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Health of the Older African-American Population

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HEALTH OF THE OLDER AFRICAN - AMERICAN POPULATION

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ABSTRACT

Health promotion and disease prevention has made a major impact in the United States in the past 20 years. However in terms of disease and risk behavior minority groups in this country are not uniformly disadvantaged. African - Americans had age - adjusted mortality rates well above the rates of white Americans, whereas Hispanic Americans have rates that are comparable to white Americans. Asians and Pacific Islanders and American Indians and Alaska Natives have mortality rates lower than white Americans.

The challenge for chronic disease prevention among minority groups is to get the attention of church and other community leaders who are currently focusing more on problems of violence, drug use, and HIV/AIDS.It is true that those problems or concerns are urgent problems in the minority communities. Chronic diseases, however, remain the leading causes of death among the minority groups.

African - American elderly population health problems may well be traced to poverty and undereducation. The most effective intervention against chronic disease in the long run for elderly African - Americans is to address these disparities.

African - Americans must take an active role to improve their health status and close the gap between themselves, other minority groups and white Americans.

African - Americans need to become aware of their own health needs, be willing to change behavioral practices and life styles. Empower themselves economically, become more active in the political arena. The African - American community must set its goal of well being, physically, socially, and mentally.

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DEDICATION

To my family and friends for supporting, encouraging, and allowing me to pursue my goal.

Thank God for his patience and for giving me wisdom, but most of all for God's love that gave me the strength to complete my goal.

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LITERATURE REVIEW

According to Edwin B. Fisher, health promotion and disease prevention have had a definite impact in the United States in the past 20 years. However, the one group that has remained underserved is low - income, urban African - Americans. Fisher speaks about how African - Americans continue to smoke at a higher rate. Mortality rates are greater among African - Americans. Specifically, hypertension, diabetes, poor control of diabetes, and mortality from diabetes are all greater among African - Americans (Fisher 252).

David M. Levine of the Division of Internal Medicine, Johns Hopkins Health Institutions, describes individuals with low incomes who experience death rates twice as high as those above the poverty level. African - Americans, the single largest minority group, suffer nearly 60,000 excess deaths per year. Dr. Levine notes that black men die from strokes at almost twice the rate of men in the total population, and their risk of nonfatal strokes is also significantly higher.

There is also evidence that severe hypertension affects black men four times as much as any other group because rates of smoking and obesity continue to be higher among the African - American population. Another significant health problem in the African - American population is diabetes, with the highest rates among black women. Complications of diabetes, such as heart disease and renal failure, are all more prevalent among African - Americans (Levine 319).

Dr. K. F. Ferraro, Associate Professor of Sociology at Purdue University believes they both epidemiological and service use studies have shown substantial racial differences in the health status of adult Americans. Ferraro recognizes that on most measures of life expectancy, morbidity, or mortality, African - Americans clearly do not enjoy the same levels of health status as their white counterparts.

Dorothy Smith Ruiz, Ph.D., at the University of North Carolina points out that the black elderly population is increasing at a rate faster than their white counterpart, and the elderly black is the fastest growing segment of the black population. Dr. Ruiz explains that the projected increase in the elderly population serious implications for health care services (Ruiz 303).

In order to increase the quality of health in the black population, more and more efforts must be made to educate the elderly to be more involved with their own health care. It is very important that black elderly become involved in the most current health promotions and disease prevention activities: health promotion, health protection measures, and health prevention health services. Visiting a health screening program will enable the African - American to check for early signs of cancer, hypertension and other disease. Dr. Ruiz notes that a variety of factors goes into promoting good health and preventing disease, however there are some factors that are beyond the control of the individual. Individuals will need to change their life styles in order for any change to take place.

Sharon A. Bryant, Ph.D., the Minority Health Coordinator at Rhode Island Department of Health, states that the African - American elders have become a target group for health promotion activities. These activities are designed to reduce disability, pain, and encourage fitness which can prolong the African - American elders' ability to maintain productive, independent, and fulfilling lives (Bryant 27).

Dr. Bryant to recognized that poor health status of many elderly African - Americans begins at birth and accumulates throughout their life span. Health problems that begin in childhood do not just fade away, they either become chronic health problems or lead to other serious and fatal diseases and disabilities (Bryant 27).

It should be evident that health problems faced by the African - American community are monumental. These difficulties can be understood by looking at the history of the African - American. There are three variables that seem important in explaining the fact that mortality rates are higher for the African - Americans: poverty, discrimination and social-psychological barriers. These variables tend to prevent people from using services that are available to them. All three factors together reinforce the other problems faced by African - Americans.

It has been noted by Charles Zastrow of the Social Welfare Department of University of Wisconsin that class and race influence one's chances of staying healthy. The lack of medical care among poor elderly minorities leads to higher rates of serious illness resulting in shortened life expectancies (Zastrow 439).

African - Americans' life expectancy compared to their white counterpart is six to seven years shorter and they have higher rates of illness than their white counterpart. For the most part the delivery of health care services is geared to the upper and middle-class culture. Health care services take on all the qualities of a commodity for sale and the affluent are the preferred market. This is also true in the preventive health care areas. Due to profit motive, many health care services are located in affluent urban areas and in suburbs, difficult for the elderly African - American to reach. Due to the lack of transportation the poor African - American elderly have much more difficulty in obtaining access to medical care or events that promote wellness (Zastrow 439).

Zastrow notes how many older adults who are African - American believe that driving a car is a luxury. Only the more affluent and physically vigorous elderly can afford and automobile. So many African - Americans must depend on inexpensive or public transportation that does not always take them to health care events (Zastrow 417).

The National Caucus and Center of Black Aged, Inc. gives various reasons for the health concerns of older African - Americans. Income level is one factor. One out of every six aged African - American males and one out of every three elderly African - American females have annual incomes below $5,000.T he majority of African - Americans aged 65 or older have annual incomes below $10,000.

A report by the National Caucus and Center on Black Aged, Inc. defined that individuals 65 or older as poor if their annual

income was below $6,700 ($8,500 for the aged couple), according to the Bureau of the Census. This translates to $129 per week ($163 for an elderly couple) to pay for housing , food, health care, transportation, and daily necessities. Another concern is the overall health of the African - American elder. Four out of every nine of all African - Americans aged 65 years or older consider their health to be poor or just fair. Only one out of four older African - Americans believes that their health is very good or excellent.

David M. Levine discusses community - based approaches that offer important opportunities to decrease premature morbidity, disability and mortality and to enhance the health status of elderly African - Americans. Dr. Levine asserts community based programs may be the only way to alter how the gaps that exist between the health status of African - Americans and the white majority. In order for the community - based program to work, the community must be viewed as a system with important subsystems, such as the political educational, health, economic, religious, communications, social welfare, and recreational sectors, along with grassroots community organizations (Levine 296).

According to Robert C. Atchley the lack of transportation for the elderly African - American is an important part of aging. Aging changes the needs and resources related to transportation in several ways. Having lower income than their white counterpart forces the African - American to give up their car or to use it sparingly. However there are ways that transportation could be made more available to all seniors to go to the doctor or preventive health screenings. Giving low - income elders fare deductions or

discounts on all public transportation is a way to make transportation more accessible to the older adult (Atchley 184). Public subsidies are needed for adequate scheduling and routing of existing public transportation, and taxi cabs could give discounts to seniors (Atchley 184). Additional monies should be allocated to senior centers to purchase vehicles so that they can transport the older adult to their prospective appointments (Atchley 184).

Chronic Disease in Minority Populations explains how cardiovascular diseases, homicide and cancer deaths contribute nearly half the deaths in the African - American population. Mortality rates for African - Americans are inclined to be greater for stroke, diabetes, cirrhosis, and cancers of the cervix and prostate (Satcher 2-33).

