

Eliminating Health Disparities in the African American Population: The Interface of Culture, Gender, and Power

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Since the release of former Secretary Margaret Heckler's *Secretary's Task Force Report on Black and Minority Health* more than two decades ago, excess death from chronic diseases and other conditions between African Americans and Whites have increased. The conclusion of that report emphasized excess death and thus clinical care, paying little attention to the sociocultural environment and its effects on risk of disease. The authors of this article contend that eliminating health disparities between the African American and White populations in the United States requires a focus on improving the social environment of African Americans. They examine the interface of culture, gender, and power and how those are central to analysis of the root causes of health disparities. The REACH 2010 project of the Centers for Disease Control offers examples on how a coalition of community and research organizations can infuse community interventions with informed considerations of culture, gender, and power to eliminate health disparities.

Keywords: African American; health disparity; culture; power; gender

Publication in 1986 of the *Secretary's Task Force Report on Black and Minority Health* marked the beginning of a national agenda to examine and take action to eliminate health disparities in the United States (U.S. Department of Health and Human Services [USDHHS], 1986). Since then, however, not only has the gap in excess deaths that was identified in the report not been closed, but for some conditions it has widened. For example, among African Americans, death rates from heart disease (the leading cause of death in both Blacks and Whites) were 10% lower than in Whites in 1980 (USDHHS, 1986) but 30% higher in 2000 (National Center for Health Statistics [NCHS], 2003). On the other hand, death rates from stroke (the third leading cause of death in the United States) were 80% higher in African Americans in 1980 (USDHHS, 1986), but in 2003, they were 41% higher than in Whites (NCHS, 2003). Cancer is the second-leading cause of death in the United States (NCHS, 2003), and African Americans have moved from having a death rate from cancer below that for Whites in 1950 to a rate 30% higher than for Whites in 2000 (NCHS, 2003). On a population basis,

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deaths from cancer among African Americans are now 40% higher than they were in 1950 (NCHS, 2003). Similarly, in people of similar age, the prevalence of type 2 diabetes is 1.6 times higher among African Americans (www.cdc.gov/diabetes/index.htm). Type 2 diabetes, whose prevalence has increased dramatically in recent years, places African American women at extraordinary risk (www.cdc.gov/diabetes/index.htm). Type 2 diabetes—which is linked to obesity and physical inactivity, accounts for 90% to 95% of diabetes cases, and most often appears in people older than 40 (Mokdad et al., 2000)—has been diagnosed in an estimated 10% of African American women. As more than 80% of African American women older than 40 are categorized as either overweight or obese (Flegal, Carroll, Ogden, & Johnson, 2002; Mokdad et al., 2003), in the absence of dramatic changes, this population will continue to be at great risk for type 2 diabetes in decades to come. Finally, in 2003, African Americans accounted for 50% of all diagnosed HIV or AIDS cases in the United States (<http://www.cdc.gov/hiv/pubs/Facts/At-A-Glance.htm>), even though they made up only 13% of the total population (NCHS, 2003). Taken together, these data portray a state of emergency among African Americans.

To better understand the root causes of these health disparities, we need to examine the social environment in which these chronic conditions persist. To begin, residential neighborhoods in urban and suburban communities around the country continue to demonstrate historical patterns of segregation by race (Williams & Collins, 2004; Williams & Jackson, 2005). Theoretically, racial segregation that does not deny equal opportunities, as may be observed in middle- and upper-middle-class Black communities, might portend a positive health benefit in Black communities, but additional research is needed to confirm that this could be the case. More generally, as has been observed by several scholars (Brown et al., 2003), the degree of residential segregation is a code (that consistently disadvantage African Americans) for the quality of the public schools; the quality of, and access to, services (e.g., shopping, health care, property values, and the investments of the local government in creating a “livable community”); and police surveillance and protection, among other things.

In the United States, communities that are primarily or exclusively inhabited by African Americans typically have lower assessed property values, and this is a concern because the property tax is the primary source of revenues for the school systems. The result has been that the children of families that can afford to live in middle- to upper-class housing developments and communities with proportionately higher property taxes are privileged in their school resources and educational opportunities over their peers in lower income communities.

