Volume VIII:
Hispanic Health Issues

Inventory of
DHHS Programs

Survey of Non-Federal
Community

Report of the Secretary's Task Force on

Black & Minority Health

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SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH

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VOLUME VIII

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INTRODUCTION TO THE TASK FORCE REPORT

Background

The Task Force on Black and Minority Health was established by Secretary of Health and Human Services Margaret M. Heckler in response to the striking differences in health status between many minority populations in the United States and the nonminority population.

In January 1984, when Secretary Heckler released the annual report of the Nation's health, Health, United States, 1983, she noted that the health and longevity of all Americans have continued to improve, but the prospects for living full and healthy lives were not shared equally by many minority Americans. Mrs. Heckler called attention to the longstanding and persistent burden of death, disease, and disability experienced by those of Black, Hispanic, Native American, and Asian/Pacific Islander heritage in the United States. Among the most striking differentials are the gap of more than 5 years in life expectancy between Blacks and Whites and the infant mortality rate, which for Blacks has continued to be twice that of Whites. While the differences are particularly evident for Blacks, a group for whom information is most accurate, they are clear for Hispanics, Native Americans, and some groups of Asian/Pacific Islanders as well.

By creating a special Secretarial Task Force to investigate this grave health discrepancy and by establishing an Office of Minority Health to implement the recommendations of the Task Force, Secretary Heckler has taken significant measures toward developing a coordinated strategy to improve the health status of all minority groups.

Dr. Thomas E. Malone, Deputy Director of the National Institutes of Health, was appointed to head the Task Force and 18 senior DHHS executives whose programs affect minority health were selected to serve as primary members of the Task Force. While many DHHS programs significantly benefit minority groups, the formation of this Task Force was unique in that it was the first time that attention was given to an integrated, comprehensive study of minority health concerns.

Charge

Secretary Heckler charged the Task Force with the following duties:

- Study the current health status of Blacks, Hispanics, Native Americans, and Asian/Pacific Islanders.
- Review their ability to gain access to and utilize the health care system.
- Assess factors contributing to the long-term disparities in health status between the minority and nonminority populations.

- Review existing DHHS research and service programs relative to minority health.

- Recommend strategies to redirect Federal resources and programs to narrow the health differences between minorities and nonminorities.

- Suggest strategies by which the public and private sectors can cooperate to bring about improvements in minority health.

Approach

After initial review of national data, the Task Force adopted a study approach based on the statistical technique of "excess deaths" to define the differences in minority health in relation to nonminority health. This method dramatically demonstrated the number of deaths among minorities that would not have occurred had mortality rates for minorities equalled those of nonminorities. The analysis of excess deaths revealed that six specific health areas accounted for more than 80 percent of the higher annual proportion of minority deaths. These areas are:

- Cardiovascular and cerebrovascular diseases
- Cancer
- Chemical dependency
- Diabetes
- Homicide, suicide, and unintentional injuries
- Infant mortality and low birthweight.

Subcommittees were formed to explore why and to what extent these health differences occur and what DHHS can do to reduce the disparity. The subcommittees examined the most recent scientific data available in their specific areas and the physiological, cultural, and societal factors that might contribute to health problems in minority populations.

The Task Force also investigated a number of issues that cut across specific health problem areas yet influence the overall health status of minority groups. Among those reviewed were demographic and social characteristics of Blacks, Hispanics, Native Americans, and Asian/Pacific Islanders; minority needs in health information and education; access to health care services by minorities; and an assessment of health professionals available to minority populations. Special analyses of mortality and morbidity data relevant to minority health also were developed for the use of Task Force. Reports on these issues appear in Volume II.

Resources

More than 40 scientific papers were commissioned to provide recent data and supplementary information to the Task Force and its subcommittees. Much material from the commissioned papers was incorporated into the subcommittee reports; others accompany the full text of the subcommittee reports.

An inventory of DHHS program efforts in minority health was compiled by the Task Force. It includes descriptions of health care, prevention, and research programs sponsored by DHHS that affect minority populations. This is the first such compilation demonstrating the extensive efforts oriented toward minority health within DHHS. An index listing agencies and program titles appears in Volume I. Volume VIII contains more detailed program descriptions as well as telephone numbers of the offices responsible for the administration of these programs.

To supplement its knowledge of minority health issues, the Task Force communicated with individuals and organizations outside the Federal system. Experts in special problem areas such as data analysis, nutrition, or intervention activities presented up-to-date information to the Task Force or the subcommittees. An Hispanic consultant group provided information on health issues affecting Hispanics. A summary of Hispanic health concerns appears in Volume VIII along with an annotated bibliography of selected Hispanic health issues. Papers developed by an Asian/Pacific Islander consultant group accompany the data development report appearing in Volume II.

A nationwide survey of organizations and individuals concerned with minority health issues was conducted. The survey requested opinions about factors influencing health status of minorities, examples of successful programs and suggestions for ways DHHS might better address minority health needs. A summary of responses and a complete listing of the organizations participating in the survey is included in Volume VIII.

Task Force Report

Volume I, the Executive Summary, includes recommendations for department-wide activities to improve minority health status. The recommendations emphasize activities through which DHHS might redirect its resources toward narrowing the disparity between minorities and nonminorities and suggest opportunities for cooperation with nonfederal structures to bring about improvements in minority health. Volume I also contains summaries of the information and data compiled by the Task Force to account for the health status disparity.

Volumes II through VIII contain the complete text of the reports prepared by subcommittees and working groups. They provide extensive background information and data analyses that support the findings and intervention strategies proposed by the subcommittees. The reports are excellent reviews of research and should be regarded as state-of-the-art knowledge on problem areas in minority health. Many of the papers commissioned by the Task Force subcommittees accompany the subcommittee report. They should be extremely useful to those who wish to become familiar in greater depth with selected aspects of the issues that the Task Force analyzed.

The full Task Force report consists of the following volumes:

Volume I: Executive Summary

Volume II: Crosscutting Issues in Minority Health:
- Perspectives on National Health Data for Minorities
- Minority Access to Health Care
- Health Education and Information
- Minority and other Health Professionals Serving Minority Communities

Volume III: Cancer

Volume IV: Cardiovascular and Cerebrovascular Diseases

Volume V: Homicide, Suicide, and Unintentional Injuries

Volume VI: Infant Mortality and Low Birthweight

Volume VII: Chemical Dependency
Diabetes

Volume VIII: Hispanic Health Issues
Survey of the Non-Federal Community
Inventory of DHHS Program Efforts in Minority Health

HISPANIC HEALTH ISSUES

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INTRODUCTION TO HISPANIC HEALTH ISSUES

Presenting an accurate picture of the health status and needs of Hispanic Americans offers a difficult and complex challenge. National data on the health status of Hispanics in the United States are sparse. With the exception of the Hispanic Health and Nutrition Examination Survey (HHANES), few, if any, reports address Hispanic health issues from a national perspective. Thus, there is a gap in information that prevents policy makers, planners, and administrators from identifying appropriate interventions to promote the well-being of many sectors of the Hispanic population in the United States.

Hispanic Advisory Group

To provide more information about the health problems of the Hispanic community, the Task Force on Black and Minority Health worked with several distinguished consultants outside the Federal government and a group of scientific advisors within DHHS who have been active in promoting Hispanic issues in the Department. These individuals were designated the Hispanic Advisory Group. Its tasks were to identify the most pressing health problems faced by Hispanics, to provide the Task Force members with some perspectives and insights into Hispanic health problems, and to suggest activities that could be implemented within the constraints under which the Task Force operated. The long-term goal of this effort is improved health and health services for Hispanics.

Activities of the Hispanic Advisory Group

The Hispanic Advisory Group met to discuss a number of problems they identified as critical to Hispanic health. Three non-Federal scientific consultants--Dr. Sylvia Villarreal, Ms. Henrietta Villaescusa, and Dr. Fernando Trevino--were invited to present their analyses of selected Hispanic health issues to the Task Force. Their topics included an overview of Hispanic history and demographics, current issues in Hispanic health, and national statistical data systems that relate to Hispanic populations. These presentations are summarized in this volume.

An annotated bibliography of selected research topics in Hispanic health, commissioned as a separate activity of the advisory group, also appears in this volume.

Each of the Task Force subcommittees also obtained information from other experts in Hispanic health whose particular field related to the subcommittee topic. For example, a report on Hispanic nutritional status and dietary patterns appears in Volume II, a report on diabetes in Hispanics appears in Volume VII, reports relating to cardiovascular disease in Hispanics appear in Volume IV.

Many of the concerns expressed and activities proposed by the Hispanic Advisory Group have been incorporated into the recommendations of the Task Force and into the more specific activities cited in the "Opportunities for Progress" sections of the subcommittee reports.

Critical Issues Identified by the Hispanic Advisory Group

In their discussions, the Hispanic Advisory Group included the following points as most important in Hispanic health:

- Data.

  -- Vital statistics. At the present time, states vary widely in their vital statistics compilation procedures. In areas of concentrated Hispanic settlement such as Florida and New Jersey, Hispanic identifiers are not entered on birth and death records. Other states such as California assign ethnic identity by matching persons with computerized lists of selected Hispanic surnames. Many Hispanics are not recorded because of uncommon surnames, non-Hispanic married names, or are classified as White or Black based only on appearance.

  -- Population-specific medical descriptors. Subgroups within the Hispanic population, i.e., Cuban, Puerto Rican, or Mexican origin, differ greatly from one other in many variables including demographic descriptors and health needs. The lack of population-specific data sometimes results in misinterpretion of needs. For example, migrant health is sometimes considered the major health problem of Hispanics, but actually, migrants represent only one percent of the total Hispanic population while 88 percent of Hispanics live in urban areas. Specific data in which Hispanics are classified according to major subgroups, will permit the the population's medical needs to be defined more precisely.

  -- Data are not adequate to confirm the leading national health problems for Hispanics.

  -- National data collection efforts should include samples of Hispanic populations large enough to permit reliable analyses of Hispanic health indicators.

- Limited access to health care systems.

  -- Hispanic's limited access to health care facilities and limited use of these services frequently stem from lack of awareness of the services available and the benefits of good health practices. The community health centers now providing care to many Hispanics need to assess their relevance to the population in terms of bilingual and bicultural staff and health information targeted to

local interests. Health promotion messages and health care to Hispanic groups are most effective when delivered within their social frame of reference, focusing on problems known to exist in the community. Widespread communications with the Black community, for example, about hypertension has led to increased responsiveness of that population to health issues in general.

-- Health care to Hispanic groups delivered in accord with Hispanic cultural preferences is important. For example, many Hispanics prefer their medical treatment by one general practitioner rather than by multiple specialists.

-- Mental health care, particularly because of its basis in communication, requires staff members who can not only speak the patients' language but appreciate their cultural orientation as well. Hispanic clients, who historically have had little exposure to the mental health care field, have not benefited from prevention efforts, education, early identification of problems, and intervention.

-- Lack of medical insurance inhibits participation by Hispanics in regular health care. A study by the Rand Corporation showed that many fewer Hispanics have health insurance than many other groups. With health insurance generally being offered by employers, and because this population tends to work for small businesses or for themselves, health-related fringe benefits are minimal at best.

- Lack of role models and advocates within the health professions and related government agencies.

