



Issues in Women's Health

Message from the Director: *Dr. Jerry Johnson, MD*

Over the years, it has become increasingly evident that minority women are at a disadvantage in several health related sectors. Not only are minorities more susceptible to several serious diseases, they often suffer from lack of together with a focus on minority women and specific health problems that they encounter, illustrating some quality health care, and life styles that affect their health negatively. This issue of Spectrum was put of the risk factors that contribute to their health.

Dr. Rhonda Boyd writes an intriguing article about the effects of depression on women and their children, while articulating the differences of depression between various ethnicities. In her article, she writes about a pilot investigation, which studied depressed parents in community mental health centers throughout Philadelphia. On a different note, Norma D. Thomas talks about her study which focused on the lives of older minority women, their personal struggles, and experiences which led to health problems during their later years. She mentions the *double jeopardy* of being a woman and a minority and how it greatly affects so many women.

From the basic health issues to lack of health benefits, this issue illustrates some important studies that have found interesting results pertaining to the health of minority women.

Maternal Depression and Contextual Issues Among Urban Minority Woman



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Depression is a significant mental health problem that is devastating to the lives of women and their families. The National Comorbidity Survey Replication showed that 6.6% of women had experienced a major depressive disorder within the previous year and 12.9% during their lifetime; these prevalence rates are approximately twice as high as the rates for men.¹ As reported by the World Health Organization,² of all medical conditions, depression is the greatest cause of disability in women. The

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problem of depression in women is critical also because of the potential impact on children. Extensive evidence has documented the deleterious effects of maternal depression on children's functioning in a number of domains, including cognitive, social, and developmental.³

The consequence of these effects identifies a need to focus on depression in women of childbearing age. In addition, it is necessary to understand the cultural and environmental influences on disorder diagnosis and development, as well as intervention for its prevention.⁴ Unfortunately, although race or ethnicity appears to play a role in depressive symptoms, limited research is available on depression in ethnic minority women. One study of African American, Latina, and White women showed that African American women are more likely to report psychological distress, whereas Latinas were more likely to be classified as severely depressed than the other groups.⁵ Another study focusing on low-income women during the postpartum period found that African American women reported higher rates of clinically significant depressive symptoms than did Latina women at 3 weeks postpartum but not at later weeks.⁶ Evidence is also available that ethnic minority women are likely to emphasize the somatic, rather than the psychological symptoms of depression.⁷ Nevertheless, even within ethnic minority groups, the expression of depression varies widely. Research on ethnic minority women should take into account the context of the women's lives, to gain a better understanding of their depressive disorder.⁸

Ethnic minority women are confronted with a host of environmental factors that are stressful and likely increase their vulnerability to depression.⁷ Contextual factors, such as poverty, residence in inner-city environments, exposure to violence, and racism, are commonly experienced by African Americans and Latinas⁹ and can have profound impacts on maternal and child functioning.¹⁰ For example, maternal depression has been suggested to affect parenting when African American mothers have limited personal resources and greater contextual stress.¹¹

To help address these issues, with funding from the W.E.B. DuBois Collective Research Institute at

the University of Pennsylvania, was conducted a pilot investigation of depressed parents in community mental health centers in Philadelphia. The research team included Guy Diamond, of the University of Pennsylvania School of Medicine and the Children's Hospital of Philadelphia; Joretha Bourjolly, of the University of Pennsylvania School of Social Work; and Alicia Veit, a medical student at the University of Pennsylvania and a FOCUS fellow. The study's purpose was to determine the contextual issues facing urban, ethnically diverse depressed parents and their children with the aim of developing a preventive intervention. Few studies take a phenomenological approach to examining depressed parents. This study involved conducting focus groups with depressed parents

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Reaching Out to African-American Women About Breast Cancer Education

By Dr. Chanita Hughes-Halbert Ph.D. *With Our Voices*



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Painting by D. Halbert
Commissioned by *With Our Voices*

personal and family history of breast or ovarian cancer that is suggestive of hereditary disease. Even though genetic counseling may be useful for increasing knowledge about breast cancer risk factors and may also provide information about options for cancer prevention and control, participation in genetic counseling and testing for BRCA1 and BRCA2 may be limited among African American women.