A high proportion of the African - American population lives in physical and social environments that do not reinforce positive health choices. The elderly African - American population needs to be recognized so that culturally appropriate interventions and health promotion activities may be designed that will include reinforcement of positive behaviors (Satcher 2-33). Public health agencies at the local level have the abilities to increase their efforts to expand the scope of surveillance to include those African - Americans who are not easily reached by traditional methods. Health promotion, health protection, and disease prevention are the three components that the elderly African - American will need to focus on to continue a long and healthy life (Satcher 2-34).

An article in Chronic Disease In Minority Population states that African - Americans are disproportionately more disadvantaged

than whites. Of persons aged 25 years and older, African - Americans have fewer years of education than do whites. In 1990, a lower percentage of African - Americans (63%) than whites (78%) had completed high school, and lower percentage of African - Americans (11%) than whites (22%) had completed college. In 1990, the difference between the median incomes for whites and African - Americans who worked full-time and year round ranged from $2,200 for those who had not completed high school to $6,100 for those who had completed college (Satcher 2-6). African - Americans tend to hold attitudes that are distinct from non - Hispanic whites in two areas: use of alternative health providers and fatalism for the use of alternative health practitioners among African - Americans may be related to their historical experience of limited access to medical care because of poverty and discrimination (Blendon 278).

When looking at the socioeconomics of the American Indians and Alaska Natives 65 percent have a high school education or higher compared with the general US population (75%). Fewer than 50 percent had attained a college degree or higher. The median income for American Indians is substantially lower than that of all races ($19,865 vs. $30,056) and a greater percentage (32% vs. 13% of all races) is below the official poverty level. On many American Indian reservations, the standard of living is similar to the Third World - poor sanitary conditions, no running water, poorly paved roads, and inadequate or substandard public facilities (Satcher 3-6).

Members of federally recognized tribes and certain Indians of California are eligible for services administered by the Indian Health Services (IHS) of the Public Health Service. The IHS has funded programs to increase the number of American Indian and Alaska Native health professionals and to improve health care access for American Indians and Alaska Natives who live in urban areas. American Indian and Alaska Native tribes incorporate traditional folk medicine into their healing practices and rely on current medical practice.

As in ancient times, a number of tribal healing practices and folk medicines are used on some reservations by medicine men and other healers. They employ a variety of useful treatments for infectious diseases, chronic conditions and injuries. Dozens of native plants used medicinally have been officially recognized in the United States Pharmacopoeia. American Indians and Alaskan Natives are subject to barriers that confront many populations with lower socioeconomic status, who live on reservations and tribal members who have access to reservation health facilities. Though they are served by the IHS, many still have problems accessing health care. This is particularly true in certain rural areas where the availability of physicians and other health care services may be much lower than the national average.

A report of the National Medical Expenditure Survey indicated that 9.8 percent of American Indians and Alaska Natives have cardiovascular disease. This percentage is comparable to the prevalence of 10 percent of persons in the general US population (Taylor 31).

In the last census almost two million Americans identified themselves as American Indian or Alaska Native. There are approximately 1.9 million American Indians and 81,000 are Alaska Natives. This group still remains less than one percent of the US population.

In general, information on the incidence and prevalence of chronic disease is consistent with mortality rates for American Indians and Alaska Natives. American Indians have lower incidence rates of cancer than do whites, whereas the rates for Alaska Natives are comparable to the rates for whites. This is particularly true for Tobacco related cancers. However this minority has above average rates for cancers of the stomach, gallbladder, uterine cervix, and kidney. Cardiovascular disease and chronic obstructive pulmonary disease rates are also low but the rates of diabetes and chronic liver disease are high (Satcher 3-25).

Despite all the problems of lower mortality and morbidity rates, American Indians and Alaska Natives are clearly at a disadvantage in two areas. First , they more commonly report fair or poor health status and limitations in activity than do whites. Findings may be because measures are crude reflections of the burden of chronic disease or because such chronic diseases are not as well controlled in this population. Secondly, the rates of smoking and obesity for American Indians and Alaska Natives are higher than those for whites (Satcher 3-26).

Great socioeconomic diversity exists within the Hispanic population subgroups. The median family income for Hispanics is $25,064 which is lower than that for all Americans $35,225.

Educational levels are also lower for Hispanics than for non - Hispanics. Among the three main subgroups, indicators of high socioeconomic status, such as years of formal education, income, and home ownership, were highest for Cuban Americans and lowest for Puerto Ricans. Unemployment rates, poverty rates, and the percentages of households maintained by women were highest among Puerto Ricans. Many Hispanics believe that health is a state of balance in the body and disease a state of imbalance. The hot - cold theory of disease is an example of medical treatment restoring balance: illnesses classified as hot are treated with a cold liquid and cold illnesses are balanced by treating with a hot liquid (Harwood 1153).

Other problems for Hispanics are language barriers between Hispanic patients and non - Hispanic health professionals which may prevent some persons from obtaining adequate health care services. Even if the health care professional is Hispanic, different Spanish idioms and cultural norms within the Hispanic subgroups may hamper communication. Available health education materials may not meet the varying needs of those with different language skills. Economic barriers to receiving adequate health services include high medical costs and lack of health insurance. For any one minority or the white counterpart the lack of continuity in medical records and health care services is a detriment to good health care. Hypertension is the most prevalent chronic condition among Hispanic and non - Hispanic women. Hispanics have about the same prevalence of stroke as that of non Hispanic women and a two fold higher prevalence of ischemic heart disease. Hypertension

is the most prevalent chronic condition also in Hispanic men (Satcher 5-145).

The Hispanic population is a young, diverse rapidly growing minority group with large subgroups, of Mexican Americans, Puerto Ricans, and Cuban Americans. It's been estimated that by the year 2010, the Hispanic population will surpass the African - American population as the largest minority group in the United States. Although great socioeconomic diversity exists within and across the Hispanic subgroups, as a whole Hispanics have lower education and income levels than non - Hispanics. Different surveys show that about a third of Hispanics lack health insurance. The life expectancy of Hispanics is similar to non - Hispanic whites (Satcher 5-29). Mortality rates for cirrhosis and diabetes are higher for Hispanics than for non - Hispanics for both men and women. Like non - Hispanics, hypertension, asthma, and chronic bronchitis are predominate chronic conditions among Hispanic men and women. Another concern for Hispanics is cigarette smoking, even though cigarette smoking is lower among Hispanics than non - Hispanics. Among persons who reported smoking, the number of cigarettes smoked per day is lower among Hispanics. Binge drinking is higher among Hispanic than among non - Hispanic men. The two main health behaviors that need to be addressed are problems in society at large: lack of exercise and obesity (Satcher 5-30).

According to the US Bureau of the Census the current socioeconomic indicators among Asians and Pacific Islanders in the United States range from relative affluence to the very poor. Asians and Pacific Islanders are often depicted as a model minority, hard

working, self reliant overachievers with good socioeconomic indicators across and within the ethnic subgroups. The 1990 census showed that about 14 percent of Asian Americans and 17 percent of Pacific Islanders lived in poverty, whereas 13 percent of persons in the total US population lived in poverty.

Ancient eastern philosophies of holistic health and traditional medicine emphasizes elements of prevention, such as a balance for good health, the importance of good diet and healthy behaviors, the use of ginseng and other herbs, and acupuncture. Attitudes and behaviors are ultimately a function of initial influences, the length of time in the United States since immigration. The level of Western acculturation and assimilation, level of education and income, socioeconomic stability, and access to Western medicine. Due to the lack of information on chronic disease and risk factors on a number of Asian and Pacific Islander groups, recommendations will be limited. Asian and Pacific Islanders like many Americans, poor educated, malnourished, having poor access to quality medical care. Exposure to hazardous lifestyles and environments, stressful life events, and social and cultural changes are likely to be associated with higher rates of mortality (Taylor 6).

Researching the four minority groups was a way of providing information on the diversity within each population, and the similarities of each population. A vast amount of information was discussed such as socioeconomic indicators, health care, prevalence of selected diseases and public health implications. Learning the similarities and differences of the four minority groups provides

general information that could be used as a source to create interventions for chronic disease prevention and health promotion.