As recently as September 2005, in response to public outcries about the slow-moving evacuation of victims of Hurricane Katrina, President Bush acknowledged during a news conference that a history of racism is responsible for the present condition of poverty in which a disproportionate number of African Americans find themselves. Such a history of being consigned to conditions of poverty results in what Wilson (1978) referred to as “accumulation of disadvantage.” When neighborhoods have a high concentration of Black families and poor school systems because of disproportionately low-tax properties and low political engagement, the quality of their sociocultural environment is often well below that found in comparable White communities (Dressler, 1993; King & Williams, 1995). In fact, Wilson (1991) has argued that there is a stark difference between a jobless family stuck in a community with a relatively low rate of unemployment and one that is stuck in a community with other jobless families. Communities with weaker social environments are clearly more vulnerable to economic instability.

One example of how a compromised social environment can lead to economic instability comes from certain changes in housing patterns that may have had their origin in

the larger economic environment. As prices for gasoline have risen, so has the return of White families to inner-city communities, with the effect of dislocating Black families from their neighborhood roots. These more affluent families can afford to transform “ghetto” houses, occupied for the last 60 to 70 years by African Americans, into prime real estate. The power of this new urban demographic to transform property, raise property values, and increase rates of property taxes results in better schools than those attended by the African Americans who previously resided there. In summary, the gentrification of these communities is directly linked with the displacement of Black families and the destruction of their social networks and support systems (Brown et al., 2003).

In African American communities, there are more fast-food restaurants and vendors of alcoholic beverages per capita than in White communities, and the consumption of the same is arguably higher among African Americans as well (Williams, 1998)—not unrelated to the aggressive marketing of these products to African American consumers. The frequent absence of major grocery chains, farmers’ markets, and whole-food markets in these same neighborhoods has meant that there are fewer affordable sources of fresh fruits and vegetables. This may well have implications for maintaining a healthy diet, as a study in an African American community in North Carolina found that the availability of grocery stores was directly related to consumption of fresh fruits and vegetables (Morland, Wing, & Roux, 2002). Increasing the ratio of food markets to fast-food restaurants and liquor stores in African American communities is a feasible structural change that might reap improved health benefits for the future.

Because of the persistent challenges of the social conditions experienced by a significant portion of the African American community and the elusiveness of improved population health for African Americans, public health workers, researchers, and scholars have been working diligently during the past 20 years to reverse the tide of poor health in these communities. Public health educators have been leaders in conducting community-based participatory research, advocating for policies that support health promotion in African American communities, and advocating for a research agenda that centralizes the social contexts of African American communities in meaningful public health efforts to eliminate health disparities. Analyses of culture, gender, and power in both producing and eliminating health disparities have been a central anchor of this research. The Society for Public Health Education’s (SOPHE) inaugural research summit on eliminating health disparities created a space to further deepen and strengthen health education strategies that will accelerate the dissemination of new knowledge and the implementation of effective interventions whose solutions are based on the positive interface of culture, gender, and power.

In this article, we examine the interface of culture, gender, and power in both the structuring of health disparities among African Americans and in framing solutions. We review relevant literature across multiple disciplines not only on culture, gender, and power but also on identity and racism, and we apply it to the dissemination and translation of promising practices, context-based interventions, and cutting edge research on health disparities. We conclude with dissemination strategies useful to researchers and practitioners in public health who are working in communities disproportionately affected by the leading causes of death and disability in the United States.

CULTURE AND HEALTH DISPARITIES

The study of culture in the United States dates back over a century in which several schools of cultural thought have evolved. In the main, culture reflects “the patterned ways

that we have learned to think about and act in our life worlds and that replicate the social structure of those worlds” (Kleinman, 1988). In this article, we define culture as a collective sense of consciousness that can audibly or silently reveal itself through history and language (Airhihenbuwa, 2005). Culture, which is never static, is commonly reinforced through structures, even though those structures are not always palpable and visible as are physical structures. Understanding the structural influences of mainstream, largely White culture on African American life is particularly important in any examination of health disparities. Wilson (1991) has argued that culture and social contexts coexist; we argue that just as structures support positive behaviors, values, and habits, structures also support negative behaviors, values, and habits that produce and reproduce disparities in health.