-- Hispanic role models and mentors throughout the health professional community have dual importance for the Hispanic community: they encourage and support Hispanics' joining the health professions, and they can serve as advocates for securing attention to Hispanic concerns. The allied health professions, in particular, stand to gain Hispanic membership if their credibility and accessibility are visible through successful Hispanic role models.

-- More jobs and opportunities for advancement of Hispanic applicants in the Federal government should be encouraged. A stronger commitment by the government's top managers and administrators to increased Hispanic employment, and to identification of more positions where bilingual and bicultural qualifications are specified as selection factors in filling certain positions might promote increased employment of Hispanics.

Hispanic Demographics*

The Hispanic population of the United States, according to the Census Bureau in March 1983, consists of 16 million persons of Spanish ancestry. Mexican Americans represent the largest and probably the most concentrated sector of the Hispanic community, numbering 9.9 million. There are 2 million Puerto Ricans, 1 million Cuban Americans, and 3 million other Hispanics in the United States. Most of the demographic information thus relates to Mexican Americans.

Hispanics, with a median age of 23 years, are younger than the U.S. population as a whole. Among subgroups, the median age of Cubans is 38, while the Puerto Rican and Mexican American median age is 22. Their numbers are rapidly increasing. About 6 percent of families have six or more children. It is projected that Hispanic Americans will comprise the largest minority group in the United States by the year 2000.

Hispanics are poor. About 30 percent of all families are living below the poverty level, compared with 15 percent for the total population. Many have not had the opportunity of schooling. One out of every five adults 25 years of age or older has completed less than five years of school. This pattern is changing, however. In 1970, 45 percent were high school graduates, in 1983, 59 percent had graduated from high school. In 1970, only 5 percent of Hispanics were college graduates; by 1983, the proportion had increased to 10 percent.

Hispanics live in every state, but 60 percent are concentrated in the five southwestern states of Arizona, California, Colorado, New Mexico, and Texas. In 1980, more than 50 percent resided in Texas and California. One-third of the population of New Mexico are Hispanic. One-fifth of the population of Texas and California are Hispanic. One-tenth of the population of Arizona, Colorado, Florida, and New York are Hispanic. Other states with at least 50,000 Hispanics are Illinois, Indiana, Washington, and Ohio.

Hispanics are more urban than the population as a whole, with nearly 88 percent living in urban areas. In 1980, half of all Hispanics resided in central cities--73 percent of Puerto Ricans, 83 percent of Cubans, and 55 percent of Mexican Americans live in cities with a population of 1 million or more. Yet, many programs are planned in the migrant health or rural health field, which do not really affect most of the Hispanic population.

Eighty percent of Hispanics claim Spanish as their mother tongue; 29 percent speak English poorly or not at all; only 10 percent are monolingual in Spanish. Others do not speak Spanish or do so with English accents.

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* This is a summary of remarks prepared by Ms. Henrietta Villaescusa, a consultant to the Task Force on Black and Minority Health.

Lack of adequate housing is a problem for many Hispanics. One-quarter live in overcrowded housing. The unemployment rate among Hispanics is high--13.8 percent, versus 8.3 percent for the general population. The proportion of Hispanic males in the labor force is about 78 percent; for women about 49 percent. The largest area of employment is in manufacturing. More than one-fourth of the working males are in white collar occupations. Hispanic women work in clerical, service, and agricultural occupations, earning on the average, less than $4,000 a year. Twenty-three percent of Hispanic families are headed by women. Forty percent of the 23 percent are Puerto Rican families, while only 13 percent are Mexican American families.

As a whole, 29 percent of the United States population is foreign-born. Contrary to popular belief, only 33 percent of the Hispanic population is foreign-born.

Hispanics are of all colors: black, brown, and white. They are bilingual and bicultural and frequently, multicultural. Hispanics, whether they resided in this country for many generations, or came later as immigrants, have a common bond that unites them all--their language and their culture. Through the years, changes and modifications have occurred in both language and culture, depending on geographic areas and outside influences. Many Hispanics have been able to make these changes and have been accepted into the larger American community. These Americans are not often easily identified as Hispanics because they are light skinned, speak English without an accent, are urban dwellers, and do not look different.

For the past 15 years, Hispanic employees in the Department of Health and Human Services have worked to promote Hispanic issues within the Department. Hispanic Heritage Week, an annual festivity honoring Hispanic Americans, is supported by this group. In 1978, the Hispanic employee organization of the Public Health Service (PHS), which participates in the planning and operation of Hispanic Heritage Week, sponsored a seminar focusing on various issues related to the health status of the different population groups that make up Hispanics in the United States. The proceedings of this seminar, called the Hispanic Mosaic, was the first in a series of annual publications about Hispanic health in the United States. Subsequent seminars in the PHS concentrated on special groups within the Hispanic population, such as Hispanic children, Hispanic families, Hispanic women, Hispanic elderly, and Hispanics in science and research.

Current Issues In Hispanic Health

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CURRENT ISSUES IN HISPANIC HEALTH

Sylvia F. Villarreal, M.D.

According to the U.S. 1980 census, the Hispanic population in the United States totals 14.6 million people. Mexican Americans comprise 59.8 percent; 13.8 percent are of Puerto Rican origin, 5.5 percent Cuban, and 20.9 percent other Hispanic origins (National Center for Health Statistics 1984a). This paper constitutes a review of the literature addressing Hispanic issues of access, burden of illness, certain disease prevalence, Hispanic health providers, suggestions for other areas of research, and recommendations for policy initiatives.

Access

The Robert Wood Johnson Foundation Special Report "Updated Report on Access to Health Care for the American People" addresses the problems of the medically underserved (Weisfield 1983). Access is determined by characteristics of the population, i.e., health status, age, education, employment, income, and insurance status. Access is multifactorial, dependent on indicators of process, such as personal source of health care and insurance status; utilization indicators demonstrating amount and kind of health care received; and satisfaction indicators, such as degree of courtesy shown by the health care provider and cost of primary care visit to the client (Andersen et al. 1981). In order to understand access of the Hispanic population to the health care system, these characteristics will be described individually.

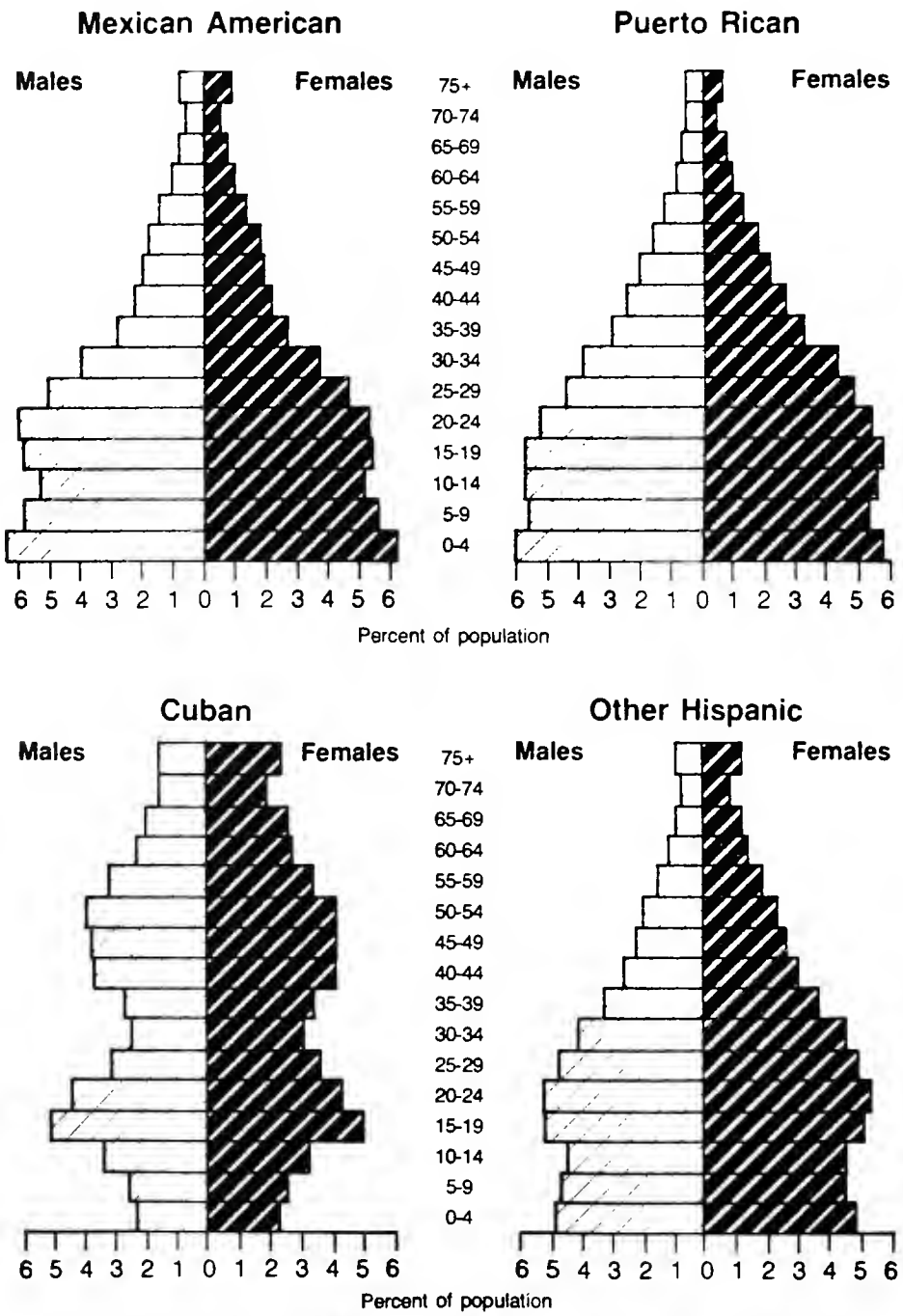
Age

Age distributions of the distinct Hispanic groups vary considerably (Davis et al. 1983). The Cuban-American population is proportionately more elderly, with 16 percent of all Cuban Americans 65 years of age or older (figure 1). This is in contrast to 4 percent of all other Hispanic people in this age group. Mexican Americans are a younger population; 36 percent are under 17 years, compared with 32 percent of all other Hispanic Americans (National Center for Health Statistics 1984a). Being a younger population influences fertility, utilization of health care, and prevalences of certain injuries and illnesses. As will be discussed in the remainder of this paper, this age variable plays a critical role in policy decisions for the different groups of Hispanics.