As genetic testing for breast cancer risk is incorporated into the clinical management of women at increased risk for hereditary breast and ovarian cancer; more counseling programs, that enhance informed decision-making about genetic testing and translate risk information effectively, will be needed. The *With Our Voices* research program is an important first step for the evaluation of the impact of cultural values on decisions about genetic testing, quality of life, and health-related behaviors among African American women.

With Our Voices is a research program at the University of Pennsylvania for African American women who have a personal and/or family history of breast or ovarian cancer that is suggestive of hereditary disease. Through this program, participants have an opportunity to meet with a genetic counselor to discuss their family history of cancer; how cancer may be transmitted within families; and recommendations for screening and prevention. This process is called cancer risk assessment or genetic counseling. Although recommendations have been made to increase the cultural sensitivity of breast cancer risk counseling programs, data on cultural values and beliefs have not yet been translated into psycho educational genetic counseling programs. This project is designed to increase our ability to provide African-

Each year thousands of African American women are diagnosed with breast cancer. Efforts have been made to ease the burden of breast cancer through education about early detection and prevention. Despite the overall success of these efforts, breast cancer continues to be a special concern for African-American women. Compared to women from other ethnic and racial groups, African American women experience excess rates of breast cancer morbidity and mortality. Factors that may contribute to the lower breast cancer survival among African American women include differences in screening practices and tumor characteristics.

Two genes related to susceptibility to breast and ovarian cancer—named *BRCA1* and *BRCA2* (breast cancer 1 and breast cancer –2, both early onset)—have been identified, and it is now possible for patients and their high-risk family members to learn whether they carry a cancer-predisposing mutation (altered gene). Recent epidemiological studies have shown that the prevalence of risk-conferring BRCA1 and BRCA2 mutations ranges between 12% to 21% among African American women who have a

The Health of Older Women of African Descent During the Life Course

By Norma D. Thomas, DSW, LSW, ASCW,

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Norma D. Thomas

This article is based on data that were generated through a research study, funded by the Lindback Foundation, entitled Care Management for Older Adults: Development of a Culturally Sensitive Model. This research explored the theory that elders who are members of racial minority groups would use services accessed through care management in the Pennsylvania Area Agency on Aging system in greater numbers and receive higher levels of service in proportion to their needs, provided that the original interview and subsequent assessment and care planning components were delivered in a culturally sensitive manner. Studies done by Thomas^{1, 2} indicated that even when minority elderly, a population known to be at risk,^{3, 4} are served at rates equal to or greater than their numbers in a given service area, the amount of service that they receive is less than expected (ASA, 1992).⁵ This article provides information on the health status of the women in the study, as well as other demographic data and life history information that influence their current state of health.

The study utilized a narrative approach to data gathering. This approach essentially allows respondents to tell their stories in their own manner.⁶ A few guided questions encourage respondents to recount their stories from a life

course perspective. Some questions were standardized so that the results could be compared with those obtained from interviews in which the standardized assessment instrument of the Pennsylvania Department of Aging was used. These questions included descriptions of health status, activities of daily living, income, environment, family support, as well as other assessment domains. However, in addition, a number of nontraditional questions included place of origin, descriptions of the original home environment, work history, description of early life and the community of origin, and, if the respondent came from another part of the country or world, what prompted immigration to this area. The assessments were conducted at the participant's place of residence.

In total, seventy-seven people were assessed, fifty-eight (75%) of them were women. All received services through a variety of programs administered by Area Agencies on Aging in Pennsylvania. Although the original design was limited to people of color, two European Americans, misidentified in the database, were interviewed.

In terms of race, fifty-four (93%) of the women in this study were of African descent, two (3%) were European Americans, one (2%) was Asian, and one (2%) was Latina. The average age of the respondents was 71 years. On the basis of the program requirements, most of the women fell into the category of low income: forty-two (72%) had incomes between \$0.00 and \$14,064; twelve (21%), from \$14,065

Osteoporosis, Calcium, and Phosphorus: A Different Approach to Treatment

By Michael Pazianas, MD



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2030, the number of this older population is expected to reach the 70 million mark.

Aging and Risk of Fracture

The aging body shows a natural decline in the strength of bone (from osteoporosis), as well as a malfunction of organs such as kidney and intestine. Aging reduces the compressive strength of vertebral bone in normal elderly individuals, both men and women, by nearly 65 percent. Therefore, the maximal strength of bone acquired during the second or third decade of life (that is, peak bone mass) usually determines the lifetime risk of osteoporotic fracture. Because women in general live longer than men, their chance of sustaining a fracture is greater. In addition, the peak bone mass of women is lower than that of men, and their rate of bone loss increases significantly during menopause.