Within a structural framework for understanding cultural behaviors, we are better able to resist the tendency to associate culture in health with only negative assumptions about local customs and norms, to assume that these factors constitute a “barrier” to achieving changes in health behaviors (Airhihenbuwa, 1995, Airhihenbuwa & Webster, 2004). A negative representation of culture typically results in a “deficit model” that relegates behaviors related to culture as unhealthy and behaviors to be overcome. Such a mind-set on the part of researchers and health practitioners working in African American communities has been particularly pervasive and counterproductive. For example, there are instances when public health researchers and practitioners have asserted that the presence of “unhealthy” cultural norms in a community has caused their programs to fail. Furthermore, in reporting their research results, many researchers unwittingly hide the cultural lenses that are normalized in the institutional structures within which their analyses have been framed, lenses that all too often ignore the agency of local communities to choose both when and how they will participate in community health initiatives. According to Bayne-Smith (1996),

The difficulty most people experience is that culturally conditioned behaviors, responses, and ways of interacting become at the most profound levels the total framework out of which they not only operate but also *interpret and judge* [italics added] the behaviors of others. (p. 36)

Unfortunately, there is an absence of a language of positive aspects of health behaviors that reveal cultural strengths.

Increasingly, many scholars have begun to value the role of culture in health behavior even though the “complex whole” of the influence of culture is not fully understood. Because culture is not static, the process of learning about culture in heterogeneous African American communities must be considered something that is ongoing. In that context, we offer a caution about the growing and unproblematized, that is, unquestioned and taken for granted as “truth,” discourse on cultural competency.

Cultural competency entered into the public health training language by way of skill development in medical training. As health care providers in the United States are encountering patients from diverse backgrounds and nationalities, it is essential that they understand the unique perspectives and beliefs of the patient in order to enhance the quality of care they provide. Cultural competency, as commonly framed, assumes a threshold of skills to be acquired by the physician above which the provider is presumed to be culturally competent. The acquisition of some basic competency in communicating with a patient in a clinical setting, while adequate for such a setting, is insufficient to addressing the broader domain of incorporating cultural sensitivity and appropriateness in the dissemination and translation of health information to the community.

There is so much to be addressed within culture that reducing it to only clinical skills for communicating with patients is unquestionably shortsighted. In the Sullivan Commission's (2004) report, three levels of competency were addressed. This report recommended that the focus of cultural competency should be the system level, which deals with policy. Although we acknowledge that the policy level of cultural competency is very important, if a policy focuses only on clinical competency, for example, ensuring that providers can communicate with patients effectively during the clinical encounter, it is too limited in scope and does not offer the institutional support to address the broader issue of engaging the community in the dissemination of health programs, nor does it deal with how existing structures sideline communities in research and dissemination.

These observations raise an important point in the discourse on eliminating health disparity; that is, how a problem is defined is not necessarily how the solution should be framed. The problem of physicians not having relevant skills to adequately communicate with diverse patients is important, but acquiring such skills encompasses only one aspect of the complex web of social, political, and economic structures and policies needed to more fully address cultural insensitivity in particular and health promotion more broadly. Only a crosscutting, coordinated, and sustained strategy of change, particularly in addressing gender inequity, will ensure the ultimate elimination of health disparities.

GENDER AND HEALTH

Although we are born male and female, the process of becoming a *man* and a *woman*, *masculine* and *feminine*, is socially constructed. Inherent in this process is the need to understand the social construction of gender identity as embedded in the study of relationships. "Research that treats gender as a demographic variable often implicitly posits it as a characteristic of individuals rather than as a relationship between groups of women and men" (Calasanti, 2004, p. S306). Thus, the study of gender is more about the study of relationships. These relationships are those between men and women, men and men, and women and women, as well as their relationships with the entire society. The formation of gender identities begins at birth and is learned through many channels, including families and social networks, community and governmental institutions, and the media. Cultural constructs of manhood/manliness and womanhood and the supporting attitudes, beliefs, and behaviors that express gender identities, as well as the structural forces that align economic, educational, and other opportunities with gender, have a direct bearing on health outcomes (Bayne-Smith, 1996; Braithwaite & Taylor, 2001; Sabo & Gordon, 1995; Williams, 1998). A full discussion of how structural forces align opportunities with gender and the impact of these alignments on health is beyond the scope of this article. Considerable research has examined the relationship between gender and health. This knowledge, however, has not been widely applied in the elimination of health disparities in the African American population. When it has, the focus has been mostly on empowerment of women. Although this focus continues to be critical, the goal of eliminating health disparities will not be met if we do not also address the health problems of African American men. When the study of gender focuses on women's health, it tends to focus on the question of power in women's relationships and where that power is located. For example, several programs to stop the spread of HIV and AIDS have as their goal the need to empower women. And yet the question of empowerment of a woman without an examination of her social and cultural environments, particularly those concerning the status and health condition of the men in her social cultural contexts, is limited.