Education

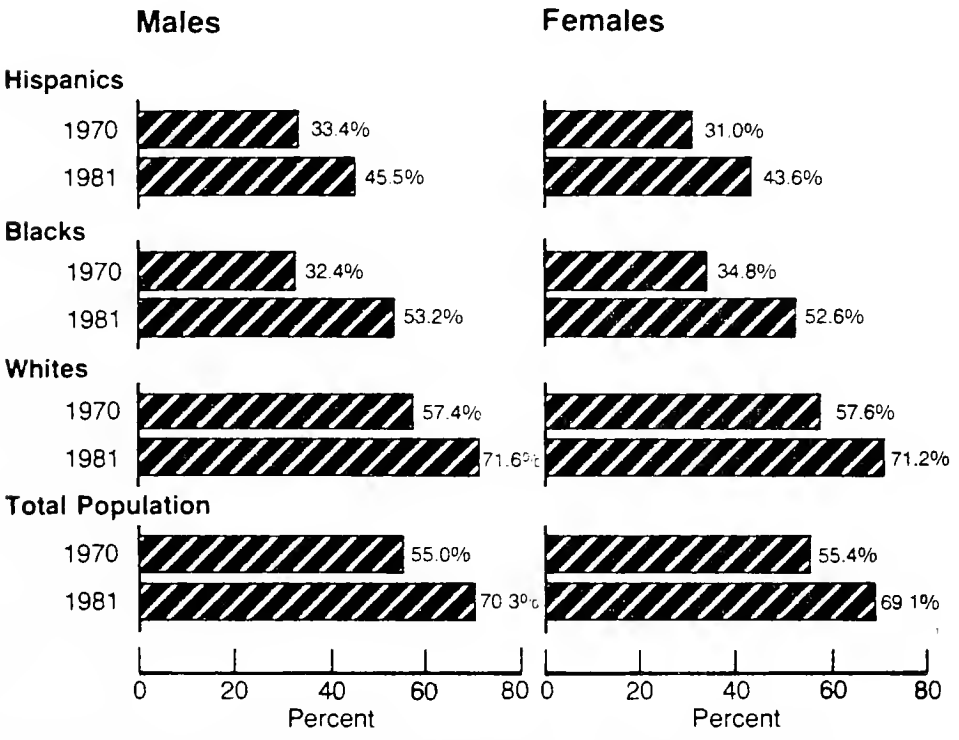
Data for 1981 reveal that 45 percent of Hispanic men over 25 years of age completed high school (figure 2). This compares with 72 percent of white males and 53 percent of black males. Hispanic females did more poorly, with 43.6 percent completing school. This figure becomes higher when examining the rate of teen pregnancy and educational attainment: In 1981, only half of all Hispanic mothers had completed at least 12 years of schooling, compared with 83 percent of white non-Hispanic women and 64 percent of black non-Hispanic women (National Center for Health Statistics

Figure 1. **Age-sex composition of the four Hispanic groups: 1980**



Sources: Bureau of the Census *1980 Census Population. General Population Characteristics.* PC80-1B, various state issues (as presented in Davis *et al.* 1980, p. 11).

Figure 2. **Hispanics, blacks, whites, and total population aged 25 and over who completed 4 years of high school or more: 1970 and 1981.**



Source: Bureau of the Census. "Population Profile of the United States: 1981." *Current Population Reports*. Series P-20, No. 374. 1982. Table 6-3 (as presented in Davis *et al.* 1983, p. 32).

1984b). Thirty-eight percent of Mexican-American, 46 percent of Puerto Rican, and 73 percent of Cuban-American women had attained high school education. The level of education is a powerful indicator of access to health care, for the less education the head of household has, the poorer are the family's health status and access to care (Weisfield 1983).

Employment

Unemployment limits access to health care. The 1982 unemployment rate for the last quarter, among Hispanics over age 20, was more than 40 percent higher than the national average of 10.7 percent (Davis et al. 1983). In 1981, Hispanics were more concentrated in lower paid, lesser skilled occupations than the overall work force. A study done by the U.S. Commission on Civil Rights of minorities' work experience found that Hispanic women, more than any other minority group, are paid a lower wage for equal work (Davis et al, 1983). Sixteen percent of Hispanic families in 1981 were headed by a woman alone (Davis et al. 1983). This figure becomes important when it is known that children and adults in families whose head of household was not in the labor force are worse off in a number of access-related characteristics than the employed and unemployed populations (Weisfield 1983). They tend to characterize their health as fair or poor, their ill health keeps them from the work force, and the vicious cycle of poverty is continued.

Income

In 1981, Hispanics' income was 70 percent that of all white families--a median income of $16,401 for Hispanics, compared with $23,517 for the white population (Davis et al. 1983). Almost a quarter of all Hispanic families fell below the Census Bureau's poverty level, 2.7 times the proportion of all white families so classified (Davis et al. 1983). Hispanic poverty definitely compromises this population's acces to care. The poor more often rank their health status as poor, and poor families have more than twice the probability of being unable or failing to obtain care when they needed it (Weisfield 1983).

Insurance

Hispanics are less likely than any other group to have insurance. One-third have neither private health insurance nor coverage through a governmental program such as Medicare or Medicaid, which compares with 11 percent of the general population (Andersen et al. 1981). The adjusted rate, controlling for equal education and income levels, is still considerably below that of 89 percent for the sample population. This implies that other reasons still exist for limited Hispanic insurance coverage--perhaps factors such as occupational status, underemployment, and part-time jobs and their correlation with adequate health insurance coverage (table 1).

Access Summary

More than 12 percent of Americans appear to have particularly serious trouble coping with the health care system and obtaining care when they need it. Fully one-fifth of Hispanic adults, 2.6 million, are medically disadvantaged: They lack health insurance, do not have a regular source of medical care because of financial problems or because they did not know where to seek care, and they needed care in the previous 12 months but were unable to obtain it (Weisfield 1983). In order to best understand burden of illness, access illuminates the multifactorial problems incorporated in defining illness and ways of approaching its study. Access affects major

Table 1. Process indicators of access to medical care for the Hispanic population of the Southwest

Adjustment variables	Percentage with health insurance	Percentage with regular source of medical care	Percentage with waiting time at regular source of 30 minutes or less
Hispanics			
Unadjusted	66% (5.4)	83% (4.6)	63% (5.4)
Adjusted for need			
Age	67 (5.4)	83 (4.6)	64 (5.4)
Disability days	67 (5.4)	84 (4.6)	65 (5.4)
Worry	67 (5.4)	84 (4.6)	65 (5.4)
All need combined	68 (5.4)	84 (4.6)	64 (5.4)
Adjusted for socioeconomic factors			
Education of head	70 (5.4)	83 (4.6)	70 (5.4)
Family income	70 (5.4)	84 (4.6)	68 (5.4)
Health insurance	–	86 (3.5)	66 (5.4)
Physician-population ratio	67 (5.4)	84 (4.6)	64 (5.4)
All socioeconomic combined	72 (5.4)	85 (4.6)	71 (5.4)
Adjusted for need and socio-economic factors combined	75 (5.1)	86 (3.5)	70 (5.4)
Total U.S. population	89% (0.5)	88% (0.5)	64% (0.9)

Note: Numbers in parentheses in this and subsequent tables are the estimated standard errors.

Source: Andersen et al. 1981, p. 83.

health policy issues of burden of illness, disease prevalence, and Hispanic health manpower.

Burden of Illness

The burden of illness model uses the number of deaths as a measure of global health status (Rice et al. 1976). Until recently, the Hispanic population has not been counted as a distinct racial group in many predominantly Hispanic States. Therefore, data necessary to calculate national Hispanic excess mortality rate are unavailable.

Regional data from Texas on relative causes of death are presented in tables 2 and 3. One cannot extrapolate these numbers to assume population death rate. They are presented to show comparative data and what is currently available in both the literature and vital statistics.

Infant Mortality

Infant mortality is a critical index of health status. California cohort data report 8.8 Hispanic infant deaths/1,000 population, compared with 8.5 white infants and 10.2 black infant deaths (Center of Health Statistics 1984). Table 4 shows the causes of infant mortality in South Texas. The Harris County, Texas, cohort study reveals that Spanish surname neonatal and postneonatal mortality rates were only slightly higher than non-Spanish rates and considerably lower than black rates (Selby et al. 1984). This important paper underscores the fact that, when neonatal, postneonatal, and risk-factor-specific mortality rates were computed from linked birth and infant death records, the paradoxically low mortality rates for high birth order, high maternal age, and delayed or absent prenatal care can be explained only by loss of infant death data secondary to migration and underregistration of deaths. Again, it must be reiterated that excess infant mortality rates are valid indicators of health status only when birth and death registrations are complete and comprehensive for the entire Hispanic population.

Fertility

The 1981 Hispanic fertility rate is the highest of any population, 97.5 births per 1,000 women aged 14-44 years, 50 percent higher than the 65 rate for non-Hispanic women (National Center for Health Statistics 1984b). This averages to 2.5 births per Hispanic woman versus 1.8 per white woman (Davis et al. 1983). In 1980, a differential in birth and fertility rates existed among Mexican-American, Puerto Rican, and Cuban-American groups as illustrated in table 5 and figure 3. In 1981, the fertility rate for Mexican Americans was 112.3, 53 percent higher than Puerto Rican women's rate of 73.5 and more than double the Cuban Americans' rate of 47.2 (National Center for Health Statistics 1984b).

Teen and Unmarried Parentage

Teen birth rates are higher than those of non-Hispanic white women: 19 percent of Mexican-American and 23 percent of Puerto Rican women less than 20 years old had births, compared with 12 percent of white non-Hispanic (National Center for Health Statistics 1984b). Figure 4 shows 1980 data for unmarried women. In 1981, nearly one-fourth of all Hispanic births were to unmarried mothers (National Center of Health Statistics 1984b). The confounding factors of teen, unmarried, low educational status, unemployed, and

Table 2. Ten leading causes of deaths to South Texas residents by sex and ethnicity, 1975

Cause of death	Percent of all causes			
	Anglos		Mexican-Americans	
	Males	Females	Males	Females
Neoplasms, total	20.20	20.40	14.89	18.95
Heart disease*	35.12	34.67	28.88	29.44
Ischemic heart disease	30.31	29.54	24.41	23.57
Other heart diseases	4.81	5.13	4.47	5.87
Cerebrovascular disease	8.32	13.83	7.16	9.66
Diseases of arteries	4.96	4.14	(1.81)	(1.83)
Influenza and pneumonia	2.90	3.06	2.77	3.52
Bronchitis, emphysema, and asthma	2.34	(1.09)	(0.85)	(0.64)
Certain causes of mortality in early infancy	(1.03)	(0.78)	3.89	3.75
Death by violence*	11.70	6.01	17.69	6.45
Accidents	7.67	3.98	11.93	5.08
Suicides	2.95	1.56	(1.65)	(0.38)
Homicides	(1.08)	(0.47)	4.11	(0.99)
Infective and parasitic diseases	(0.85)	(0.81)	(1.59)	2.32
Diabetes mellitis	(1.05)	2.01	3.54	5.31
All other causes	11.53	13.20	16.93	18.13
	n=5738	n=4479	n=3650	n=2639

*The categories "heart disease" and "death by violence" are in this table for the interest of the reader. They are not considered in the ranking of the 10 leading causes of death.

Note: Figures in brackets indicate that the particular cause was not among the leading 10 for that particular sex and ethnic group.

Source: Data on death certificates obtained from the Texas Department of Health Resources (as presented in Lyndon B. Johnson School of Public Affairs 1979, p. 23).