Osteoporosis: A Systems Approach

Why do we suffer from osteoporosis? Critical to understanding this “natural” deterioration is to view the skeleton as part of the human body rather than as a system that constitutes an independent entity. The body uses the skeleton as a reservoir for the elements calcium and phosphorus. Although the mechanical integrity of the skeleton depends on the presence of these elements, it is also true that almost every metabolic function in the body depends on them as well. In other words, we need calcium and phosphorus in every cell of our body to stay alive. The skeleton is one of the systems used to ensure adequate supplies of calcium and phosphorus, the intestine and kidneys being

Osteoporosis is a progressive skeletal disease characterized by low bone mass and micro architectural deterioration of bone tissue, with a subsequent increase in bone fragility and susceptibility to fracture. Osteoporosis is the principal cause of hip and vertebral fractures in women, with acceleration of bone loss after the menopause accounting for a much greater age-specific incidence of these fractures among women than among men. As such, osteoporosis is an increasingly important cause of morbidity and mortality.

In the United States, hip fractures alone cause hospitalization, disability, and loss of independence for an estimated 300,000 individuals annually. The national direct expenditures (hospitals and nursing homes) for osteoporotic and associated fractures were estimated at \$17 billion in 2001 (\$47 million each day) - and the cost is rising¹. The population aged 45 to 84 years is responsible for almost two-thirds of the total expenditures associated with osteoporotic fractures.

The U.S. Administration on Aging estimated that, in 1995, 20 million women and 14 million men—or 12.3 percent of the total U.S. population—were age 65 years and older. This total number of 34 million was almost 11 times greater than the 1990 figure of 3.1 million. By the year

the other two major partners in the same contingency plan. The intestine provides both elements by means of food, and the kidney regulates the amount to be removed (excreted) as surplus. As we know, all three systems orchestrate their efforts to maintain the concentrations of calcium and phosphorus in the blood and the fluid surrounding the cells (extra-cellular fluid) at a level that is optimal for cellular function. The integrity of the skeleton is not the primary concern of the regulation of calcium and phosphorus concentrations.

Parathyroid hormone (a product of the parathyroid glands, which are behind the thyroid gland) and 1,25-dihydroxyvitamin D (the active metabolite of vitamin D produced in the kidney) are well-known hormones that coordinate all three systems (parathyroids, kidneys, and skeleton) to keep calcium and phosphorus at normal concentrations in the blood and the tissues of the body. The routine process of continuous breakdown and renewal of bone in the skeleton makes both elements available to fluid that surround the cells in the body (extra-cellular fluid), a common buffer connecting these systems. At the same time, the skeleton uses calcium and phosphorus from the same extra-cellular fluid to build new bone! The net balance of this bidirectional flux of elements is a constant calcium ion concentration estimated at 1.25 millimoles/liter in the buffer (extra-cellular fluid). The kidney, almost certainly, uses the same concentration as a reference point as it regulates the excretion of both elements into the urine. However, if the reference point is not the same in both the kidney and the skeleton, the physiological outcome (ie. loss of calcium from bones would depend on which system has the higher concentration. If the kidney is keeping the calcium concentration below 1.25 millimoles/liter, the skeleton must provide more calcium to raise the concentration up to that point, but it does so in vain. The long-term result is less calcium in the bones. If the kidney's reference concentration of calcium is higher than that of bone, the kidney tries to support increased calcium levels in the extra cellular fluid of the bone.

A New Treatment

At the present time, we can prevent future bone loss, but we can do nothing to restore the bone's already damaged structure. Despite optimism about new anabolic agents, such as Parathyroid Hormone, that may improve our ability to treat the disease, we still must find a way to divert more calcium to bone and help the body maintain a good quality skeleton throughout an individual's lifetime. We could be able to achieve that if we raise the reference point of the calcium (and phosphorus) concentrations in the extra-cellular fluid in the kidney. This approach could offer another avenue of treatment with a more optimistic view concerning the health of the 70 million individuals who will be older than 65 years in the United States in the year 2030.