The intersection of race and gender is a critical context for examining the influence of identity (i.e., gender identity, ethnic identity, socioeconomic position, etc.) on health in the United States. Consider the health status of African American men. Black men experience a shorter life expectancy than any other racial or ethnic group, and they experience higher mortality in every age-group up to age 65. Their death rate for heart disease is one and one-half times greater than that experienced by African American women and two times greater than that of White men. Unintentional injuries and homicide also disproportionately affect Black men (Braithwaite, 2001). In addition, African American men bear a great burden of HIV/AIDS, drug and alcohol abuse, strokes, type 2 diabetes, and other chronic illnesses (Staples, 1995). Contributing to these health disparities among Black men is what Staples describes as the “masculine mystique”: “The masculine mystique often indoctrinates men into ignoring an illness until it becomes disabling” (p. 123). According to Braithwaite,

Men have traditionally been socialized that they should not cry, that they should be cavalier about certain things that affect them, that it is weak to show pain, and that it is cowardly to run from danger. They have also been encouraged to detach themselves psychologically from feelings of fatigue or discomfort that might prevent them from completing their tasks. (p. 65)

In addition, African American men tend to fear hearing a diagnosis of disease or a “poor prognosis” and exhibit high levels of distrust of the health care industry. At the structural level of the political economy and racial inequality, African American men have the highest rates of unemployment and therefore are less likely to have health insurance; are overrepresented in the prison industrial complex (comprising more than 60% of persons under correctional supervision); have higher exposures to toxic substances in their living and work environments; and are at higher risk of occupationally induced diseases, injuries, and death (Braithwaite, 2001; Staples, 1995).

As gender identities are socially constructed and learned, they can be *unlearned* and *reconstructed*. A contemporary example of such a shift is the increasing participation of fathers in childrearing as more and more women are assuming paid positions outside the home. In response to the tendency of some men to internalize pain and endure suffering alone, support groups have emerged around the country for men confronting prostate cancer. These groups provide a safe space for men to talk openly about their concerns related to this disease and its effect on their personal, family, and occupational lives. Research on health disparities that focuses on the formation of gender identity and strategies for reconstructing “masculine” behavior to be health promoting and not destructive is an important pursuit if we are to reduce health risks among Black men. For example, recent research conducted among African American men with type 2 diabetes revealed among the participants perceptions of diabetes as “inescapable, a form of social inequality, a ‘private hell,’ and a loss of one’s identity as proud, robust, sexual, independent, and invincible (i.e., masculine)” (Liburd, Namageyo-Funa, Jack, & Gregg, 2004). As these men began to experience diabetes-related complications, they actively sought out health information and alternative treatments to manage the disease if they believed these actions would preserve their independence and quality of life. They welcomed information from other men with diabetes, and they willingly accepted support from family and friends for managing the disease. Typically, however, they maintained the attitude that controlling their diabetes was ultimately their responsibility alone. This research concluded with a call for additional research to establish stronger theoretical and empirical

associations between African American men, "Black masculinity," and the prevention and control of type 2 diabetes. To address the question of masculinity among African American men is to address the interface of power, race, and identity.

POWER, RACE, AND IDENTITY IN AFRICAN AMERICAN HEALTH

How power is defined and analyzed has often depended on the disciplinary background of the researcher on one hand and the perspective(s) of authority and domination on which the theorizing is anchored on the other. Depending on the disciplinary foundation and lived experience that nurtures the theorizing, debates and analysis have been offered to understand the different kinds of power including constitutive versus repressive power, "power to" and "power over," and power as relation and power as action (Kaler, 2001). In examining the interface of power, race, and identity, we offer a transdisciplinary perspective that contains elements of the different forms of power and its role in the elimination of health disparities. As a foundation, we draw from the sentinel work and thinking of the French philosopher and historian Michel Foucault. Foucault defines a relationship of power as "a mode of action which does not act directly and immediately on others. Instead it acts upon their actions: an action upon an action, on existing actions or on those which may arise in the present or the future" (Foucault, 1982, p. 220). Foucault (1982) added that the exercise of power

is a total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of actions. (p. 220)

The exercise of power is not static or in Foucault-speak, a naked fact, "It is elaborated, transformed, organized; it endows itself with processes which are more or less adjusted to the situation" (Foucault, 1982, p. 224).