Table 3. Five leading causes of death to South Texas residents by age, group, sex, and ethnicity, 1975

	Percent of all causes			
	Anglos		Mexican-Americans	
Cause of death	Males	Females	Males	Females
Individuals 14 years of age or younger	n=191	n=131	n=371	n=266
Certain causes of mortality in early infancy	30.89	26.72	38.27	37.22
Accidents	21.43	24.08	14.29	13.16
Congenital anomalies	18.85	19.08	17.52	14.29
Neoplasms, total	4.71	9.16	2.97	(4.89)
Influenza and pneumonia	4.71	3.82	4.31	5.64
Infectious and parasitic diseases	(1.56)**	(2.29)	2.97	5.27
All other causes	17.85	14.85	19.67	19.53
Individuals 15 to 29 years of age	n=290	n=99	n=349	n=94
Death by violence*	80.29	64.17	81.69	54.25
Accidents	58.97	40.40	52.44	39.36
Suicide	12.07	15.15	8.31	5.32
Homicide	9.25	8.62	20.92	9.57
Neoplasms, total	7.24	13.13	3.44	11.70
Infective and parasitic diseases	(0.34)	--	2.29	(3.19)
Major cardivascular diseases	3.10	4.04	3.44	11.70
Complications of pregnancy	--	(2.02)	--	5.32
All other causes	9.03	16.64	9.16	20.22
Individuals 30 to 44 years of age	n=231	n=111	n=249	n=133
Death by Violence*	44.60	30.63	53.81	21.81
Accidents	21.65	14.41	30.12	15.04
Suicide	14.29	16.22	(5.22)	(0.75)
Homicide	8.66	--	18.47	6.02
Heart disease*	21.65	31.54	11.24	13.53
Ischemic heart disease	18.61	--	7.23	9.02
Other heart diseases	(3.04)	6.31	(4.01)	4.51
Neoplasms, total	13.85	25.23	5.22	26.31
Cerebrovascular disease	(4.76)	(3.60)	(3.21)	4.51
Diabetes mellitus	(0.43)	3.60	(0.80)	(3.01)
Cirrhosis of liver	(1.73)	(0.90)	7.63	(3.01)
All other causes	12.98	29.73	18.09	27.82

Table 3. Continued

Cause of death	Percent of all causes			
	Anglos		Mexican-Americans	
	Males	Females	Males	Females
Individuals 45 to 64 years of age	n=1568	n=775	n=913	n=537
Heart disease*	37.95	20.90	35.05	26.07
Ischemic heart disease	35.72	16.00	30.12	19.55
Other heart diseases	5.23	4.90	(4.93)	6.52
Death by violence*	12.12	13.68	12.60	(5.21)
Accidents	5.42	(4.65)	8.65	(3.72)
Suicide	6.12	8.52	(1.53)	(0.56)
Neoplasms, total	27.04	37.81	20.48	29.43
Cerebrovascular disease	(3.32)	6.71	6.02	7.64
Diabetes mellitus	(0.89)	(1.94)	(3.83)	7.45
Cirrhosis of liver	(3.50)	(3.13)	6.02	(4.10)
All other causes	15.18	15.83	16.00	20.10
Individuals 65 years or older	n=3454	n=3360	n=1609	n=1764
Heart disease*	39.40	41.01	39.46	37.97
Ischemic heart disease	34.19	35.65	33.73	31.39
Other heart diseases	5.21	5.36	5.73	6.58
Neoplasms, total	19.46	16.88	18.14	17.09
Cerebrovascular disease	11.90	16.70	10.88	12.80
Diseases of arteries	4.46	5.24	(3.06)	(3.04)
Diabetes mellitus	(1.27)	(2.11)	4.93	5.97
All other causes	23.51	18.06	23.53	23.13

*The categories "heart disease" and "death by violence" are placed in this table for the convenience of readers of this report. They are not considered in the ranking of the 10 leading causes.

**Figures in brackets indicate that the particular cause was not among the leading 10 for that particular sex and ethnic group.

Source: Data on death certificates obtained from the Texas Department of Health Resources (as presented in Lyndon B. Johnson School of Public Affairs 1979, p. 24).

Table 4. Cause of specific infant mortality rates per 10,000 live births by ethnicity in South Texas, 1975

	Total	Anglos	Mexican-Americans
Number of births	44,740	12,849	31,789
Number of deaths	717	194	461
Cause of death	Rate per 10,000 live births		
Infective and parasitic diseases	8.7	2.3	10.4
Enteritis and other diarrheal diseases	4.9	2.3	5.0
Septicemia	2.9	-	4.1
Avitaminoses and other nutritional deficiencies	0.4	-	0.6
Menengitis	2.5	3.1	2.2
Influenza and pneumonia	8.0	7.0	7.2
Congenital anomalies	31.5	35.8	26.7
Certain causes of mortality in early infancy	81.4	73.2	75.5
Birth injury	47.6	50.6	42.2
Symptoms and ill-defined conditions	12.5	10.1	7.6
All external causes	7.4	11.7	4.7
Accidents	6.0	7.8	4.4

Source: For deaths: data on death certificates from the Texas Department of Health Resources; for births: Texas Department of Health Resources, unpublished data (as presented in Lyndon B. Johnson School of Public Affairs 1979, p. 23).

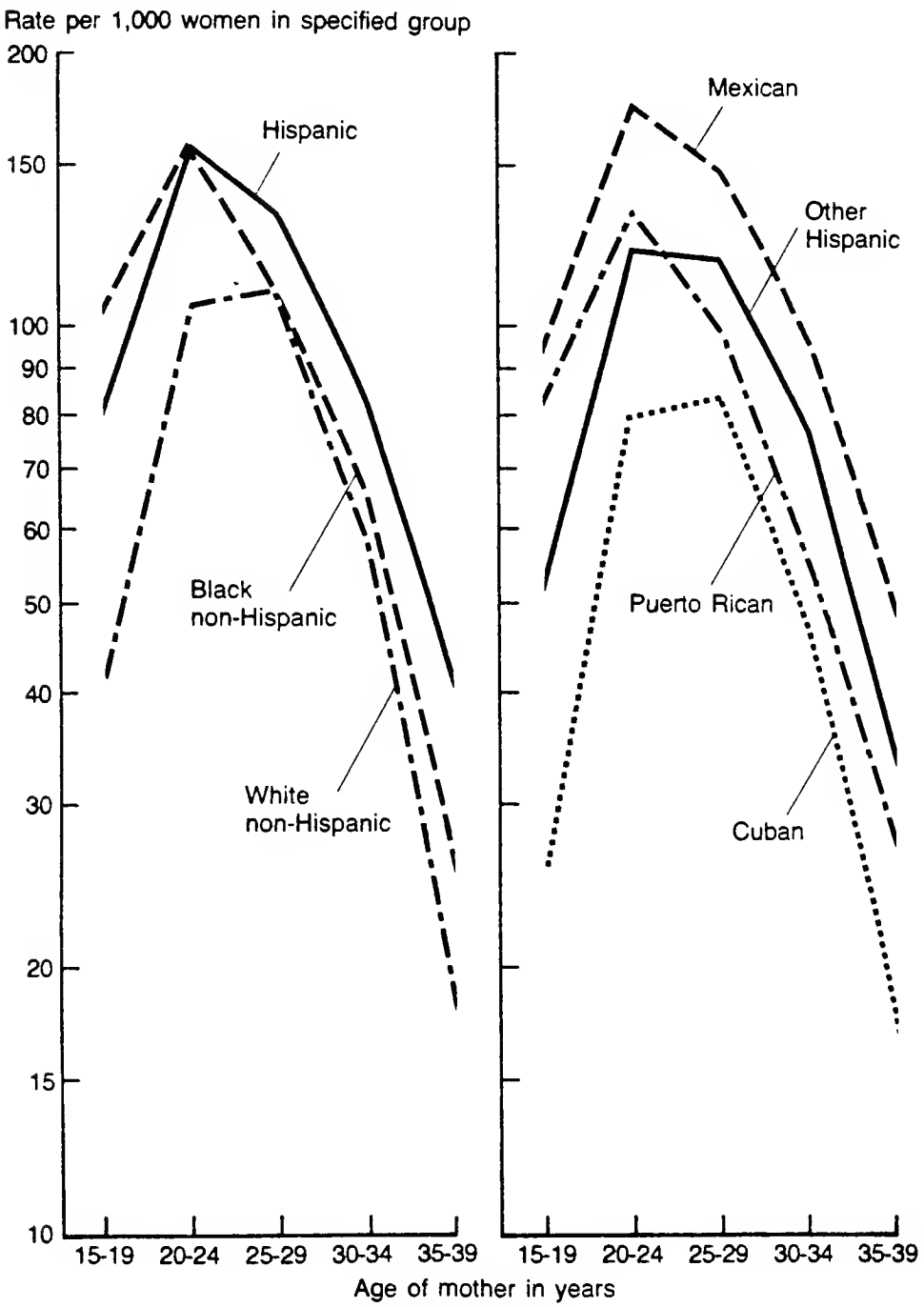
Table 5. Birth rates and fertility rates, by Hispanic origin: nine states, 1979

Ethnic group	Births per 1,000 population	Births per 1,000 women aged 15-44
All origins	15.6	66.7
Non-Hispanic	14.7	63.2
All Hispanic	25.5	100.5
Mexican American	29.6	119.3
Puerto Rican	22.6	80.7
Cuban	8.6	39.7
Other Hispanic	25.7	95.9

Note: The nine States are Arizona, California, Colorado, Florida, Illinois, Indiana, New Jersey, New York, and Ohio.

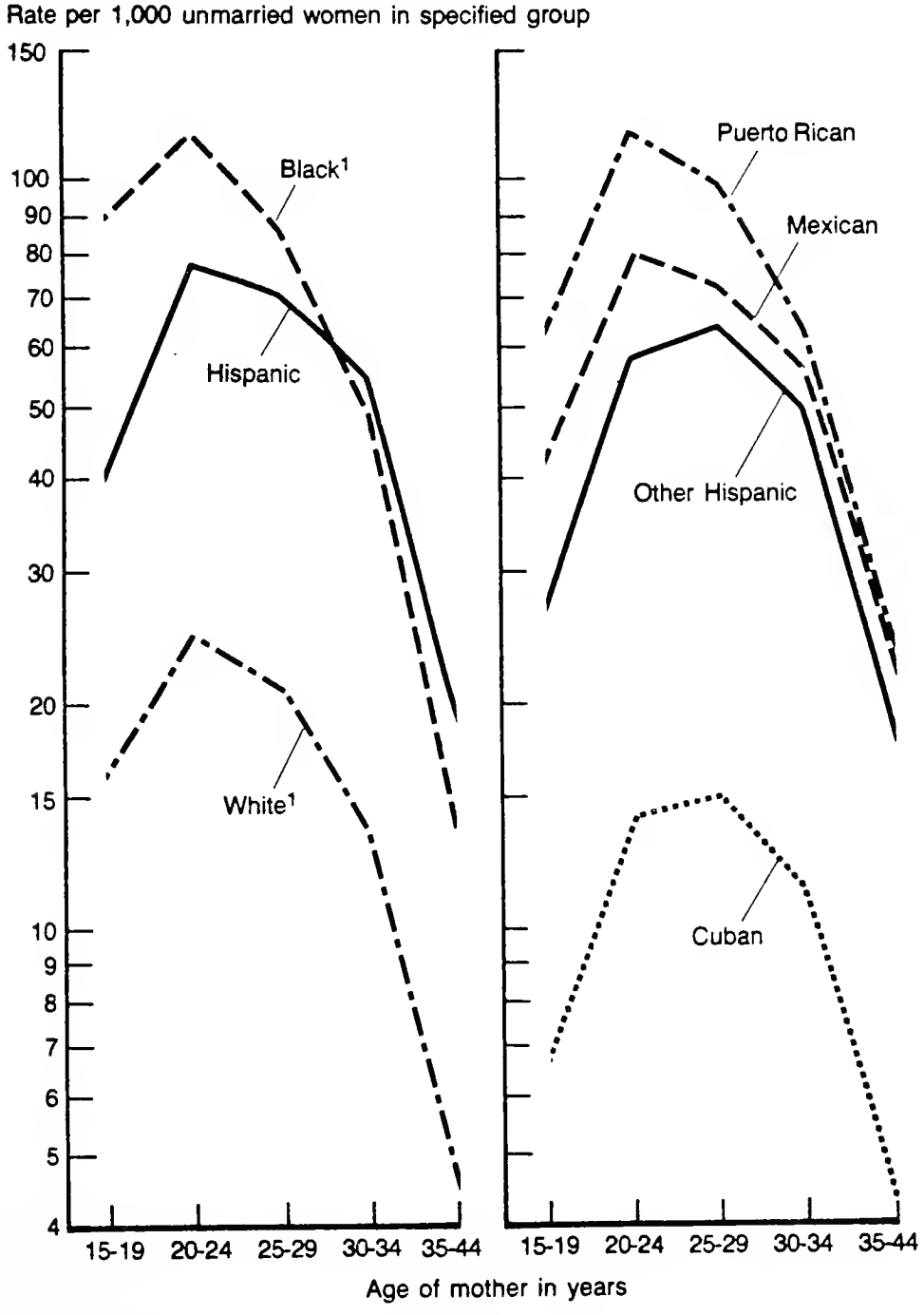
Source: Stephanie J. Ventura. "Births of Hispanic Parentage. 1979." Monthly Vital Statistics Report, Vol. 31, No. 2, Supplement, May 1982 (as presented in National Center for Health Statistics 1983, p. 15).