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<http://osteoporosis.org/docs/47.821117075.html>

"Breast Cancer Education..." Continued from page 3

American women with culturally sensitive genetic risk assessment by integrating cultural health beliefs and values into the education and counseling process. This program also aims to increase our knowledge about the influence of these values and beliefs on decisions about genetic testing, quality of life, and breast cancer prevention and control

practices among African American women.

For more information about this program, please contact Aliya Collier at (215) 746-7168.

5th Annual Regional Research Conference on Ethnic and Minority Health

Policy makers, professors, health administrators and others, all sharing the common interest of current minority health issues came together on July 29th and 30th for the 5th Annual Regional Research Conference on Ethnic and Minority Health of the Penn Center of Excellence. The event was co hosted with the Penn-Cheyney EXPORT Center and the Penn Center for Population Health and Health Disparities and was a two-day conference. The theme of the conference was “Community-Based Participatory Research (CBPR): What, Why and How?”

On Friday, the program began with the keynote speaker of the conference, Stephen B. Thomas, Ph. D., the director for the Center of Minority Health at the University of Pittsburgh Graduate School of Public Health as well as a Philip Halen Professor of Community Health and Social Justice. The focus of his speech was “The Health Black Family Project: A Community-Based Intervention for Elimination of Health Disparities.” Following Dr. Thomas, the program was comprised of a series of short research project presentations. Gary Foster, Ph.D did a presentation called “School Nutrition Policy Fights Childhood Obesity,” Ian Bennett, M.D. presented “Take Charge or Your Health: A Participatory Health Literacy Intervention,” and Chanita Hughes-Halbert, Ph.D. presented “Developing an Academic-Community Partnership for Research in Prostate Cancer.”

Saturday’s event at the Pinn Memorial Church concentrated on developing partnerships in research in order to improve the health of the overall community. Some of the major goals of the symposium were to highlight ways CBPR can improve the health of people in communities, discuss ways in which research can work with communities to make a difference, and talk about what a “true” partnership between research and community really is. The symposium featured many different activities including a skit, question and answer period, a “building trust” event, and a film, along with guest speeches by Ernestine Delmoor of National Black Leadership Initiative on Cancer, Philadelphia Chapter, Courtney Bennett of New York City Mission, and Alex Allen the Vice President of Community Planning and Research Isles, Inc.

The major goal of the conference was to discuss the importance and benefits of Community-Based Participatory Research, and to come up with ways to improve and expand such research. With two full days of discussion about current problems minorities face in the health arena, and potential solutions to solving these problems, including a more active involvement with the community, the conference pinpointed major concerns, and the participants shared many new approaches to fixing the problems.

6th Annual Regional Research Conference

Summer 2006

Date TBA

who are undergoing active treatment for a primary diagnosis of depression and are the parents of school-age children who reside with them. In the parent focus groups, all participants were women with a racial ethnic composition as follows: 67% African American, 28% White, and 5% Latino. To provide another perspective and assess the feasibility of a preventive intervention, focus groups were conducted with the mental health staff at two local centers. A multi-phased process was used to analyze the transcribed interview data based on content analytic methods. The core themes were identified, and the initial sets of categories were reorganized around these core themes.

The findings demonstrated themes that were consistent across both parent and staff focus groups, such as: social support, life stress, child problems, and parenting difficulties. Many parents and providers discussed the lack of social support and feelings of isolation, even when the mothers were married. Social support was particularly salient for single mothers. The mothers identified numerous life stresses that impacted their families' lives including financial strains, adequate child care, community violence, housing problems, and trauma. The depressed mothers had many of the concerns and fears about children's safety and raising children successfully as do all other parents. Although some children are functioning well, others had identified problems including Attention Deficit-Hyperactivity Disorder, learning disability, school difficulties, depression, and legal problems. The data suggest that parenting is not targeted in current mental health treatment for adults. Parents in treatment for depression face multiple challenges that can be intervened. This qualitative information will assist in designing a family-based, culturally appropriate program for prevention of depression.

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to \$22,502; and four (7%), above \$22,503.

Thirty-six (62%) of the women who participated in this study were from the South and had migrated North for the promise of a better economic and social existence. An additional five (9%) had come from states north of Pennsylvania, also in hopes of better economic conditions; while five (9%) were from other parts of the world (Costa Rica, Afghanistan, Barbados, Liberia, and Sierra Leone). Only twelve women (20%) were originally from the immediate Philadelphia area.