The article, "The Health Care Status of African - Americans" by Randolph Quaye, discusses how an inequality in health care for African - Americans. For example, life expectancy for African - Americans declined from 69.7 years in 1984 to 69.4 years in 1989. Quaye discusses how diabetes is 33 percent more common in African - Americans than among whites. Obesity is 44 percent more prevalent in African - Americans than among whites. Obesity is 44 percent more prevalent in African - American women aged 20 years and older.

Quaye also noticed that poor nutrition and tobacco smoking appeared more common among African - Americans. He attributes this to the position of African - Americans' within the US economy and the direct result of poverty and discrimination (Quaye 13). This is similar to racial discrimination in the labor market which creates income disparities between whites and African - Americans (Quaye 13). Because of this disparity, African - Americans employed in the secondary sectors of the market have little access to the health services or health insurance. African - Americans are more likely to be uninsured than whites, poor African - Americans are more likely to be uninsured despite Medicaid. Twenty - two percent of all African - Americans are without any medical insurance coverage (Quaye 13).

According to Quaye the most severely impoverished are the elderly African - American, who live on fixed incomes. One out of every four African - American seniors who are approaching

retirement has less than $4,000 net worth. Having such a low net worth has a direct impact on health care and strains Social Security income that cannot continue paying for increasing medical costs (Quaye 14).

Even though the federally funded health care programs have contributed to improvements in health care and well being, only one - third of all Medicaid beneficiaries or 6.6 million individuals were African - Americans. In other words Medicaid coverage was used by only one - half of all poor African - Americans. The main objective of Medicaid is to get the poor continuity physician care, however the African - American is still less likely than whites to see one particular physician for care. Seventy - eight percent of whites, compared to 68 percent of African - Americans have a regular family physician. For the majority of health care seekers the port of entry to the health care system is by government clinics, hospital outpatient departments, or emergency rooms (Quaye 14).

Hospital records show that the poor and African - Americans have higher rates of hospitalization than higher - income groups. High use of hospitalization among the poor, and African - Americans does not mean they are getting higher quality health care. In reality, such high hospitalization rates probably reflect the poorer health status of many African - Americans (Quaye 15). Quaye found out that Medicaid covers less than one - half of the poor population, and of that 22 percent are African - Americans without any medical insurance. Even though Medicaid was designed to assist the poor, many who are excluded are the poor elderly African - Americans who often enter the health care system

through the emergency room. Quaye found out that African - Americans use hospital emergency rooms at a rate 50 percent greater than whites. Quaye believes that President Clinton's health proposal deals with three issues impacting negatively on African - Americans' health: poverty, lack of insurance and access. At any time 18 percent of the African- American population has no health insurance. Clinton's health care plan is a serious attempt to fill the gaps in the financing and delivery of health services. Clinton's proposal has six basic principles: security, simplicity, savings, quality, choice and responsibility. The focus of Clinton's proposal is managed care (Quaye 16).

Quaye believes that the United States health care system as it is currently constructed does not provide equal distribution of health resources to all ethnic groups and social classes. The large number of African - Americans who are in poverty are in a precarious position within the health care system. With recent federal cut backs, African - Americans who do receive Medicaid have been placed at a disadvantage. It is evident that any attempt to improve the health of African - Americans should resolve the central issue of equity in health care and by implication address both the racial and class determinants of health. The focus of Clinton's health care plan is on universal coverage and lower costs overall and can offer some solutions to the current financing of health care (Quaye 17).

An article in Missouri Medicine on "Racial Differences in the Prevalence of Cardiovascular Risk Factors Among Persons with Diabetes" speaks about persons with diabetes being a greater risk of other health complications including heart disease and stroke. The

data for this survey was obtained by telephone in order to assess racial variations in the level of cardiovascular risk factors among Missouri diabetics. The four primary risk factors are physical inactivity, obesity, hypertension, and cigarette smoking. These risk factors are more common among African - Americans than among any other group. According to the article there are and estimated 1,075,000 individuals who knew they had diabetes. Approximately 3.6% of all African - Americans have been diagnosed as diabetics, compared with 2.8% of all Americans. Diabetes is the seventh leading cause of death in the White population but sixth leading cause of death in the African - American population. Diabetes has a wide range of health complications and some of the most common complications are strokes, heart disease, blindness, and end-stage renal disease. Because of these limitation, persons with diabetes in Missouri, especially African - Americans, are at the greatest risk of all heart disease. The state of Missouri recognizes that there is a need for focused and effective interventions in the African - American population (Weaver 751).

According to Stephen B. Thomas, growing disparities in life expectancy and health status of Black Americans compared with whites threaten the well being, economic productivity, and social progress of our society as the 21st century approaches. Health status is profoundly affected by poverty and racism. However poverty is the single most profound risk factor for disease. Lack of adequate housing, nutrition, and access to health care contribute to the death toll of African - Americans. Failure to close the gap in

health status between whites and African - Americans can be directly attributed to lack of access to health care.

Thomas believes that the United States must assure access, not only to medical care, but also to a better standard of living. Assuring nutritious food, basic education, safe, water, decent housing, secure employment, and adequate income are the prerequisites of a healthy life style. If prerequisites are absent, the health status of African - Americans will continue to be cause for righteous indignation well into the 21st century. To decrease the disparity in the African - American population, a frame work for health promotion and disease prevention activities should be adopted. Through black churches, doors to the future can be opened. The church has a long history of addressing health and human service needs of the African - American community. Many of the community outreach programs included various activities aimed at addressing health needs, like (1) programs to feed the unemployed (2) free health clinics, (3) recreational activities, and (4) child care programs. Black churches have been used by public health and medical professionals to gain access to African - Americans who are more difficult to reach through mainstream systems.

Closing the health status gap between African - Americans ands white Americans will require health care professionals to draw on the strength, commitment, and credibility of the African - American church supported by adequate infrastructure. As national health care continues to grow, it will become necessary for health care professionals and health and policy makers to include the black

church as an important component for delivery of health promotion and disease prevention services needed to achieve health objectives for all Americans (Thomas 579).

THEORETICAL AND ORIENTATION

As today's society looks toward the opportunity and challenges of a new century, many social problems must be faced, particularly inequality in health and health care. Americans are born, live, and die in an environment where some persons have better health care than do others. The health care community has recognized the inequality in health services. For the health care community the main objective is to reduce health disparities among all Americans. These disparities exist within and across all groups of Americans but are more visible in the health of our racial and ethnic minorities. From a variety of sources the level of health among the minority population has diminished. The African - American population will be the focus of concern, however looking at all minority groups will give the health community a focus of what preventive measures need to be taken to ensure more awareness , and knowledge among the minority population (Johnson 125)

Heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, and cirrhosis have increased the morbidity and mortality rates among the minority groups of African - Americans, American Indians and Alaska Natives, Asians and Pacific Islanders, and Hispanic Americans. This is a concern to the health care community. The health care community now knows that educational information, and providing access to preventive services to minority groups should be their first order of concern.

In this study we will look at how heart disease, cancer, stroke, diabetes, chronic obstructive pulmonary disease, and cirrhosis, contribute to the morbidity and mortality to the minority population.

By addressing the needs of the minority population the health community has recognized that they will need to target preventive efforts according to the needs and the particular disparities experienced by these groups.

According to the National Medical Association (NMA) representing over 16,000 physicians throughout the United States, the Virgin Islands and Puerto Rico who are the primary providers for the medically underserved and minority populations. NMA are painfully aware of the disparity between the health status of uninsured and underinsured minority populations in comparison to the general population of the United States. NMA views first hand the disproportionately high rates of cancer, heart disease, acquired immunodeficiency among the African - American population and other minorities. According to the statistics from the 1985 Report of the Secretary's Task Force on Black and Minority Health state that 60,000 or more deaths among African - Americans and other minorities could have been prevented if they only had received health care equivalent to that received by their white counter part. It is necessary that health care become more accessible in cost and liability to the nation's minority communities (Johnson 125).

According to Chronic Disease In Minority Populations, heart disease, stroke and cancer (lung, breast, and colorectal) are the leading causes of death for African - Americans and for whites.