Figure 3. **Birth rates by age of mother, by Hispanic origin of mother, and by race of child for mothers of non-Hispanic origin: Total of 22 reporting States, 1980.**



Source: National Center for Health Statistics, 1983

Figure 4. **Birth rates for unmarried women by age of mother, by Hispanic origin of mother, and by race of child. Total of 22 reporting States, 1980.**



[1]Rates shown are those for the U.S. white and black populations, regardless of Hispanic origin.
Source: National Center for Health Statistics, 1983.

lack of insurance lead to the perpetuation of the Hispanic feminization of poverty.

Low Birth Weight

Low birth weight incidence for Hispanic babies is generally comparable to that of white non-Hispanic babies. Data for 1981 reveal 5.6 percent of Mexican-American infants and 5.8 percent of Cuban-American infants weighed less than 2,500 grams (National Center for Health Statistics 1984b). At risk for low birth weight were Puerto Rican women with 9.0 percent and black non-Hispanic women with 12.7 percent (table 6). Despite this apparently favorable distribution of birth weights, research has shown that very low birth weight infants of foreign-born Spanish-surname parents had very high neonatal mortality rates (Selby et al. 1984). Again, this underreporting has been attributed to undocumented alien parents fearing deportation or lay midwives fearing prosecution for high-risk pregnancies. The potential majority of very low birth weight Mexican-American infants appear more likely to die than very low birth weight infants of other ethnicity. The term "very low birth weight" needs definition; it was noted to be less than 3 pounds 5 ounces. More research and documentation are needed to assess the true infant mortality of low birth weight Mexican-American infants.

Childhood Immunizations

Vaccination status data are not available for Hispanic children. But data do exist on the incidence of measles, mumps, and rubella in the four border States of Texas, New Mexico, Arizona, and California (Proceedings of the Conference on Maternal and Child Health 1981). This area includes only 18.4 percent of the U.S. population, but a high percentage of the U.S. totals of these preventable diseases are found here, such as 43.9 percent of total measles (first 43 weeks, 1981), 17.3 percent of total mumps, and 32.6 percent of total rubella cases.

Prevalence of Selected Diseases

Malignancies

Hispanics have a lower prevalence of cancer than the overall white population (Menck 1977; Berg 1980). But biliary, stomach, cervical, and renal malignancies have a greater frequency among Hispanics (table 7).

The incidence of gallbladder cancer is extremely rare in the general population. In 350,000 autopsies done in southwest Texas, the age-adjusted incidence of this cancer is 2.2/100,000. For Hispanic women, however, the incidence is 12/100,000, compared with white women's incidence of 4/100,000 (Bornstein 1970). The high incidence of gallbladder carcinoma in the Mexican-American woman has been correlated to obesity, cholesterol stone formation, and diabetes (Bornstein 1970; Fraumeni 1975).

Cervical cancer is twofold greater in prevalence in Hispanic women 40-50 years than in white or Native American women in this age group in the Southwest (Jordan and Key 1981). This could be explained, perhaps, because the critical elements of preventive examinations and education are less in Hispanic women. No data were found to explain the increased incidence of stomach and renal carcinomas.

Table 6. Percent low birth weight by age and Hispanic origin of mother and by race of child for mothers of non-Hispanic origin: total of 22 reporting States, 1981

Age of mother	Origin of mother									
		Hispanic						Non-Hispanic[2]		
	All origins[1,2]	Total	Mexican	Puerto Rican	Cuban	Central and South American	Other and unknown Hispanic	Total[3]	White	Black
All ages	6.9	6.1	5.6	9.0	5.8	5.7	7.0	7.0	5.7	12.7
Under 15	13.0	7.7	6.7	14.2	18.2	–	7.3	14.8	12.8	15.8
15-19	9.4	7.5	6.9	9.9	8.8	7.1	9.0	9.8	7.7	13.9
15-17	10.4	8.0	7.2	10.2	13.4	7.5	10.5	11.1	8.7	14.5
18-19	8.8	7.2	6.7	9.7	7.0	6.9	8.2	9.1	7.3	13.5
20-24	7.1	6.1	5.6	9.2	5.8	5.8	7.0	7.3	5.8	12.9
25-29	5.9	5.3	4.8	8.2	4.7	5.5	6.3	5.9	5.0	11.6
30-34	5.9	5.7	5.4	8.4	5.5	5.6	5.8	6.0	5.2	11.5
35-39	6.8	5.9	5.4	8.1	5.2	5.4	7.5	6.9	5.9	12.1
40-49	8.4	6.7	6.4	10.8	9.8	4.9	6.2	9.1	7.9	13.3

[1]Incudes origin not stated.
[2]Figures for non-Hispanic births are based on a 20-percent sample.
[3]Included races other than white and black.

Source: National Center for Health Statistics 1984b.

Table 7. Relative risks for cancers in Colorado Hispanics compared to Non-Hispanic whites (comparison group rates=100%. Urban and rural values averaged.)

	Percent	
	Men	Women
Biliary tract	298	399
Stomach	280	148
Cervix	-	158
Kidney	126	150
Uterus	-	26
Bladder	38	15
Lung	28	68
Lymphomas	43	43
Large bowel	42	45
Breast	-	48
Prostate	66	-
All cancers	58	66

Source: Berg 1980.

Gallbladder Disease

The incidence of gallbladder disease in Mexican-American women was approximately three times that of black women, with the incidence of white women falling in an intermediate range (Diehl et al. 1980). There was a positive association with increasing age and diabetes, and there was no correlation with cholesterol, use of oral contraceptives, conjugated estrogens, parity, hypertension, menstruation status, or smoking.

Cardiovascular Risk Factors

Hypertension

"Actual" hypertension in Hispanics is midway between the prevalence of whites and blacks (table 8a). Low-income Mexican-American males do have a higher prevalence of actual hypertension than does the white male. Mexican-American males 60-69 years essentially match the very high rates recorded for black males of the same age (table 8b). Hispanic men are at risk for having the level of control, diagnosis, and treatment fall behind that of national average (table 9).

Overweight

The incidence of overweight in the Laredo, Texas, Project, Northern California communities, and HANES I was higher in Hispanics than whites, and lower than that of Pima Indians (tables 10 and 11).

Hyperglycemia

Hyperglycemia, defined as a serum glucose greater than 140 mg./100 ml, was found to be significantly higher in Hispanics than whites but lower than that of Pima Indians (table 12).

Lipids

Serum lipids revealed cholesterol equivalent in Hispanic men and white men but slightly elevated in Hispanic women. Triglyceride levels showed a striking elevation in Hispanic women ages 65-74 (table 13).

Diabetes

Diabetes is a major health problem in the Hispanic population, accounting for increased morbidity and mortality (table 14). Trends now show that age-adjusted mortality from diabetes is decreasing, yet the gap is still enormous between whites and Hispanics in the Southwest (figure 5). Again, these data must take into consideration that approximately 53.5 percent of the population are Mexican Americans living in south Texas in 1975.

Gastrointestinal Disease in Children

No data were found to demonstrate the incidence of acute or chronic diarrheal diseases of Hispanic children. Similar to the typical situation in developing countries, enteritis and diarrhea ranked as the fifth cause of death in the States of Arizona, California, and Texas and the fourth cause of death in New Mexico (table 15). Close proximity to Mexico affords these border States the problems of undeveloped countries: poor water, poor sanitation, poor nutrition, and lack of access to health care.

Injuries and Violence

Injuries and violence constitute the major cause of death of youth and middle-aged Hispanic men (table 3). In a Houston, Texas, study, Hispanic men were three times as likely as white males to be homicide victims. Eighty-six percent of Hispanic victims were killed by Hispanic offenders. Victim and offenders typically lived at the same address or within a mile or two range (Braucht et al. 1980). Little research has gone into the victim-

Table 8a. Mean systolic blood pressure (±SD) in Laredo Project participants and HANES I subjects, by sex

Age (years)	n	Laredo Project	HANES I (1) "Spanish-Mexican American"	HANES I (1) US white	HANES I (1) US black
Men					
35-44	18*	129.2 ± 19.1	124.7 ± 12.8	127.0 ± 14.8	136.7 ± 18.8
45-54	37	134 ± 18.1	140.1 ± 15.0	134.7 ± 19.7	141.7 ± 28.2
55-64	42	132.1 ± 25.7	139.9 ± 19.9	139.6 ± 20.4	144.2 ± 23.0
65-74	30	150.3 ± 29.2	146.0 ± 19.4	146.0 ± 24.1	156.6 ± 28.3
Women					
35-44	34*	119.2 ± 20.6	122.4 ± 19.8	122.6 ± 18.7	130.5 ± 21.4
45-54	93	126.9 ± 18.3	130.0 ± 17.5	131.1 ± 22.2	150.8 ± 35.1
55-64	70	134.8 ± 21.6	144.8 ± 28.0	143.0 ± 25.2	153.4 ± 27.4
65-74	65	155.7 ± 25.5	150.1 ± 21.2	151.6 ± 24.7	161.3 ± 28.7

*Age range 40-44 years for Laredo Project participants.

Table 8b. Mean diastolic blood pressure (±SD) in Laredo Project participants and HANES I subjects, by sex

Age (years)	n	Laredo Project	HANES I (1) "Spanish-Mexican American"	HANES I (1) US white	HANES I (1) US black
Men					
35-44	18*	89.6 ± 13.3	81.8 ± 9.7	84.2 ± 11.3	91.2 ± 12.1
45-54	37	88.3 ± 10.6	86.5 ± 9.3	87.5 ± 12.7	91.9 ± 16.5
55-64	42	82.6 ± 12.6	86.8 ± 7.3	86.4 ± 12.0	93.4 ± 14.1
65-74	30	84.5 ± 11.5	82.4 ± 10.6	84.9 ± 13.0	90.9 ± 14.0
Women					
35-44	34*	79.2 ± 13.0	78.3 ± 11.8	79.3 ± 12.0	86.9 ± 13.7
45-54	93	80.5 ± 9.3	83.7 ± 10.5	82.6 ± 13.1	93.5 ± 15.8
55-64	70	80.9 ± 10.3	85.8 ± 9.9	86.2 ± 12.4	90.6 ± 13.9
65-74	65	77.5 ± 12.4	81.6 ± 10.8	85.4 ± 12.5	90.4 ± 15.9

*Age range 40-44 years for Laredo Project participants.
Source: Stern et al. 1981b.