In addition to Foucault's work, and particularly because his work did not focus on the question of racism, we draw from the work of W. E. B. DuBois. The legacy of DuBois is strongly anchored in his tireless efforts to address the location of racism and power in the discourse on African American identity. As an African American intellectual trained as a sociologist whose discursive projects were deeply philosophical, DuBois's central intellectual contribution to our understanding of human behavior is framing the question of African American identity and belonging. Indeed, identity and belonging were primary themes in his prophetic mantra that "the problem of the 20th century is the problem of the color line." The question of race and identity in America has always been central to how belonging, ownership, and citizenship have been politically constructed (Bell, Grosholz, & Stewart, 1996), academically theorized (Dyson, 1996), and judicially reinforced (Wu, 1996; Higginbotham, 1991). According to Shiriki Kumanyika (2005), DuBois had concluded in 1903 that the health problems of "the Philadelphia Negro" required an examination of the conditions in which Black Philadelphians lived even as we examined their disproportionately high mortality rates from diseases.

Identity framed as a collective for African Americans becomes very important given the differences in institutional mechanisms by which the experience of the group is framed. Using a cultural analysis to understand the focus on individualism in health

behavior is particularly timely in the formation of racial identity in the United States. There have been several debates about whether to continue to use race or ethnicity in studying different groups in the United States. Some scholars have offered a strong argument for maintaining both forms of identity in social science research (Oppenheimer, 2001), whereas others have suggested the elimination of race as an independent variable in psychological research (Helms, Jernigan, & Masher, 2005; Wang & Sue, 2005). Those who defend the use of race cite the reality of how race continues to be used to define American identities. Consequently, they argue, the use of race ensures an alignment with the historical legacy of legal and political identity. Others argue for ethnicity because ethnicity does not carry the oppressive identity burden that has become synonymous with the term *race*. Moreover, ethnicity, it is argued, also offers possibilities to examine the intragroup differences rather than assume all African Americans are the same as the racial categorization may condition people to assume.

Indeed, both race and ethnicity are needed but for different reasons. Clearly, without a determined understanding and examination of race and racism, we would fail to understand the ways in which institutions and structures of racialized societies like the United States and South Africa maintain forms of domination that render individual-level solutions to health problems quite limiting. Jones (2000) has offered an analysis that clearly historicizes racism in its current social and institutional arrangements. She does this not simply at the level of defining the racist contexts of health disparities but also at the level of the process by which institutional and structural racism continue to maintain these gaps while resources are extended on individual-level solutions. Thus, the relevance of race in defining the problems of health disparities is affirmed as we also affirm the centrality of ethnicity, culture, and spirituality in framing solutions to eliminate health disparities, as will be discussed below.

How then does the structure of power in the United States act upon the actions, identity, and possibilities of African Americans over time such that health disparities are produced and perpetuated through successive generations? What agency exists within African American communities to counter the oppressive forces of power imposed on this population? Surely, institutionalized racism structurally acts on the actions, internalized identities, and possibilities of African Americans. We will now describe more fully the intersections of race and power acting on African Americans below.

Wilkinson (2000) found that in societies where there is more socioeconomic equality, there is less sickness and violence. He argued that what matters to health are not absolute income and living standards but relative income and social status. Described as the "psychosocial links to health," Wilkinson contended that "many of the biological processes that lead to illness are triggered by what we think and feel about our material and social circumstances." It is well documented that African Americans are marginalized and undervalued in the United States (Bayne-Smith, 1996; DuBois, 1899/1973; Krieger, 2000; Staples, 1995; Williams, 2000). The internalization of such social oppression and repression can result in feelings of hopelessness, powerlessness, and self-hatred among U.S. Blacks (King & Williams, 1995; Williams, 2000).