Mortality rates are higher from these diseases among African - Americans than any other group. Increased rates smoking, hypertension, and obesity among African - Americans are undoubtedly some of the reasons for higher mortality rates (Satcher 2-16)

The leading causes of death among African - American women between the ages of 45-64 are is Ischemic heart disease, lung cancer, and breast cancer (Table 1). Ischemic heart disease is also the leading cause of death among African - American women who are 65 years and older. The second and third leading causes of death for African - American women who are 65 years and older are stroke and diabetes. The death rate from diabetes for African - American women 45-64 years is three times the rate for their white counterpart, and the rate for African - American women 65 years old and older is twice the rate for white women of the same age.

Table 1 - Rank order of age - specific crude mortality rates for major chronic diseases as underling cause of death for African - American women and white women, United States, 1990

Persons Aged 45-64 years		**Persons Aged 65 Years and Older**	
African -American	**White**	**African - American**	**White**
Ischemic h/d	Ischemic h/d	Ischemic h/d	Ischemic h/d
142.0	75.1	1085.8	1179.0
Lung cancer	Lung cancer	Stroke	Stroke
75.4	68.0	480.9	420.6
Breast cancer	Breast cancer	Diabetes	Lung cancer
75.0	60.3	227.5	180.7
Stroke	COPD	Lung cancer	COPD
67.6	24.1	156.1	176.8
Diabetes	Stroke	Colorectal cancer	Breast
51.5	24.	142.6	135.3
Colorectal cancer	Colorectal cancer	Breast cancer	Colorectal
31.8	20.2	130.4	120.8
Cirrhosis	Diabetes	COPD	Diabetes
23.4	16.4	81.7	106.3
COPD	Cirrhosis	Cirrhosis	Cirrhosis

22.6	12.6	21.7	24.8
Cervical cancer	Cervical cancer	Cervical cancer	Cervical
14.0	2.5	19.3	12.1

Rates per 100,000 persons.
COPD- Chronic obstructive pulmonary disease.
Source: CDC, National Center for Health Statistics, National Vital Statistics System, 1990.

As far as men are concerned, the African - American male who is between the ages of 45-64 years Ischemic heart disease, lung cancer, and strokes (Table 2). The rank order for men aged 65 years and older is the same as that for men in the 45-64 age group. However, the rates of death are much higher: five times higher for Ischemic heart disease and stroke and three times higher for lung cancer.

Mortality rates for chronic diseases are higher for African - American men who are 45-64 years compared to their white counterpart. However it is very interesting to note that African - American men who are 65 years and older actually have lower mortality rates for Ischemic heart disease, chronic obstructive pulmonary disease, and cirrhosis than do white men of the same age. Strokes are three times higher among African - American men who are 45-64 years compared to their white counterpart. However, African - American men who are 65 years and older have a two times higher rate of prostate cancer than white men of the same age.

Table 2 - Ranks order of 1990 age specific crude morality rates for underlying cause of death from major chronic disease for African - American men and white men, United States, 1990

Persons Aged 45-64 Years		**Persons Aged 65 Years and Older**	
African - American	**White**	**African - American**	**White**
Ischemic h/d	ischemic h/d	Ischemic h/d	Ischemic h/d
278.7	237.1	1374.9	1584.0
Lung cancer	Lung cancer	Lung cancer	Lung cancer

219.1	127.1	596.8	473.6
Stroke	Cirrhosis	Stroke	Stroke
99.8	31.5	518.4	363.9
Cirrhosis	COPD	Prostate cancer	COPD
509.7	31.3	472.2	343.1
Diabetes	Colorectal cancer	COPD	Prostate
51.3	29.4	266.0	217.5
Colorectal cancer	Stroke	Colorectal cancer	Colorectal
41.3	29.2	194.6	164.9
COPD	Diabetes	Diabetes	Diabetes
39.6	19.5	176.8	106.3
Prostate cancer	Prostate cancer	Cirrhosis	Cirrhosis
31.9	12.1	43.9	47.6

Rate per 100,000 persons.
COPD- Chronic obstructive pulmonary disease.
Source: CDC, National Center for Health Statistics, National Vital Statistics System, 1990

American Indians and Alaskan Natives are a relatively young populations which causes them to have more concerns about injuries, infectious diseases, and maternal and child health problems. However two of the greatest concerns among this minority population is the threat of alcohol and tobacco use.

Ischemic heart disease is the leading cause of death for American Indian and Alaska Native women aged 45 - 64 and for women aged 65 years and older. There is a much higher rate of cirrhosis and diabetes among women in the minority population. Diabetes is higher for American Indian and Alaska Native women aged 65 years and older than for white women in the same group.

Table 1- Rank order of age specific crude mortality rates for major chronic diseases as underlying cause of death for American Indian and Alaska Native women and white women, United States, 1990

Persons Aged 45-64 years		**Persons Aged 65 Years and Older**	
American Indian/ Alaska Native	**White**	**American Indian/r Alaska Native**	**White**

Ischemic h/d	Ischemic h/d	Ischemic h/d	Ischemic h/d
69.1	75.1	517.2	1179.0
Cirrhosis	Lung cancer	Stroke	Stroke
43.	68.	215.5	420.6
Diabetes	Breast cancer	Diabetes	Lung
42.4	60.3	182.8	180.7
Lung cancer	COPD	COPD	COPD
35.2	24.1	93.6	176.8
Breast cancer	Stroke	Lung cancer	Breast
26.1	24.	86.2	135.3
Stroke	Colorectal cancer	Colorectal cancer	Colorectal
25.4	20.2	62.4	120.8
COPD	Diabetes	Breast cancer	Diabetes
13.7	16.4	49.	106.3
Colorectal cancer	Cirrhosis	Cirrhosis	Cirrhosis
10.4	12.6	44.6	24.8
Cervical cancer	Cervical cancer	Cervical cancer	Cervical
7	2.5	8.9	12.1

Rate per 100,000 persons.
COPD-Chronic obstructive pulmonary disease.
Source: CDC, National Center for Health Statistics, National Vital Statistics System, 1990.

The leading cause of death for American Indian and Alaska Native men aged 45 - 64 and for men 65 years and older is ischemic heart disease, and the second leading cause of death is cirrhosis, however cirrhosis is the third leading cause of death for their white counter part.

Cirrhosis is about twice as high for American Indian and Alaska Native men, compared to white men. But lung cancer is twice as high for white men than American Indians and Alaska Native men. Diabetes rates higher as the leading cause of death among American Indian and Alaska Native men than white men in both age groups.

Table 2 - Rank order of age specific crude mortality rates for major chronic disease as underlying cause of
death for American Indian and Alaska Native men and white men, United Stated, 1990

Persons Aged 45-64 **Persons Aged 65 Years and Older**

American Indian/ Alaska Native	White	American Indian/ Alaska Native	White
Ischemic h/d	Ischemic h/d	Ischemic h/d	Ischemic h/d
177.3	237.1	838.9	1584.
Cirrhosis	Lung cancer	Lung cancer	Lung cancer
60.8	127.1	251.7	473.6
Diabetes	COPD	COPD	COPD
43.8	31.3	225.1	343.1
Stroke	Colorectal cancer	Diabetes	Prostate
24	29.4.	157.5	217.52
COPD	Stroke	Prostate cancer	Colorectal
17.7	29.2	104.3	164.9
Colorectal cancer	Diabetes	Cirrhosis	Diabetes
10.6	19.5	67.5	106.3
Prostate cancer	Prostate cancer	Colorectal cancer	Cirrhosis
5.7	12.1	65.5	47.6

Rate per 100,000 persons.
COPD - Chronic obstructive pulmonary disease.
Source: CDC, National Center for Health Statistics, National Vital Statistics System, 1990.

When looking at health concerns of Asian and Pacific Islander women aged 45 - 64 years (Table 3), breast cancer, stroke, ischemic heart disease, and lung cancer are the leading causes of death for this age group. The mortality rates for this group of Asian and Pacific Islander women are 32 to 65 percent of white women, and stroke and cervical cancer is 84 to 120 percent of the white rates.

