guide*[7] Task Force that prepared the report on interventions that promoted cultural competence in the health care system found an insufficient number of evaluation studies to allow conclusions about

intervention effectiveness. Likewise, the Institute of Medicine (IOM) has noted the lack of research on culturally appropriate intervention strategies. The task force recommended that researchers working in this area develop comparative research to assess intervention effectiveness; identify meaningful health outcomes; focus on what works best, where and for whom; and use methods that include measurements of the feasibility and cost-effectiveness of interventions.

Although we must await data on the outcomes, intervention efficacy, and cost effectiveness of specific social and cultural appropriateness strategies, health promotion and intervention modifications designed to address these issues are appropriate and feasible. The modifications and the issues of concern can be quite complex, but involve identifying, understanding and addressing the populations' health concerns; attitudes; values; knowledge; behavioral preferences; resource needs and preferences; and access to what is currently available. Also, we must measure the community's willingness to create or modify interventions. While this knowledge permits us to design, promote, and disseminate interventions and materials that may address health disparities, these activities should be informed by the data available.

HOW IS THIS ACCOMPLISHED?

The processes and benefits derived from application of an EBPH approach are applicable to efforts to introduce interventions designed to meet the needs of diverse communities. Practitioners must first determine if data exists on health status and intervention efficacy for a particular population or community; and when this evidence is not available, they must use many strategies and alternative data sources to determine what health needs should be addressed and the interventions required. Any interventions implemented should address differences in situational circumstances, issue involvement, and under-

standings of disease, which are driven by cultural and social circumstance. Data that might inform how socially and culturally diverse populations differ along these dimensions assist practitioners in health communication and intervention selection and modification. These data are more readily available than data on specific cultural competence approaches to interventions.

The first step in a socially and culturally appropriate approach to EBPH is community involvement in the definition of health issues and concerns. Data are not abdicated despite the fact that community input is sought. Practitioners can access pan-ethnic (ethnicity without respect to nationality, religion or other differentiating characteristics) demographic and descriptive epidemiological data from national, state and local sources. These are shared with community leaders and representatives of community constituencies. Public health practitioners share their understanding of the health issues suggested, who might be affected and how, as well as the likely risk factors and protective factors for the health issues of concern based on these data, and any gaps in knowledge that exist.

Then, community representatives assist in understanding the level of knowledge, issue involvement and beliefs about the cause of health concerns, and in prioritizing health concerns. They assist public health practitioners in understanding the extent to which health beliefs and practices differ from those noted in the general population, and how the health concerns under discussion might be assessed and better understood. Surveys, focus groups, key informant interviews, community observations, brainstorming sessions, story board development and other creative techniques can be used to facilitate this process.

THE DECISION-MAKING PROCESS

The data obtained and analyzed in step one facilitates the discussion and decision-making processes of step two. Data and community input support decisions about which community members or segments should be included in intervention selection and modification. The scientific literature is examined to select interventions that have received empirical support and seem appropriate given community attitudes and needs. Resources such as the *Community Guide and Cancer Control Planet*[8] can provide assessments of interventions. In addition, practitioners may consult sys-

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tematic reviews or meta-analysis of multiple well-designed studies. Public health practitioners should obtain and share information on the extent to which the studies supporting the interventions included members of the diverse constituent groups within that community. When the community is not represented in the literature supporting the intervention, assessments must be made related to the extent to which the community differs from the population(s) studied.

Intervention data can then be shared with community representatives. Community members assist practitioners in several ways at this point: understanding the extent to which interventions express or promote values, beliefs and behaviors inconsistent with community norms and values; identifying barriers to implementation; and identifying features that are well-suited to the community. In the best-case scenario, the intervention selected for implementation will have prior empirical support with some population, the least number of cultural conflicts and social and structural barriers, and the most opportunities to make use of community strengths. In addition to population match, the selected intervention should match community resources — human, economic and technological — to increase the likelihood of sustainability.

In a smoking cessation effort within a Bosnian community, the process worked as follows. Health center officials believed that they were observing an unusually large number of Bosnians who smoked. In addition to examining the literature for tobacco use and factors associated with tobacco use in the general population, community health providers — collaborating with social service professionals and church and mosque leaders — initiated a series of focus groups and key informant interviews to better understand smoking attitudes in this community.

This activity was followed by a community survey that provided data on smoking rates among adults, as well as knowledge of the consequences of tobacco use and smoking cessation interests. These data substantiated concerns that smoking

rates were higher than observed in the general population indicated less knowledge and aware- ness of the detrimental effects of cigarette smok- ing on health. The smoking cessation interven- tions listed in the *Community Guide* as empiri- cally supported were found to be insufficient because they did not address cultural differences in smoking attitudes and the effects of trauma on smoking cessation efforts. Community members worked with professionals to develop education in English and Bosnian on the effects of tobacco use. They also established support groups in local churches and mosques that supplemented smok- ing cessation efforts with the opportunity to pro- cess psychosocial experiences and needs.

CONCLUSION

Practitioners should plan to evaluate the interven- tion selection and modification process; as well as intervention outcomes, particularly when cultur- ally sensitive interventions have been selected. Evaluation data are then used to refine interven- tions. Importantly, public health workers should recognize that culture is not static, thus evalua- tion should be well-integrated into the interven- tion process and should use the data obtained to adjust interventions and communications to be relevant to shifting cultural dialogues and dynam- ics. The evaluation component advocated in EBPH supports the development of the evidence base that the IOM and the *Community Guide* Task Force responsible for the cultural compe- tence report called for. ■

NOTES

1. National Center for Health Statistics, *Health, United States, 2002: With Chartbook on Trends in the Health of Americans* (Hyattsville, MD: U.S. Department of Health and Human Services, 2002).
2. Office of Minority Health, "Eliminating Racial & Ethnic Disparities," www.cdc.gov/omh/AboutUs/ disparities.htm (modified May 23, 2007).
3. Ahmedin Jemal et al, "Annual Report to the Nation on the Status of Cancer, 1975-2001, with a special feature regarding survival" *Cancer* 101 no. 1 (July 1, 2004): 3-27.
4. Cindy Brach and Irene Fraser, "Can Cultural Compe- tency Reduce Racial and Ethnic Health Disparities? A Review and Conceptual Model," *Medical Care Research & Review* 57 (Supplement 1) (2000): 181-217.
5. Chanthika Pornpitakpan, "The Persuasiveness of Source Credibility: A Critical Review of Five Decades' Evidence," *Journal of Applied Social Psychology* 34 (2004): 243-281.
6. Kathleen Gillespie "Evidence-Based Public Health Benefits Communities," *Health Progress,* (March-April 2008): 6-7.
7. The Community Guide — Social Environment, www.thecommunityguide.org/htm.
8. Cancer Control Planet, http://cancercontrolplanet. cancer.gov.