African Americans have a rich heritage of surviving and sometimes thriving in hostile contexts, and much of their resilience is grounded in spirituality and the agency of the "Black church." More than 100 years ago, DuBois (1899/1973) documented the centrality of the Black church in African American life:

The Negro church is the peculiar and characteristic product of the transplanted African, and deserves especial study. As a social group the Negro church may be said to have antedated

the Negro family on American soil; as such it has preserved, on the one hand, many functions of tribal organization, and on the other hand, many of the family functions. Its tribal functions are shown in its religious activity, its social authority and general guiding and co-ordinating work; its family functions are shown by the fact that the church is a center of social life and intercourse; acts as newspaper and intelligence bureau, is the center of amusements—indeed, is the world in which the Negro moves and acts. (p. 17)

The Black church remains a vital and influential institution in the Black community (Lincoln & Mamiya, 1990). There is also a growing literature that suggests that both involvement in a religious community and personal commitment to religious beliefs and practices are positively associated with health outcomes (Matthews et al., 1998; Strawbridge, Cohen, Shema, & Kaplan, 2001). Faith-based health promotion programs and partnerships between public health agencies, academic researchers, voluntary health organizations, and faith-based institutions are effectively creating new portals for the infusion of needed health information and culturally appropriate interventions intended to eliminate health disparities among African Americans (Baskin, Resnicow, & Campbell 2001; Jackson & Reddick, 1999; Mann et al., 2000; Sanders, 1997; Smith, Merritt, & Patel, 1997).

A TRANSDISCIPLINARY PUBLIC HEALTH PRACTICE: THE EXPERIENCE OF REACH 2010

A careful examination of the interface of race and gender leads to an analysis of relations of power necessary to promote strategies for both racial and gender equity. Such an examination, which one would hope would lead to the goal of achieving racial and gender equity, challenges health educators to engage in a transdisciplinary approach to the dissemination of research in health education. The Centers for Disease Control and Prevention's (CDC) REACH 2010 program is beginning to bridge race, gender, and power in community strategies intended to eliminate disparities in health care.

REACH 2010, the acronym for Racial and Ethnic Approaches to Community Health by year 2010, was launched in 1999 as part of President Clinton's initiative to eliminate health disparities in racial and ethnic communities. REACH 2010 is anchored in community coalitions whose programs are designed, implemented, and evaluated on the basis of community-driven strategies to eliminate disparities in six priority areas—cardiovascular disease, immunization, screening for and managing breast and cervical cancer, diabetes, HIV/AIDS, and infant mortality. The program focuses primarily on African Americans, American Indians, Alaska Natives, Asian Americans, Hispanic Americans, and Pacific Islanders.

Of the numerous successes documented in the REACH program, we will address only three. Even though the principal interest of this article is eliminating health disparities in African Americans communities, we include a REACH program from a Vietnamese community because it has cross-cultural salience. The first is in South Carolina, coordinated by the Medical University of South Carolina, and implemented in African American communities in the town of Georgetown and the city of Charleston (Jenkins et al., 2004). The community coalitions work to improve diabetes care and control for more than 12,000 African Americans with diabetes. Some of their strategies include walk-and-talk groups, providing diabetes medicines and supplies, and creating learning environments where health professionals and people with diabetes learn together. These strategies are relevant in a discourse

of race and power. The impact and legacy of centuries of slavery and social inequality have not been erased from African American communities particularly in the South. The health education programs sponsored by the REACH 2010 program in South Carolina not only build skills in diabetes self-management but also teach adults the process of learning that is transferable to other areas of their life. In other words, the health education programs become a source of continuing education for adults who have historically not had access to the same health information as their White counterparts. In addition, having opportunities to interact with physicians and other health care providers outside of the hierarchical structure of the clinical setting has been instrumental in demystifying the position of power held by physicians and is teaching adults with type 2 diabetes their entitlements to a particular quality of health care that has historically been withheld from them. Last, African Americans are learning that despite what they have observed and construed to be inevitable outcomes of type 2 diabetes, such as end stage renal disease and lower-extremity amputations, there are proven strategies to prevent these devastating outcomes, and these strategies are available and accessible to them. Hopelessness and fear are being eliminated, and REACH 2010 is documenting impressive health impacts.

Just 2 years after the program began, African Americans in Charleston and Georgetown, South Carolina, are more physically active, they are being offered healthier foods at group activities, and they are getting better diabetes care and control. In addition, what has been particularly noteworthy about this program is that African Americans are now receiving the recommended care for preventing complication of diabetes, such as testing for hemoglobin A1C values or blood sugar concentrations, lipid profiles, and kidney function, and they are getting dilated-eye exams annually. Participants are also having their blood pressures monitored regularly. The initial 21% disparity in hemoglobin A1C testing between African Americans and Whites has been virtually eliminated in these two communities (Jenkins et al., 2004).