For Asian and Pacific women who are 65 years and older the leading causes of death are ischemic heart disease, stroke, and lung cancer. Mortality rates for this age group are 30 to 74 percent that of white women of the same age group.

Table 3 - Rank order of age specific crude mortality rates for major chronic diseases as underlying cause of death for Asian and Pacific Islander women and white women, United States, 1990.

Persons Aged 45-64		Persons Aged 65 Years /Older	
Asian and Pacific Islander	White	Asian and Pacific Islander	White
Breast cancer	Ischemic h/d	Ischemic h/d	Ischemic h/d

29.5	75.1	512.1	1179.
Stroke	Lung cancer	Stroke	Stroke
29.2	68.	281.3	420.6
Ischemic h/d	Breast cancer	Lung cancer	Lung cancer
27.9	60.3	95.8	180.7
Lung cancer	COPD	Diabetes	COPD
22.6	24.1	78.	176.8
Colorectal cancer	Stroke	Colorectal cancer	Breast
13.2	24.	55.	135.3
Diabetes	Colorectal cancer	COPD	Colorectal
9.3	20.2	54.6	120.8
COPD	Diabetes	Breast cancer	Diabetes
7.7	16.4	15.4	106.3
Cirrhosis	Cirrhosis	Cirrhosis	Cirrhosis
6.	12.6	15.4	24.8
Cervical cancer	Cervical cancer	Cervical cancer	Cervical cancer
2.1	2.5	3.6	12.1

Rate per 100,000 persons
COPD - Chronic obstructive pulmonary disease
Source: CDC, National Center for Health Statistics, National Vital Statistics System, 1990.

The leading causes of death for Asian and Pacific Islander men who are between ages of 45-64 (Table 4) are ischemic heart disease, breast cancer, and strokes. Mortality rates among Asian and Pacific Islander men from the same age group are 27 to 63 percent of their white counterpart. For Asian and Pacific Islander men who are 65 years and older, the three leading causes of death are ischemic heart disease, and lung cancer. The mortality rate for this group of men is 45 to 76 percent of the white counterpart (Satcher 4-11,12)

Table 4 -Rank order of age specific crude rates for major chronic disease as underlying cause of death for Asian and Pacific Islander men and white men, United States, 1990.

Persons Aged 45-64 Years		**Persons Aged 65 Years/Older**	
Asian and Pacific Islander	**White**	**Asian and Pacific Islander**	**White**
Ischemic h/d	Ischemic h/d	Ischemic h/d	Ischemic h/d
81.1	237.1	762.3	1584.
Lung cancer	Lung cancer	Stroke	Lung cancer

39.6	127.1	317.9	473.6
Stroke	Cirrhosis	Lung cancer	Stroke
29.2	31.5	253.8	363.9
Colorectal cancer	COPD	COPD	COPD
16.2	31.3	169.3	343.1
Cirrhosis	Colorectal cancer	Colorectal cancer	Prostate
15.	29.4	100.2	217.5
Diabetes	Stroke	Prostate cancer	Colorectal
12.3	29.2	99.7	164.9
COPD	Diabetes	Diabetes	Diabetes
10.8	19.5	81.	106.3
Prostate cancer	Prostate	Cirrhosis	Cirrhosis
3.2	12.1	21.7	47.6

Rate per 100,000 persons
COPD - Chronic obstructive pulmonary disease.
Source: CDC, National Center for Health Statistics, National Vital Statistics System, 1990.

When looking at the four groups of minorities: African - Americans, American Indians and Alaska Natives, Asians and Pacific Islanders, and the Hispanic Americans, ischemic heart disease is less common among the four minority groups than among white Americans, whereas diabetes is less common among white Americans than among the minority groups.

The minority population also shows evidence that there are behavior risk factors that are related to chronic disease. It's been shown that many members of the minority groups are more likely to have a sedentary lifestyle and be overweight than white Americans. However the Indian and Alaskan Natives are far less likely to report that they have higher rates of cigarette smoking and chronic drinking than white Americans. As far as African - Americans and Asians and Pacific Islanders are concerned, they are less likely to report binge drinking than white Americans (Satcher 6-2).

The American minority population is a growing yet aging segment of our society today. Their contribution to the total population's burden of chronic disease is most likely to be much

greater in the future. As minority populations age, greater numbers will move into the age groups that are associated with certain chronic disease. Fortunately the youth of the minority population have the greatest potential for early intervention to prevent chronic disease.

In order for prevention program to be successful can not be perceived as coming from the majority population. Interventions work best in areas where there is a sizable population of a particular minority group.

After looking at the different minority populations each has its own set of problems in accessibility to the health system, and the problems that are created from that lack of accessibility to the health system has become a concern to the vast majority.

The African - American population will be the focus of my concern. Life expectancy, mortality rates, cancer, diabetes, hypertension, lack of activities, risk factors, preventive health, and access to health care are the concerns of the African - American population.

When focusing on the African - American population we should beware that during the 1980's population grew three times faster than their white counterpart (13% versus 4%) but yet this same growth has been the slowest since the 1940's and the smallest for any minority group. Because immigration rates and birthrates are lower among African - Americans than among Hispanics, Hispanics are expected to replace African - Americans as the largest minority group early in the 21st century (O'Hare 2).

The African - American population is currently in the Southern states. According to the census 54 percent live in the South, 18 percent live in the Northwest, 19 percent live in the Midwest, and 9 percent live in the West. The 1990 census showed that 84 percent of African - Americans and 76 percent of whites live in metropolitan areas, but almost 60 percent of African - Americans and only 26 percent of whites live in central cities (O'Hare 2).

African - Americans are more disadvantaged than whites. African - Americans have fewer years of education than do whites, a lower percentage of African - Americans complete high school than their white counterpart, and even a much lower percentage completed college compared to their white counterpart. African - Americans earn less than whites regardless of the mount of education they receive. As a matter of fact the difference between whites and African - Americans who worked full time and year round range from $2,200 for those who did not complete high school to $6,100 for those who completed college (O'Hare 3).

When it comes to health care the African - American population tend to hold attitudes that are distinct from whites in two areas: alternative health providers and fatalism regarding particular medical diagnoses. African - Americans who use alternative health practitioners do so because of the close linkage to their historical experience of limited access to medical care because of poverty and discrimination (Blendon 278).

For the minority population the access to service has its barriers. The access barrier exists when factors external to the potential client prevent the person from using any health service.

There are three types of access barriers; (1) the client's ability to get to the place where the service is being offered. If the location of the service is beyond the client's means of transportation, so it is likely that the client will not use the service, (2) second type of access barrier is affordability; clients are less likely to use a service if the costs are high relative to the individual's income (3) the third type of access barriers refers to the availability of services. For example if a particular service is not being offered or is so limited in its availability that it cannot meet the client's need, use of the service is either not possible or unlikely (Yeatts 26).

For minorities who know of services that are available to them and have the ability to access those services but lack the intent or desire to use them, will create abundance of services that are under utilized. If services are abundantly available but have little appeal to the potential client, they are less likely to be used. Another intent barrier is cultural differences. The intent to use a service is reduced if the client must come in contact with other service users or even providers who are different from themselves. An example is the older adult who turned 65 in 1989, who was 40 years old before Congress passed the Public Accommodations Act of 1964 and the Voting Rights Act of 1965 and before the federal government's affirmative action program was established. The minority elderly lived so much of their lives with discrimination, therefore it should not be surprising that cultural differences have been found to inhibit service use.

Another type of intent barrier is negative attitudes about receiving help. Elderly minorities use of service is greatly reduced

if the person has negative attitudes about being the recipient of those services. Those feelings could include humiliation, alienation, and fear of ridicule (Yeatts 26).

No matter what minority, the need to be aware of any health service is a must. However the avenue that is used to publicize the where abouts of health services in the minority community has a great reflection on how much the minority population will use that service. Using public media, commercial advertising, newspaper, television, radio, pamphlets, posters and billboards are just a few of the avenues that could be used to promote a health service in the minority community.