Table 9. Control of hypertension in Laredo Project participants and IHI* whites and blacks, by sex

Percent	Black (IHI)	Mexican American (Laredo Project)	White (IHI)
Men			
Previously diagnosed	75	71	79
On medication	59	56	59
"Under control"	43	37	44
Women			
Previously diagnosed	89	97	88
On medication	78	87	77
"Under control"	61	77	69

* Impact of Hypertension Information Program (5).
Source: Stern et al. 1981b.

Table 10. Comparison of adiposity indicators between Mexican-Americans and other whites in three Northern California communities

	Scapula skinfold thickness (mm) (mean±S.D.)	Body mass index (mean±S.D.)	Relative weight mean±S.D.)
Men			
Mexican-American (n=119)	20±8	.040±.006	1.26±.20
Other whites (n=587)	18±8	.038±.005	1.21±.16
Test statistic*	2.791	4.111	2.876
Significance	p<0.01	p<0.001	p<0.01
Women			
Mexican-American (n=180)	29±11	.041±.008	1.37±.25
Other whites (n=696)	21±10	.036±.007	1.21±.25
Test statistic*	10.721	9.837	8.085
Significance	p<0.001	p<0.001	p<0.001

* Based on age and community adjusted mean differences.
Source: Stern et al. 1975.

Table 11. Prevalence (%) of overweight by age, sex, and study group

Age (years)	Men				Women			
	HANES I*	Mexican Americans (Laredo Project)		Pima Indians†	HANES I*	Mexican Americans (Laredo Project)		Pima Indians†
		No.	%			No.	%	
10% or more over desirable weight								
35-44	39.1	9/18	50.0‡		36.6	18/34	52.9‡	
45-54	35.7	18/37	48.6		42.9	65/93	69.9	
55-64	34.0	15/42	35.7		50.2	47/70	67.1	
65-74	32.5	10/30	33.3		49.0	36/65	55.4	
20% or more over desirable weight								
35-44	17.0	4/18	22.2‡	62.9	23.3	14/34	41.2‡	90.8
45-54	15.8	12/37	32.4	43.8	27.8	46/93	49.5	85.7
55-64	15.1	10/42	23.8	32.3	34.7	31/70	44.3	66.3
65-74	13.4	6/30	20.0	29.4	31.5	26/65	40.0	58.1
Age-adjusted	15.6		25.8	43.1	29.0		44.8	76.3

* Reference 10.
† 25% overweight, reference 11.
‡ Age range, 40-44 years.
Source: Stern et al. 1981 a.

Table 12. Prevalence (%) of hyperglycemia by age, sex, and study group

HANES II subset*		Mexican Americans (Laredo Project)			Pina Indians†	
Age range (years)	%	Age range (years)	No.	%	Age range (years)	%
Men						
		40-44	1/18	5.6	35-44	39.0
45-59	3.0	45-54	3/37	8.1	45-54	35.4
		55-64	5/42	11.9	55+	21.3
60-75	5.8	65-74	5/30	16.7		
Age-adjusted	4.1			10.9		30.0
Women						
		40-44	3/34	8.8	35-44	32.7
45-59	3.3	45-54	5/93	5.4	45-54	50.5
		55-64	8/70	11.4	55+	42.3
60-75	4.4	65-74	9/65	13.8		
Age-adjusted	3.7			10.1		41.9

* Percentages are based on participating sample persons from about 60% of the 64 HANES II sample locations. The observed values are representative of participating sample persons only. See text for further details.

† Reference 12.

Source: Stern et al. 1981a.

Table 13. Serum cholesterol and triglyceride concentration (mean±SD) in Mexican Americans and Anglos

Age (years)	Men		Women	
	Mexican American (Laredo Project)	Anglo (LRC white*)	Mexican American (Laredo Project)	Anglo (LRC white*)
	Cholesterol (mg/100 ml)			
40-44	241.8±45.8	206.5±36.5	215.5±41.3	194.5±34.4
45-54	220.4±61.6	212.4±36.5	218.5±45.7	210.9±37.9
55-64	224.9±43.9	213.6±37.7	234.6±34.4	227.2±38.2
65-74	207.1±41.7	210.9±34.8	238.6±41.8	228.5±40.1
	Triglyceride (mg/100 ml)			
40-44	217.7±56.1	151.4±146.8	148.3±59.3	105.3±80.0
45-54	190.6±78.5	151.8±116.8	163.0±72.2	116.0±77.7
55-64	170.7±74.8	141.7± 90.4	177.1±67.1	125.9±76.0
65-74	161.9±61.9	133.9±114.2	181.9±86.6	130.2±99.5

Source: Stern at al. 1981a.

Table 14. Ethnic comparison of mortality data for diabetes mellitus

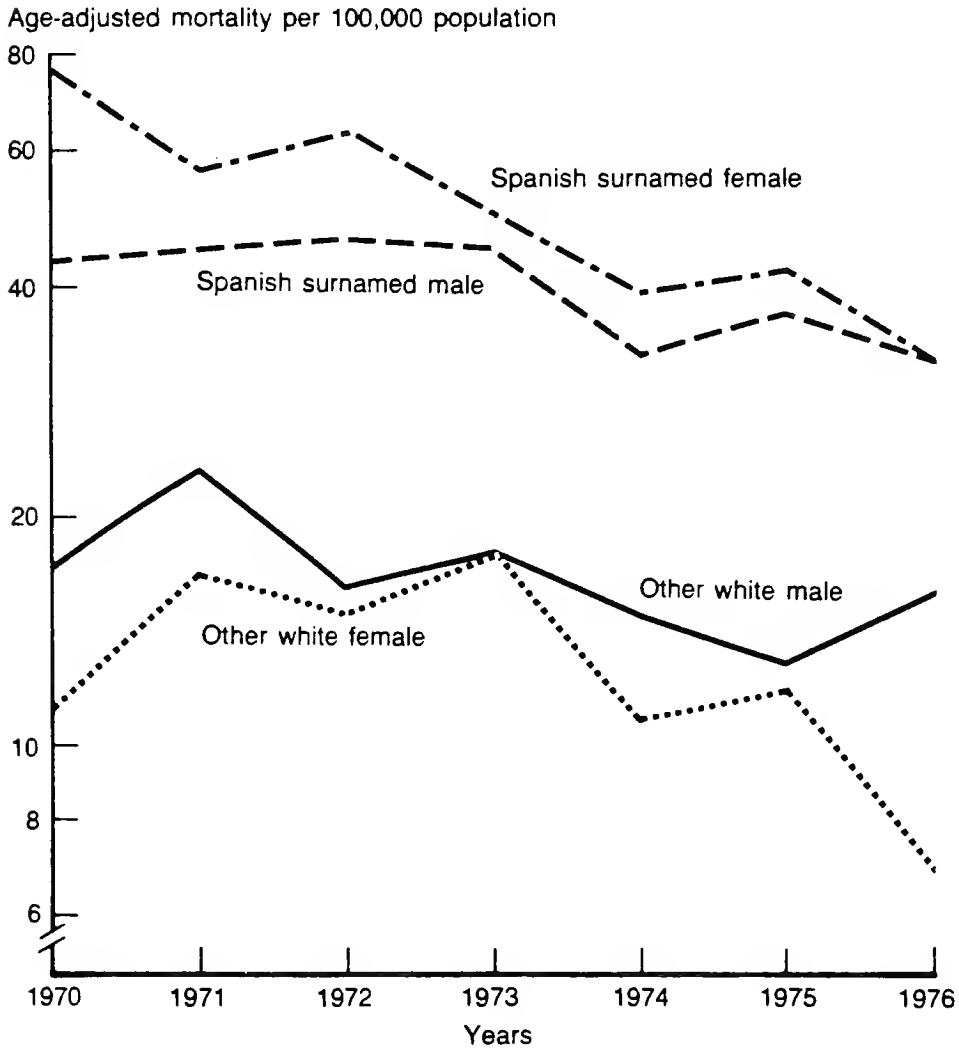
	Anglo		Mex-Am	
	Male	Female	Male	Female
Percent of 1975 deaths from Diabetes in South Texas*	1.05%	2.01%	3.54%	5.31%
Average 1969-1971 deaths from diabetes per 10,000 persons in Texas**	1.18	1.62	2.80	5.30

* Not age adjusted. Juvenile and adult.

** Mexican-American rates are age adjusted to Anglo rates.

Sources: Texas Health Department, 1975 data; Former, Edwin, Jr., "Mortality Differences of 1970 Texas Residents: A Descriptive Study," master's thesis, School of Public Health, University of Texas Health Science Center at Houston; Sept. 1975 (as presented in Lyndon B. Johnson School of Public Affairs 1979).

Figure 5. **Secular trends in age-adjusted diabetes mortality (ICDA code 250) in Bexar County, Texas, 1970-1976 by sex and ethnic group.**



Source: Stern and Gastill, 1978.

Table 15. Leading causes of death in children by rank order, birth through 4 years of age, 1971 (United States-Mexico border

State	Accidents	Congenital anomalies	cancer	Influenza and pneumonia	Enteritis and diarrhea
Arizona	1	2	3	4	5
California	1	2	3	4	5
New Mexico	1	6	6	2	4
Texas	1	2	3	4	5
Baja California Norte	2	**	**	1	3
Chihuahua	4	**	**	2	1
Coahuila	5	**	**	2	1
Nuevo Leon	3	**	**	1	2
Sonora	3	**	**	1	2
Tamaulipas	3	**	**	2	1

** Not in first 10 causes of death.

Source: Proceedings of the Conference on Maternal and Child Health 1981.

precipitated homicide, concomitant alcohol use, and such environmental factors as overcrowding, unemployment, and low education.

Anemia

Anemia was reported in 17-25 percent of all aged Hispanics in the 1970 Health and Nutrition Examination Survey (Lowenstein 1981). This was ascribed to nutritional deficiencies, although parasitic and hereditary etiologies were not excluded.

Nutritional Status

Nutritional deficiencies have been described in multiple studies (Lowenstein 1981). The following deficiences were found to be prevalent in excess in certain age and sex groups:

- Infants: iron, vitamin C
- Children 10-12 years: calcium, vitamins A and C; girls low in iron
- Pregnant and lactating women: calcium, vitamins A and C, iron
- All ages: Serum vitamin A found to be 29.9-50 percent low

Hispanics as Health Care Providers

Data concerning Hispanic enrollment in medical school are sobering (table 16). Although Hispanics comprise 6.4 percent of the total U.S. population, medical school entrants include only 4.9 percent Hispanic students.

Role models and teachers are few (figure 6). Only 2.6 percent of full-time M.D. and M.D./Ph.D. medical school faculty are minority; of those, 8.1 percent are Mexican American and 30 percent Puerto Rican. How can one expect to train more medical professionals when 45 percent of our youth never finish high school? Berryman (1983) of the Rand Corporation believes that Hispanics, blacks, and Native Americans will not soon be increasing their share of graduate science degrees. Inadequate precollege educational preparation is certainly a factor, along with those previously stated as barriers to access for health care.