The literature describes older members of minority groups as being in *double jeopardy*^{7, 8} that increases in complexity when other aspects of diversity, like gender are added to the equation. However, the stories told by the respondents would reinforce the belief that it is the lifetime accumulation of the effects of low-wage jobs, low incomes, poor housing, and poor overall medical care that has the greatest impact on health in old age.⁹ Overall, African Americans have higher rates of chronic illness than their European American counterparts and experience higher rates of functional disability.^{10, 11}

Many of the respondents were from farming backgrounds. Their families worked as sharecroppers. Several respondents described picking cotton, living in former slave quarters, and coming North during the time of the Great Migration (1910-1940) for a better life. Four of the five people who came from other countries left their homes to flee war or political persecution. One person described fleeing from her village literally under a hail of bullets; another talked about the slaughter of much of her immediate family. Seventeen (29%) of these women who migrated in search of a better life in fact ended up working in positions that required menial labor such as jobs in ship-building factories, on mushroom farms, and as house cleaners ("days-work"). Twenty (35%) worked in para-professional positions such as nurse's aide, dental assistant, salesperson, elevator operator, seamstress, and secretary; ten (17%) held professional positions such as nurse and teacher; seven (12%) reported not working outside of the

home and four (7%) were entrepreneurs in businesses such as hairdresser, seamstress and restaurateur. The women who reported not working outside of the home engaged in either childcare, caregiver for a parent or sibling, or in other activities to raise money such as hosting "card parties".

Many of the women had one or more chronic illnesses that significantly affected their ability to carry out daily activities. In this study, 17 percent of the women had cancer; 31 percent had heart disease; 41 percent had diabetes; 25 percent had had one or more strokes; 57 percent had high blood pressure; 5 percent had Alzheimer's disease; and 53 percent had arthritis severe enough to have a significant impact on their activities of daily living. Several of these women were confined to a wheelchair. They had extreme difficulty in walking, especially going up or down stairs. Several also had a high level of functional disability at relatively young ages.

Although this study's purpose was to examine the results of a culturally based assessment process, it is the richness of the stories of the study respondents that has greater implication for practice, not only in terms of how assessments are performed but also in terms of understanding that aging is a life course phenomenon. Additional information from this study will be available in the near future.

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WOMEN'S HEALTH INTERNET AND JOURNAL RESOURCE

SPECTRUM

INTERNET RESOURCES

FEDERAL

(AHRQ) Agency for Healthcare Research and Quality
www.ahrq.gov (Search: Keyword: Women's Health) Over 11,000 topics and related topics at the forefront of women's health issues.

(CDC) Centers for Disease Control and Prevention, *Office of Women's Health*
<http://www.cdc.gov/doc.do/id/0900f3ec802271b0/>

(FDA) U.S. Food and Drug Administration, *Office of Women's Health*,
www.fda.gov/womens

(HRSA) Health Resources and Service Administration, *Office of Women's Health*, Department of Health and Human Services
www.hrsa.gov/WomensHealth/
Reports available from 2004 Minority Women's Health Summit; 6/16/05 Women's Health Seminar: "Women and Depression;" 6/24/05 Women's Health Seminar: "Racial Disparities in Women's Healthcare"
www.4woman.gov
www.4woman.gov/owh/

National Center for Health Statistics
<http://www.cdc.gov/nchs/>

National Center of Minority Health and Health Disparities, National Institutes of Health
<http://ncmhd.nih.gov/>

(OMH) Office of Minority Health Division of Information and Education/ Department of Health and Human Services
www.omhrc.gov (Search: Keyword: Women's Health)

(OPA) Office of Population Affairs
www.hhs.gov/opa/

(ORWH) Office of Research on Women's Health, National Institute of Health
<http://orwh.od.nih.gov/>

UNIVERSITY

Center for Research on Reproductive and Women's Health www.med.upenn.edu/crrwh

FOCUS on Health and Leadership for Women
<http://www.cceb.upenn.edu/focus/>

University of Pennsylvania Cancer Center
www.oncolink.upenn.edu
(Search: Keyword: Women's Health)

OTHER RESOURCES

Black Women's Health Imperative
<http://www.blackwomenshealth.org/>

National Alliance for Hispanic Health
<http://www.hispanichealth.org/>

National Latina Health Network
<http://www.nlhn.net/>

SUGGESTED RESEARCH ARTICLES

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A Newsletter on Diversity & Multiculturalism

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In Health Care Education, & Research