The problem of making minorities aware of services and how to obtain those services is a never ending problem. Personal friends, social gatherings are other ways to help the elderly minority to access health services. Helping all elders to access any health service is a challenge in today's society. Trying to reach minority populations presents its own problems. To better understand the differences between minority group's we must understand a groups needs and their preference of service. By having this understanding doctors and health agencies will be able to tailor services to specific groups (Yeatts 30).

For the African - American, preventive health measures are a necessity. According to a study done by Behavioral Risk Factor Surveillance System in 1991 and 1992, cigarette smoking was lower among African - American women than among white women. However smoking was very prevalent in African - American men

who were in their middle years, but much lower in African - American men who were over 65 years old.

The sedentary life style of many African - Americans does add to the health concerns that they have. Sedentary life style seems to be more prevalent in African - American women, than in African - American men. Another health concern for the African - American population is obesity. The African - American woman is more likely to be over weight compared to the African - American man. An effort to increase awareness and promote physical activity and weight control should be directed to the entire African - American population. To educate the African - American population the traditional health fair has failed. Due to no fault of the African - American senior population, the participation has been minimum.

To produce a health fair that will target the African - American population it should have the following components to make it a success;

- Transportation to/from health fair
- Diabetes screening
- Glaucoma screening
- Cholesterol screening
- Blood Pressure screening
- Weight control information
- Nutritional information
- Heart disease information
- Medicaid representative
- Medicare representative
- Sickle cell screening
- Hearing screening
- Dental screening
- Osteoarthritic screening

- Alcohol/Drug Abuse information

Another important aspect of this health fair should be that after someone has a screening, and if the results are questionable, an appointment should be made right away and transportation provided. In order to do this, a group of doctors in all areas that were presented at the health fair need to be willing to put aside appointment times for those participants of the health fair who do not currently have a physician to care for them.

SURVEY RESEARCH METHODS

A residential/independent care facility is a home for people who are functionally able to be independent and want a safe, hygienic, and sheltered environment in which to live. Emphasis here is on meeting social and recreational needs rather than medical needs, and on providing personal services such as housekeeping and dietary requirements.

In order to find out the life style, and health concerns of a population of people a survey was under taken. A survey questionnaire was developed and used to determine what steps were being taken by the older African - American population to ensure they maintain good health.

There are many data collection and measurement processes that are called surveys. A survey will have the following characteristics. 1. The purpose of the survey is to produce statistics, quantitative or numerical descriptions of some aspects of the study population. 2. The main way of collecting information is by asking people questions; their answer constitute data that's to be analyzed. 3. Generally information is collected about only a fraction of the population that is, a sample rather than from every member of the population (Fowler 9).

There are four reasons for deciding to do a survey:

1. Probability sampling enables one to have confidence that the sample is not a biased one. Data from a properly chosen sample is an improvement over data from a sample of those who attend

meetings, speak loudest, volunteer to respond, or happen to be convenient to poll.

2. Standardized measurement is consistent across all respondents and ensures that one has comparable information about everyone involved in the survey. Without such measurement, analyzing distributions or patterns of associations is not meaningful.

3. The main reason for surveys is to collect information that is available from no other source.

4. Analysis requirements may dictate a special purpose survey (Fowler 11).

It is important to keep in mind that social survey measurement is not error free. The procedures used to conduct a survey have a major effect on the likelihood the resulting data will describe accurately what is intended to be described.

A sample survey brings together three different methodological areas: sampling, designing questions, and interviewing. Each of these techniques has many applications outside of sample surveys, but their combination is essential to good survey design (Fowler 12).

A major development in the process of making surveys useful is learning how to sample, to select a small subset of a population representative of the whole population. The key to good sampling is finding a way to give all population members the same chance of being sampled, and to use probability methods for choosing the sample (Fowler 12).

Earlier surveys and polls often relied on samples of convenience or on sampling from lists that excluded significant

portions of the population. However those surveys did not provide reliable, or credible figures.

Questions are an essential part of the survey process. The interviewer will need to be careful about the way that questions are posed. If an interviewer is sent out with a set of question objectives without providing specific questions, the wording can produce important differences in the answers that are obtained. There are books that provide practical guidelines for writing clear questions that interviewers could administer and get clear answers.

It is common to use interviewers to ask questions and record answers, but in some surveys the respondent will answer self-administered questions. If an interviewer is used, it is important they avoid influencing the answers that the respondents give.

Every survey includes a number of decisions to optimize their use of resources. The most desirable survey design will take into account all the prominent aspects of the survey process.

With respect to sampling, critical issues include the following:

1. The choice of whether or not to use a probability sample.
2. The sample frame, or those people who actually have a chance to be sampled.
3. The size of the sample.
4. The sample design, or the particular strategy used for sampling people or households.
5. The rate of response, or the percentage of those sampled for whom data are actually collected (Fowler 15).

With respect to questionnaire design, the researcher must decide the extent to which previous literature regarding the reliability and validity of questions is drawn upon.

One of the most important aspects of a survey is how the information will be collected. Will it be collected by telephone, mail, personal interview, or in some other way ? The decision on how the information will be collected affects the quality of data that will be collected (Fowler 15).

For designers and users of survey research, the total survey design approach means asking questions about all of these features, not just a few, when attempting to evaluate the quality of a survey and the credibility of a particular data set. (Fowler 16).

A thirty question survey questionnaire was developed and used to determine what steps where being taken by older African - Americans to ensure good health.

The survey sample was a random sample of older African - Americans who came from different economic backgrounds, different educational levels, and different counties, etc.

The survey was conducted from April - June 1996 by one on one interviews with fifty older African - American adults. Some problems occurred by doing this survey.

One problem was the time frame that the interviewer had to complete the survey. Another problem was finding the fifty individuals who were willing to do such a survey. Some did not understand that even though no names where being used. Many felt that they would be targeted at some later date about their answers.

Another problem was that some of the participants thought that the questions where difficult to answer.

SURVEY RESULTS

The following pages provide survey results and include tables for visual comparisons. The questionnaire ideas have been numbered one through thirty to aid in depicting the results from the survey. The order in which they are listed is maintained for all tables when listing the results of the study.

Table I lists basic information of the participants of the survey, which provided information for the survey. Table II identifies how the participants received their health information, and what were some of their health habits. Each table has been numbered one through fifteen giving a total of thirty questions to aid in graphing the results from the survey. The order in which they are listed is maintained for both tables when listing the results of the survey.

When looking at the results of the survey the largest group of respondents lived in the city of St. Louis/St. Louis County. Zip codes 63112 in the city of St. Louis had the largest number of city respondents, whereas 63136 from St. Louis County had the largest group of county respondents. The largest age group that participated in the survey was from 60-69 years old for both St. Louis City and St. Louis County; for the city it was 60.7% and it was 85.7% for St. Louis County.

Since this survey targeted the older African - American population 85.7% of the St. Louis City respondents were African - American and 76.2% of the St. Louis county respondents were African - American. St. Louis City had equal participates, male

50% - female 50% however St. Louis County had 57.1% male and only 42.9% were female.

The educational level of St. Louis City participants was from 0-12 years which was 57.1% but the most interesting findings were that high school/GED participates for St. Louis City were 21.4 %, the same percentage for those who had some college courses from St. Louis City. However for St. Louis County, 42.9% of the respondents completed high school or got their GED, but only 14.3% continued to take some college courses.

As we grow older the idea of working becomes less a desirable subject, however for many St. Louis County residents the opportunity to have extra money was very enticing, 9.5% worked part-time, 28.6% worked full-time but retirement won out with 61.9%. For those who lived in St. Louis City no one admitted to working part-time, only 3.6% worked full-time but 96.4% were retired.