Further Research Topics

The following are areas and problems in the Hispanic community that warrant further research and, most specifically, the enumeration of Hispanic origin in any census studies.

- Substance abuse: cigarette, drugs, alcohol
- Reproductive health issues: contraceptive use, sterilization, abortions, family planning use
- Migrant and nonmigrant occupational health risks
- Hispanic elderly health care issues
- Bordertown health care issues
- Sexually transmitted diseases
- Access issues for Hispanic health policy

Recommendations

The following recommendations stem from some of the data presented. It is my personal belief that more substantive data must be obtained, Hispanic identifiers must be encouraged in any NIH research, and health care policy

Table 16. Minority women in medical schools

Minority women now make up 20 percent of new first-year female entrants to U.S. medical schools. (See box.) Women, both minority and white, comprise 48 percent of the new entrants. Copies of a summary of the 1983-84 medical school admissions report are available from the Association of American Medical Colleges, Public Affairs Dept., Suite 200, One Dupont Circle, NW, Washington, DC 20036.

First-year new entrants to US medical schools
1983-84

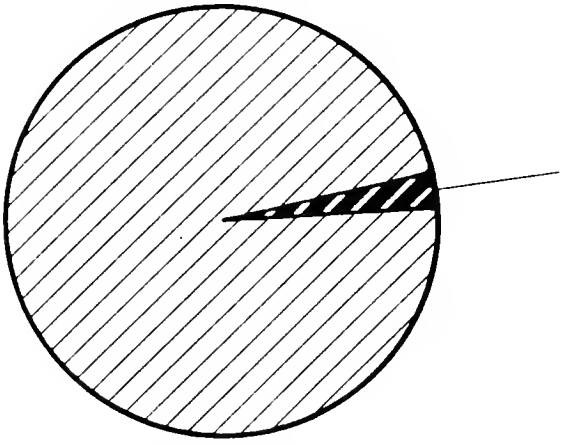
Racial/Ethnic Group	Men	Women	% of Total
US citizens			
White	9,299	4,266	82.3%
Black	527	445	5.9
American Indian/ Alaskan native	33	33	.4
Mexican American/ Chicano	174	91	1.6
Puerto Rican (Mainland)	58	38	.6
Other US students			
Asian or Pacific islander	627	322	5.8
Puerto Rican (commonwealth)	153	69	1.3
Other Hispanic	165	72	1.4
Unidentified	4		
Foreign	70	34	.6
TOTAL	11,110	5,370	

Note: US citizens redefined in 1981-82 and thereafter to include permanent residents. New entrants figures include only students entering medical school for the first time.

Source: 1980-81, Association of American Medical Colleges Student Record System; 1981-82 and thereafter, fall enrollment surveys (as presented in On Campus with Women 1984).

Figure 6. **Underrepresented minority full-time M.D. and M.D./Ph.D. medical faculty (all schools) — 1982**

All full-time M.D. and M.D./Ph.D. medical faculty



Blacks	480
Mexican Americans	66
Native Americans	21
Puerto Ricans	245
Total	812

*For the purpose of the program, the term "minority," as defined by the Association of American Medical Colleges, is used to include blacks, Mexican Americans, native Americans, and Puerto Ricans residing in the United States.

Source: *Participation of Women and Minorities on U.S. Medical School Faculties, 1982.* AAMC. Washington, D.C., July 1982, p. 28.

decisionmaking must realize that much data are regional and most probably an underrepresentation of accurate numbers.

1. Encourage continued recognition by the National Center for Health Statistics of the Hispanic population. Oversampling of Hispanics is necessary to obtain appropriate sample size.
2. Greater allocation of funding is needed for primary research in disease prevalence and sociocultural and economic issues affecting Hispanics, as well as recognition by NIH that younger Hispanic researchers need adequate time, resources, and support.
3. Increases in enrollment and retention of Hispanic students in all fields of health care are indicated. Consider programs such as the University of Colorado, Boulder, Center for Education and Science, Technology and Society's high school curriculum for teaching science and health. This will increase exposure to science and health to Hispanic adolescents.
4. Stanford University's Center for Chicano Studies has developed a Hispanic Health Database. This is an online computer search service with available telecommunications for national access. Funding should be allocated to such databases to facilitate their use and continued expansion. They could be used as national documentation centers.
5. Ecological design research in the subpopulations of Hispanics and their pertinent issues in health care access should take place.
6. Research is needed on the issue of insurance access for Hispanic populations.
7. Researchers interested in secondary data analysis, i.e., Hispanic HANES, should be encouraged. This type of data will enable more information pertinent to Hispanics to be studied and disseminated on a national level.
8. The education of health care providers and policy makers in the Hispanic culture and health issues should be encouraged. Consider the American Medical Association's educational directive on teaching cultural perspectives to practicing physicians. Encourage the development of teaching in medical schools in the Hispanic culture, its diversity, and health care issues.

References

Andersen, R.; Lewis, S.; Giachello, A.L.; et al. Access to medical care among the Hispanic population of the Southwestern United States. Journal of Health and Social Behavior 22(March):78-89, 1981.

Association of American Medical Colleges. Participation of Women and Minorities on U.S. Medical School Faculties 1982. Washington, D.C.: the Association, 1982. p. 28.

Berg, J.W. The real cancer risks in Colorado. Colorado Medicine 77:241-245, 1980.

Berryman, S.E. Special Report: Who Will Do Science? New York: Rockefeller Foundation, 1983.

Bornstein, F.P. Gallbladder carcinoma in the Mexican population of the Southwestern U.S. Pathology and Microbiology 35:189-191, 1970.

Braucht, G.N.; Loya, F.; and Jamieson, K.J. Victims of violent death. Psychological Bulletin 3:300-327, 1980.

Center of Health Statistics. California Cohort Study preliminary data. State of California, Dept. of Health Statistics, August 1984.

Davis, C.; Haub, C.; and Willette, J. U.S. Hispanics: Changing the face of America. Population Bulletin 38(3) (Population Reference Bureau, Inc., Washington, D.C., 1983).

Diehl, A.K.; Stern, M.P.; Ostrower, V.S.; and Friedman, P.C. Prevalence of clinical gallbladder disease in Mexican-American, Anglo, and black women. Southern Medical Journal 73:438-441, 1980.

Fraumeni, J.F. Cancers of the pancreas and biliary tract: Epidemiologic consideration. National Cancer Institute, NIH, 1975.

Jordan, S.W., and Key, C.R. Carcinoma of the cervix in Southwestern American Indians: Results of a cytologic detection program. Cancer 47:2523-2532, 1981.

Lowenstein, F.W. Review of the nutritional status of Spanish Americans based on published and unpublished reports between 1968 and 1978. World Review of Nutrition and Dietetics 37:1-37, 1981.

Lyndon B. Johnson School of Public Affairs. The Health of Mexican-Americans in South Texas. Policy Research Project. Report No. 32. 1979.

Menck, H.R. Cancer incidence in the Mexican-American. National Cancer Institute Monograph 47:103-106, 1977.

National Center for Health Statistics. Trevino, F.M., and Moss, A.J. Health indicators for Hispanic, black, and white Americans. Vital and Health Statistics. Series 10, No. 148. DHHS Pub. No. (PHS) 84-1576. Public

Health Service. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1984a.

National Center for Health Statistics. Ventura, S.J. Births of Hispanic parentage, 1981. Monthly Vital Statistics Report. Vol. 33, No. 8 Supp. DHHS Pub. No. (PHS) 85-1120. Hyattsville, Md.: Public Health Service, 1984b.

National Center for Health Statistics. Ventura, S.J. Births of Hispanic parentage, 1980. Monthly Vital Statistics Report. Vol. 33, No. 6 Supp. DHHS Pub. No. (PHS) 1-18. Hyattsville, Md.: Public Health Service, 1983.

On Campus with Women. University of Washington Press. 13(4), 1984. (Available from Association of American Medical Colleges, Public Affairs Dept., Washington, D.C.)

Proceedings of the Conference on Maternal and Child Health Along the Mexico/U.S. Border. El Paso, Texas, Nov. 13-14, 1981.

Rice, D.P.; Feldman, J.J.; and White, K.L. "The Current Burden of Illness in the United States." Paper presented at the annual meeting of the Institute of Medicine, National Academy of Sciences, October 27, 1976.

Selby, M.L.; Lee, E.S.; Tuttle, D.M.; et al. Validity of the Spanish surname infant mortality rate as a health status indicator for the Mexican-American population. American Journal of Public Health 74:998-1002, 1984.

Stern, M.P., and Gaskill, S.P. Secular trends in ischemic heart disease and stroke mortality from 1970 and 1976 in other whites and Spanish surnamed individuals in Bexar County, Texas. Circulation 58:537-543, 1978.

Stern, M.P., et al. Affluence and cardiovascular risk factors in Mexican-Americans and whites in three northern California communities. Journal of Chronic Diseases 28:623-636, 1975.

Stern, M.P.; Gaskill, S.P.; Allen, C.R., Jr.; et al. Cardiovascular risk factors in Mexican-Americans in Laredo, Texas: I. Prevalence of overweight and diabetes and distribution of serum lipids. American Journal of Epidemiology 113:546-555, 1981a.

Stern, M.P.; Gaskill, S.P.; and Allen, C.R., Jr. Cardiovascular risk factors in Mexican-Americans in Laredo, Texas. II. Prevalence and control of hypertension. American Journal of Epidemiology 113:556-562, 1981b.

Weisfield, V. Robert Wood Johnson Foundation Special Report. 1:3-11, 1983.

National Statistical Data Systems And The Hispanic Population

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NATIONAL STATISTICAL DATA SYSTEMS AND THE HISPANIC POPULATION

Fernando Trevino, Ph.D.

Four years ago, I was teaching at the University of Texas medical school when I received a call from the National Center for Health Statistics (NCHS), telling me they wanted to do the nation's first large-scale study of Hispanic Americans. They asked me if I would come and work for them and help them put together the study from the ground up. Being straight out of graduate school, I knew no better and accepted that challenge. Somehow we made it, and the study will be completed this December (Trevino and Moss 1984). I really think it speaks well to the dedication of the Public Health Service that they were able to put such an effort on and do it as well as they did.

While I was at the National Center, I began to look at some of the other data systems and explore what could or could not be done in terms of producing data on the Hispanic population. One of my main interests in coming to Washington stemmed from the fact that I had been out in the field, like so many of my colleagues. It is very distressing. You are out there, and you see the needs. You are constantly surrounded with poor people. They can't afford medical care. They have great needs, and you can't get the resources to serve them, because you can't prove what their health needs are. I know that all of you working with your agencies recognize the fact that any applicant has to document his or her needs very well in order to be competitive.

I began to get very interested in producing some of those needed data. Today, I would like to share with you my perceptions regarding the three largest data collection systems that are operated in this country. NCHS operates quite a few of them, but I would like to focus on just the three major ones.

Health Interview Survey

The National Health Interview Survey (HIS) is the principal source of information on the health of the civilian noninstitutionalized population of the United States. Since its beginning in 1957, it has served as a continuous survey of approximately 112,000 people per year across the country.

I would like to discuss the HIS in terms of its measurement components, because I think they offer different opportunities for producing Hispanic data. Every one of the 112,000 persons who is interviewed receives a core interview, which consists of three basic types of measures. One records short-term disability measures such as incidence of acute conditions and disability day estimates. It produces figures on average number of days per person per year that people restrict their activities, stay in bed, or miss time from work or school because of illness or injury.