The second example is in Santa Clara County in California where the University of California, San Francisco's Vietnamese Community Health Promotion Project organized the Vietnamese Reach for Health Initiative Coalition to prevent cervical cancer among Vietnamese Americans. After identifying barriers to care, the coalition developed a community action plan to promote Papanicolaou (Pap) screening by creating change among community leaders and the health care system, including Vietnamese American medical providers, as well as among Vietnamese American families. A key factor was the realization that to increase the participation of women in getting Pap smears, the men in their lives had to be involved, because they had considerable influence in the screening decision (Nguyen, McPhee, Nguyen, Lam, & Mock, 2002). This is another example of how gender, gender relations, and power intersect in decisions about health-seeking behaviors. Without the explicit support of the men in these women's lives, they were less likely to participate in screening programs for cervical cancer, thereby risking premature death. The proportion of Vietnamese American women receiving Pap tests has increased by 15% since the project began (Lam et al., 2003). The coalition uses community health workers referred to as "patient navigators" who have been major factors in the coalition's success. These patient navigators have received calls from more than 1,200 Vietnamese American women seeking information and assistance, and as a result, more than 700 women have registered to receive a Pap test. In addition, more than 50 Vietnamese American physicians have received continuing medical education about cervical cancer, screening, diagnosis, and treatment, and 29 physicians have registered more than 4,000 women in a reminder system (Lai et al., 2004). A cancer information Web site established for this program received more than 1,200 visitors and more than 10,000 hits per month.

Our third and final example of a REACH 2010 success is the Breast and Cervical Cancer Coalition at the University of Alabama at Birmingham (Fouad et al., 2004). Its success has been partly due to the coalition's ability to mobilize community-based grassroots and health care organizations in initiatives aimed at improving the use of services to screen for breast and cervical cancer. A core working group of community health advisors, nurses, other health care professionals, and clergy disseminates tailored information to increase the use of women's services for early detection of breast and cervical cancer. In Macon County, Alabama, the disparity between African American and White women in the use of screening mammography was reduced from 15% in 1998 to 2% in 2003. In Dallas County, Alabama, there was a reduction in the disparity in screening mammography between African American and White women from 15% to 8% during the same period (2004 annual report submitted to CCD). Overall, 42% of the women who reported at the start of the program that they had never had a Pap test reported having at least one Pap test in 2003, thereby reducing the risk of death because of undetected cervical cancer.

The test of the value and impact of research is typically in its dissemination. In deciding the best venues for disseminating lessons learned from REACH 2010, we ask two questions: What is the purpose of disseminating this research, and to whom are we disseminating this research? In many ways, the answers to both of these questions are reflected in the ways in which we disseminate our findings. At the community level, REACH grantees have relationships with their local newspapers and other media outlets to disseminate their success to their community. At the national level, we work very closely with our partners to disseminate our success stories to a broader audience. For example, the Vietnamese Reach for Health Initiative Coalition was one of only six organizations to receive the award for *Closing the Health Gap* for programs to resolve racial and ethnic health disparities. The award was presented to the coalition by then Secretary of the Department of Health and Human Services Tommy Thompson as part of the celebration of the 40th anniversary of the Civil Rights Act of 1964 (2004). Last, REACH 2010 projects are featured in special issues of several peer-reviewed journals, as well as on the agendas of national and international meetings on health disparities. Identifying effective strategies for dissemination is challenging and multifaceted, and the REACH 2010 projects are making important strides in increasing awareness of culturally appropriate, evidence-based interventions that eliminate health disparities.

CONCLUSION

We believe that how we define a health problem does not necessarily offer us a frame for how we construct the solution to the health problem. Because we pose a question within a racial frame does not mean we construct solutions in the same frame. The solution may lie in the cultural and ethnic frames within which the community sees itself. Those who are defined in racial terms may see themselves in those terms and only in the context of problems. This means that when they begin to offer solutions, they may see themselves as cultural and spiritual beings. Where race may define and confine, culture, ethnicity, and spirituality may liberate and refine.

The historical experience of Africans in America has been one of adapting to a hostile social, political, and economic environment—but surviving! Our discomfited citizenship has been exploited by the daily assault of marketing campaigns that lure African Americans to purchase and consume all manner of maladaptive substances that compromise mind, body, and community. It has been African American resourcefulness and discernment that

has created a legacy of resilience. It will be that same tenacity and love for life that will reverse the legacy of health disparities.

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