Yearly income was no real surprise to the interviewer: 10.7%. St. Louis City respondents made less than $5000 yearly. On the other hand of those who lived in St. Louis City, 75% made between $5000. and $14999, but 14.3% who lived in St. Louis City made over $15,000. St. Louis County respondents did not indicate that anyone made under $5000, 65% made between $5000/$14999 but 35 % made over $15,000 a year.

When the respondents were asked about their health insurance a few of them got confused about HMO's and Medicare. In both St.Louis City and St. Louis County Medicare was 57.1 % in both areas. St. Louis City had a larger percentage of Medicaid

participants than St. Louis County, but St. Louis County had more participants in HMO's.

When the question, "How is your health?" was asked the survey respondents from St. Louis County was 42.9% indicated they had good health, St. Louis City responded to the same question with 39.3% of its respondents having good health. However St. Louis City respondents had no one with excellent health, whereas St. Louis County respondents had 4.8%.

The respondents from St. Louis County had the largest percentage,61.9% who had not been sick in the last thirty days, but St. Louis City had 28.6% for one - two days and 21.4% for three - five days sick in the last thirty days. When the question of "Year of your last physical check - up" was asked both St. Louis City, and St. Louis County participants proved to be 67.9% , 85.7% of the county participants had physicals in the last year but St. Louis City had 25% that had not had a physical in the last two years. St. Louis City 7.1% had not had a physical between two - five years. This information verifies that in the question of " How is your health?" 14.3% of St. Louis City respondents had poor health.

It was good to know that the respondents of this survey did not use hospital emergency rooms for their routine doctor visit. St. Louis County had the highest percentage of 85.7% for making routine visits to a doctor but St. Louis City respondents had 57.1% for visiting a clinic for routine health care.

From Table II the question of "Can you see a doctor when needed?" was answered with 70% saying yes. For those who said not being able to see a doctor was 93.3% was the primary reason

not being able to see a doctor was 93.3% was the primary reason for them, then not being able to get a ride to the doctor's office was 6.7%.

The health related information that older African - Americans are getting seems to be coming from their doctor/nurse/pharmacist was 88.9%, health presentations or seminars was only reaching 2.2% of the respondents.

Ninety percent of the participants are currently getting their blood pressure, blood sugar checked, and flu shots on a routine basis, however mammogram, pap smear, colon, rectal, glaucoma check - ups are considerably lower.

When the respondents were asked "Whose responsibility it was to keep them healthy", 46% replied that they left it up to their doctor, but 42.9% thought it was their own responsibility to keep themselves healthy.

Safety issues became a factor in this survey also. When the respondents were asked "When riding or driving a car did they wear a seat belt" 36.7% wore a seat belt all the time, however 49% never wore a seat belt. For those who were still driving 40.8% always drove the speed limit, yet 51% never drove the speed limit. This question could be misleading, because we don't know if they were driving faster than the speed limit or below the speed limit.

When questioning the respondents about eating five serving of fruit or vegetables a day 51% said sometimes, but 38.8% said never. There results were not really surprising to the interviewer either, it is a proven fact that our eating habits really do affect our health.

Getting the older African - American adult to exercise is extremely difficult. Only 14.3% exercised all the time, 28.6% exercised sometimes, but 57.1% never exercised. The results from the question "Do you maintain your desired weight" had a direct result to this question. 10.2% always maintained their weight 51% held their weight steadily, but 38.8% were not able to maintain the desired weight.

It has been proven by other surveys that smoking is a major contributor to bad health and in some cases causes death by cancer. When asked the participants about their use of tobacco, the results were 18.4% always used tobacco in some form or another, 30.6% sometimes used tobacco, but 51% answered that they didn't use tobacco at any time. The interviewer was glad to know that a large position of the respondents never used tobacco.

In the older African - American population to go to the dentist was a nightmare. For most of the participants a visit to the dentist was only for an emergency. The participants responded to the survey with 69.4% never having gone to the dentist, 22.4% visiting the dentist sometimes, but only 8.2% always visited the dentist at least twice a year.

Many older adults complain about not being able to sleep 8 hours a night, 16.3% always get 8 hours of sleep, but 81.6% were able sometimes to get 8 hours of sleep,8.2% never get 8 hours of sleep.

When the final question was asked of the participants "Are you happy about your life?" 6.1% responded never, 77.6% responded sometimes, 16.3% were always happy with their life.

CONCLUSION

The role of the Church is very important to the older African - American population. Historically black churches have been seen as a viable source of support for providing informal services to African - Americans, because of the advocacy and extended kin roles that the church has played in African - American communities (Walls 33).

The structure of the black church has the ability to provide religious activities and a wide range of informal services that respond to the survival and social needs of this population. Gerontologist are exploring the feasibility of churches providing health and wellness programs, because churches have the ability to connect with the health service delivery system and connect with the older African - American population. There are a few churches currently doing just that, but more needs to be done to help the older adult in need. Churches are realizing that not only are they to address the spiritual needs of the older adult, they must also address the social needs of the older population.

According to the survey the church was not assisting the older adult with their health concerns or needs. Churches are going to have to step outside their four walls and service those who need service no matter what that service need is.

Recent literature suggest that informal support offered by the black church plays a particularly important role in the lives of older

African - Americans. The church and family networks are both important factors of well - being. African - American elders who received support from either the family or the church network experienced more information than those who received moderate support from both networks (Walls 35).

Health care issues for the older African - American population is not something that will disappear in the near future. Hypertension, diabetes, strokes, and cancer are illness that not promoted to the older African - American population enough as being life threating. The importance of promoting wellness is a challenge for health care providers who must find ways to get the information to the minority population instead of leaving the minority population uninformed of services that they need and the church is a vehicle for getting information of health services out to the general public.

Individual Information

	St. Louis Ci		St. Louis Ct		St. Charles	Warren	Lincoln	Total	
1. Where do you live	28	100%	21	100%	0	0	0	49	100%
2. How many years									
2-15 yrs.	3	10.7%	8	38.1%	0	0	0	11	22.4%
20-35 yrs.	9	32.1%	8	38.1%	0	0	0	17	34%
40-45 yrs.	7	25%	4	19%	0	0	0	11	22.4%
50-65 yrs.	4	14.3%		0	0	0	0	4	8.2%
70-over	5	17.9%	1	4.8%	0	0	0	6	12.2%
Total								49	100%
3. Zip codes									
63104	5	17.9%		0	0	0	0	5	10.2%
63108	11	39.3%		0	0	0	0	11	22.4%
63112	6	21.4%	1	4.8%	0	0	0	7	14.3%
63115	4	14.3%	1	4.8%	0	0	0	5	10.2%
63033		0	3	14.3%	0	0	0	3	6.1%
63136	2	7.1%	8	38.1%	0	0	0	10	20.4%
63142		0	3	14.3%	0	0	0	3	6.1%
63121		0	5	23.8%	0	0	0	5	10.2%
Total								49	100%
4. Age									
60-69	17	60.7%	18	85.7%	0	0	0	35	71,4%
70-79	10	35.7%	2	9.5%	0	0	0	12	24.5%
80-89	1	3.6%	1	4.8%	0	0	0	2	4.1%
Total								49	100%
5. Race									
African-American	24	85.7%	16	76.2%	0	0	0	40	81.6%
Hispanic	3	10.7%		0	0	0	0	3	6.1%
Bi-racial	1	3.6%	1	4.8%	0	0	0	2	4.1%
White		0	4	19%	0	0	0	4	8.2%
Total								49	100%
6. Sex									
Male	14	50%	12	57.1%	0	0	0	26	53.1%
Female	14	50%	9	42.9%	0	0	0	23	46.9%
Total								49	100%
7. Education									
0-12	16	57.1%	6	28.6%	0	0	0	22	44.9%
hs-GED	6	21.4%	9	42.9%	0	0	0	15	30.6%
Some college	6	21.4%	3	14.3%	0	0	0	9	18.4%
College/GRAD			3	14.3%	0	0	0	3	6.1%
Total								49	100
8. Employment									
Part-time		0	2	9.5%	0	0	0	2	4.1%
Full-time	1	3.6%	6	28.6%	0	0	0	7	14.3%
Retired	27	96.4%	13	61.9%	0	0	0	40	81.6%

Table I

Total								49	100%
9. Yearly income									
Less/$5000	3	10.7%	0		0	0	0	3	6.3%
$5000/14999	21	75%	13	65%	0	0	0	34	70.8%
%15T/24999	4	14.3%	7	35%	0	0	0	12	22.9%
Total								49	100%
10. Do you have health insurance									
Yes		28		21	0	0	0	49	100%
No		0		0	0	0	0		0
Total								49	100%
11. What type of insurance									
Private		0	1	4.8%	0	0	0	1	2.%
Medicare	16	57.1%	12	57.1%	0	0	0	28	57%
Medicaid	7	25%	1	4.8%	0	0	0	8	16.3%
HMO	5	17.9%	7	33.3%	0	0	0	12	24.5%
Total								49	100%
12. How is your health									
Poor	4	14.3%	0		0	0	0	4	8.2%
Fair	10	35.7%	5	23.8%	0	0	0	15	30.6%
Good	11	39.3%	9	42.9%	0	0	0	20	40.8%
Very good	3	10.7%	6	28.6%	0	0	0	9	18.4%
Excellent		0	1	4.8%	0	0	0	1	2%
Total								49	100%
13. Last month how many sick days									
none	11	39.3%	13	61.9%	0	0	0	24	49%
1-2 days	8	28.6%	3	14.3%	0	0	0	11	22.4%
3-5 days	6	21.4%	3	14.3%	0	0	0	9	18.4%
6-10 days	2	7.1%	2	9.5%	0	0	0	4	8.2%
10days/over	1	3.6%		0	0	0	0	1	2%
Total								49	100%
14. Last physical checkup									
Last year	19	67.9%	18	85.7%	0	0	0	37	75.5%
Last 2 yrs.	7	25%	2	9.5%	0	0	0	9	18.4%
2-5 yrs.	2	7.1%	1	4.8%	0	0	0	3	6.1%
Total								49	100%
15. Where -rountine health care									
Dr.'s office	12	42.9%	18	85.7%	0	0	0	30	61.2%
Hospital emg		0		0	0	0	0	19	38.8%
Clinic	16	57.1%	3	14.3%	0	0	0		
Chiropractor		0		0	0	0	0		
No where		0		0	0	0	0		
Total								49	100%

Table I

Health Information

1. Can you see a doctor when you need to?

Yes	35	70%
No	15	30%
Total	50	100%

2. If no, why?

Too expensive		0
Couldn't get an appointment	1	6.7%
Couldn't get a ride	14	93.3%
No phone to call doctor		0
Total	15	100%

3. Where do you get most of your health-related information?

Friends/Family	2	4.4%
Doctor/Nurse/Pharmacist	40	88.9%
Newspaper/Magazine/TV	2	4.4%
Health presentation/Seminars	1	2.2%
Missing		5
Total	45	100%

4. Check any of the following check-up combinations you have had in the last year

Mammogram/Pap smear	1	2.%
Glaucoma	4	8%
Colon/Rectal exam		0
Blood Sugar/Blood Pressure/Flu Sh	45	90%
Total	50	100%

5. Who do you think is responsible for keeping you healthy

Church		
Doctor	23	46.9%
Nurses		
Hospital	4	8.2%
Health Dept./Nursing service	1	2%
Yourself	21	42.9%
Missing		1
Total	49	100%

6. Do you wear a seat belt when riding/driving a car

Always	18	36.7%
Sometimes	7	14.3%
Never	24	49%
Missing		1
Total	49	100%

7. Do you drive the speed limit/those who drive

Always	20	40.8%
Sometimes	4	8.2%
Never	25	51%
Missing		1
Total	49	100%

Table II

8. Do you eat five servings of fruit/vegetables a day

Always	5	10.2%
Sometimes	25	51%
Never	19	38.8%
Missing		1
Total	49	100%

9. Do you exercise 3 times a week

Always	7	14.3%
Sometimes	14	28.6%
Never	28	57.1%
Missing		1
Total	49	100%

10. Do you maintain your desired weight

Always	5	10.2%
Sometimes	25	51%
Never	19	38.8%
Missing		1
Total	49	100%

11. Do you use some type of tobacco?

Always	9	18.4%
Sometimes	15	30.6%
Never	25	51%
Missing		1
Total	49	100%

12. Do you drink more than 2 alcoholic drinks/or beers a day?

Always	3	6.1%
Sometimes	8	16.3%
Never	38	776%
Missing		1
Total	49	100%

13. Do you see a dentist 1-2 times a year?

Always	4	8.2%
Sometimes	11	22.4%
Never	34	69.4%
Missing		1
Total	49	100%

14. Do you sleep 8 hours a night?

Always	5	10.2%
Sometimes	40	81.6%
Never	4	8.2%
Missing		1
Total	49	100%

15. Are you happy about your life?

Always	8	16.3%
Sometimes	38	77.6%
Never	3	6.1%
Missing		1
Total	49	100%

Table II

SURVEY

INDIVIDUAL INFORMATION

1.Where do you live: a. St. Louis city
b. St. Louis County
c. St. Charles
d. Warren
e. Lincoln

2. How long?_____years

3. Zip code:_____

4. Age:_____

5. Sex: M F

6. Racial/ethnic identification:
a. Asian/Pacific Islander
b. Black/African American
c. Hispanic
d. Inter-racial
e. Native American
f. White/Caucasian

7. Education (choose 1):
a. Less than 12 years
b. High school diploma/GED
c. Some college
d. College graduate

8. Employment status (Choose 1)
a. employed part-time
b. employed full-time
c. retired

9. Yearly household income:
a. less than $5,000
b. $5,000-14,999
c. $15,000-24,999

10. Do you have health insurance
a. yes
b. no

11. If YES, what kind(s)?
a. private
b. Medicare
c. Medicaid
d. VA, CHAMPS
e. HMO

12. How do you rate your health?

1	2	3	4	5
poor	fair	good	very	good excellent

13. *During the last month,* how many days have you been too sick to carry out your usual activities or work?
a. none
b. 1-2 days
c. 3-5 days
d. 6-10 days
e. more than 10 days

14. When was your last physical or check up ? a. within last year
b. within last 2 years
c. between 2 and 5 years
d. over 5 years ago
e. never had one

15. Where do you go for routine health care ?
a. doctor's office b. hospital emergency room
c. clinic d. chiropractor
e. don't see anyone

16. Can you see a doctor when you need to a. YES b. NO

17. If no, why ? (choose one, please)
a. too expensive
b. couldn't get and appointment
c. couldn't get a ride
d. no phone to call doctor
e. other_____

18. Where do you get *most* of your health-related information? It is from (Choose one)
a. friends/family
b. doctor/nurse/pharmacist
c. newspaper/magazine/TV
d. health fair
e. health presentations/seminars
f. other_____

19. Check any of the following that you have had in the last year:
a. mammogram/pap smear_____ b. glaucoma test _____.c.
c. colon/rectal exam _____ d. blood pressue/sugar/flu shot_____

20. Who do you think is responsible for keeping you healthy (Choose one)
a. church___ e. health dept./nursing service____
b. doctor___ f. myself___
c. nurses____
d. hospital____

Please check what best describes you:		N/A	Always-sometimes	rarely/never
21.	a. I wear a seat belt when riding or driving.	___	_____ _____	_____
22	b. I drive the speed limit	___	_____ _____	_____
23	c. I eat five servings of fruit and vegetables a day	___	_____ _____	_____
24	d. I exercise 3 times a week	___	_____ _____	_____

25 e. I maintain my desired weight ___ ____ _____ _____
26 f. I use some type of tobacco ___ ____ _____ _____
27. g. I drink more than 2 alcoholic drinks or beers a day ___ ____ _____ _____
28. h. I see a dentist 1-2 times a year ____ ____ _____ _____
29. I sleep 8 hours a night ____ ____ _____ _____
30. m. I feel happy about my life ___ ____ _____ _____

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