The second type of measure calculates long-term disability on selected chronic conditions and impairments as well as activity limitation. It

produces figures on the proportion of the population who are unable to perform major activities such as working, keeping house, or going to school; the proportion of the population limited in the amount or kind of activity; and the proportion limited in other types of activity because of permanent disability or chronic condition.

Finally, the HIS collects data regarding measures of health services utilization, such as the number of times people see a physician or dentist in the course of a year, the percentage of the population hospitalized each year, and their average length of hospital stay.

For more than 25 years, the HIS has rightfully served as the cornerstone of the national health data collection systems. The HIS produces valuable data by age and sex for the white and black populations. However, until very recently, the HIS had been totally incapable of providing estimates for the Hispanic population. The major limitation of the HIS revolves around the fact that the sample design samples Hispanics in proportion to their representation in the population. Simply stated, this methodology yields too few Hispanics in the sample to allow precise estimates for the Hispanic national origin groups.

Since the core part of the HIS--that is, the questions that are asked--does not change from year to year, we began to study the possibility of combining several years' worth of data and calculating annual averages as a statistical method for increasing the effective sample size. This method turned out to be an effective way of producing many reliable estimates for Hispanics.

We recently completed a report comparing white and black non-Hispanics, Mexican Americans, Puerto Ricans, Cuban Americans, and other Hispanics. This report was based on 3 years of data, 1978 through 1980, and is based on about 323,000 interviews.

The findings of the report reveal the important need for presenting Hispanic data by national origin--that is, not just presenting data for whites, blacks, and Hispanics. You really need to break it out according to national origin. What we found, at least in the measures that we looked at, is that Hispanics usually differ more from each other than they do from non-Hispanics.

We found that whites and blacks are fairly comparable in terms of the number of times they go to the doctor in the course of a year. Whites go 4.8 times a year, and the black population averages 4.6 visits per person per year. In comparison, Cuban Americans and Puerto Ricans go to the doctor much more frequently--6.2 and 6.0 visits, respectively. So, Cuban Americans and Puerto Ricans go to the doctor more frequently than whites and blacks. Mexican Americans, on the other hand, go to the doctor less than anybody else. They average 3.7 visits per person per year.

We found that one-third of all Mexican Americans in the United States do not see a physician in the course of a year. This compares with a fourth of the white and black populations, Cuban Americans, and other Hispanics and one-fifth of Puerto Ricans who do not go to the doctor.

There are really striking differences in terms of dental utilization. We found that fully one-fifth of Mexican Americans 4 years of age and over in this country have never been to a dentist. That proportion is twice the number of black non-Hispanics and seven times the number of white people who also have never been to a dentist in the course of their lives.

Relative to preventive dentistry, we found that almost one-third of Mexican American children between the ages of 4 and 16 have never seen a dentist. This proportion was three times as large as white non-Hispanic children and twice that of other Hispanic children.

Cuban Americans comprise the group most likely to be hospitalized in the course of a year, even after adjusting for age. Mexican Americans, again, are the least likely to be hospitalized. We found that Puerto Ricans and blacks have higher rates of work loss days and are proportionately more likely to report they are limited in their major activity because of illness or injury.

I believe that is really all we are going to be able to produce out of the HIS, except maybe studying the relationships between some of these variables that were investigated. But you really can't do much more with it the way it is now structured. To do any more than that, we would need to consider three recommendations. First, we would have to oversample Hispanics. While aggregating several years of data from the HIS core is effective, it is not efficient and does not allow for a timely analysis of cross-cultural disability and utilization patterns. Simply stated, you have to wait about 5 years--3 years to collect the data, then time to analyze and clean up what you've collected and be able to report it.

The HIS would need to be redesigned to produce reliable estimates for Hispanics on an annual basis as it does for whites and blacks. The recently completed HIS redesign effort recognized the need for data for the black population and accordingly recommended oversampling black non-Hispanics. Unfortunately, it recommended against oversampling Hispanics, making it unlikely that we will have timely data for that population from the HIS.

Another approach that probably should be taken with the HIS is to translate the instruments into Spanish. Eighty percent of Hispanic Americans live in households where Spanish is spoken, and about a third of the population usually speak Spanish. Yet, the questionnaires have never been translated into Spanish.

Currently, the HIS interview procedure calls for the interviewer or some family member who is bilingual to translate freely those questions at the time of interview. I really think this practice seriously hampers the validity and reliability of the data.

Third, besides translating the instruments, we should begin to look at hiring more bilingual interviewers. The HIS interviewers are part-time employees of the U.S. Bureau of the Census. Recently, when we were exploring this option, I asked the Bureau of Census to figure out how many of their interviewers currently were bilingual. Of the 110 interviewers thay had out in the field, only 1 was.

The second part of the HIS is the supplement, which goes into specific topics of interest such as health insurance, dental health, or some other area. These are different every year, and they are administered only to a random subsample of the household. Generally speaking, only one person per household receives the supplement interview. Therefore, you can tell quickly that this reduces the sample size even further.

In addition, the topics change from year to year, so you cannot aggregate the data as we did with the core. You really can't do a whole lot with supplement data. One exception concerned the data on health insurance, which was asked of every member of the household. Fortunately, it was asked every other year in the supplement, so it was possible to aggregate some of those data and to begin to compare Hispanics and non-Hispanics in terms of their health insurance coverage.

In a report that we were able to do for "Health: U.S., 1983," we learned that black non-Hispanics, Puerto Ricans, and Cubans lack health insurance coverage at twice the rate of the white population. Among Mexican Americans, the noncoverage rate is 3 ½ times as great. Indeed, one-half of all Mexican Americans in this country with an annual family income of less than $7,000--and I remind you they have large families, so that is a very low per capita income--do not have any health insurance. This group is the least able to afford out-of-pocket expenditures, which is probably the major reason they stay away from a doctor and the hospital.

At present, the health insurance part of the supplement appears to be the only part that can produce reliable estimates for Hispanics. We may be able to produce estimates of cross-cultural comparisons of smoking, as we have 2 years of data on that for a third of the subsample.

I think my recommendations for the supplement would be the same as those for the HIS core, and that is oversampling Hispanics, translating the instruments, and trying to hire more bilingual interviewers in the field. If this is not possible, if we can't oversample Hispanics for the core part of the HIS, then maybe we could oversample Hispanics for the supplement, for the special interviews that we conduct in relation to the HIS. In this way, over a period of years we could aggregate data from the core and produce estimates, yet, at the same time, be able to produce yearly estimates based on the supplement for the Hispanic population.

Health and Nutrition Examination Survey

The second national data collection system I would like to talk about is the National Health and Nutrition Examination Survey, the HANES. I am somewhat more intimately aware of this system, as I worked with it for 4 years. The HANES is designed to collect data that can best or only be obtained from direct physical examination, clinical and laboratory tests, and related measurement procedures. The HANES is one of our prime sources of prevalence data for specifically defined diseases or conditions of ill health. It also produces normative health-related measurement data with respect to particular parameters such as blood pressure, visual acuity, or serum cholesterol level.

Unfortunately, the sample for the HANES is even smaller than that of the HIS; also, it has never oversampled Hispanics. It, too, was extremely limited in terms of what it could produce. To be honest with you, it has never produced anything on Hispanics.

Interestingly enough, back in the late 1970s, NCHS asked the National Academy for Public Administration to take a look at the HANES Study and to make recommendations on how we could improve the quality and content of the data. They ended up making a very unusual recommendation about the content of the survey. More important, they said that data are missing for very important groups, most notably Hispanics. They recommended that NCHS consider doing a special study of the Hispanic population.

In 1982, we fielded the Hispanic HANES as a supplement to the national HANES. The Hispanic HANES is designed to collect data on Hispanics comparable with those collected previously for the white and black populations. The sample for the Hispanic HANES included Mexican Americans 6 months to 74 years of age living in the five Southwestern States. It also included Puerto Ricans living in the New York City area and Cuban Americans living in Dade County, Florida.

All interviewers for the Hispanic HANES were bilingual, as were physicians, dentists, nutritionists, just about everybody who had to collect data. In the case of X-ray technicians or people who really didn't have to establish a dialog, at least in terms of collecting data, we just provided them with training and they were fairly fluent in Spanish, at least in terms of telling the person to turn this way or stand that way. All of our questionnaires were translated into Spanish with great care, so that these instruments would be appropriate for the three major subgroups we were going to be looking at.

I am really pleased, because I think the Hispanic HANES is going to produce a wealth of data--data that we have needed for so long. Unfortunately, the Hispanic HANES is a one-time study. It will end this December. From that point on, we will have no incoming data regarding this population.

Another drawback is that the Hispanic HANES was a special population study. It sampled only Hispanics. Therefore, for comparative purposes, you need to compare the data with data that were collected for white and blacks either several years before the Hispanic HANES took place or several years afterwards. That poses a few problems.

In addition, the Hispanic HANES did not employ a national sample. The Hispanic HANES findings will be generalizable only to persons of the same national origin who reside in the same geographic area.

The Hispanic HANES was a marvelous first step for the National Center. To ensure the availability of current national epidemiological data for Hispanics, however, all future national HANES should oversample Hispanics as needed to produce reliable estimates for Hispanics by national origin group. The national HANES should capitalize on its experience and continue to utilize bilingual interviewers and questionnaires.

Vital Statistics Records

Registration of vital events in this country is a local and State function. Uniform registration practices and the use of records for national statistics, however, have been established over the years through cooperative agreements between the States and NCHS. It was not until 1978 that NCHS recommended for the first time the addition of a Hispanic identifier for certificates of birth and death.

At present, 22 States use the Hispanic identifier on certificates of death, and 23 States use it on the birth certificate. This provides coverage for about 90 percent of the Hispanic population in the United States. However, we still have some problems with the vital statistics systems.

To date, it is hard to realize, but despite the fact that Hispanics have resided in this country for well over 400 years and constitute the fifth or sixth largest Hispanic population in the world, we still do not know how many Hispanics die each year in the United States. That is a very simple estimate, probably the most simple estimate that exists in the area of public health. But, unfortunately, we do not know. The state of our knowledge of Hispanic health needs would serve as a national embarrassment for even the least developed nation, let alone the country with the most elaborate and most highly financed health monitoring systems in the world. We really ought to consider putting the information obtained from the Hispanic identifier on the data use tapes.

Let me explain that. Right now, we have 22 States that are collecting, can produce, or have data on how many Hispanic deaths occur in their States. We have a big problem with the State of California, where only about 50 percent of the certificates have that item completed. Therefore, the Center has established a policy not to put any of the Hispanic identifiers on the data use tapes that are made available to researchers across the country for any State--not just California, but all of them.

That means that any researcher who wants to look at how many deaths occurred in Arizona or Texas, let's say, has to go to those States and specifically try to get their data use tapes or get that vital statistics office to furnish them the records. It would be a lot simpler if they were just on the data use tapes that are paid for by public monies, and they could use one data tape and use the States that they so wish to use. They would not necessarily have to use California. At present, we will not do that for them, so I think that is one of the reasons we have not seen a lot of research on this data set.

NCHS also should conduct a thorough analysis of the quality of the recent death record identifier data. We have been collecting them for some years. We need to look at some of the most recent data to see how good they are and if they are worthy of being analyzed. If so, NCHS should consider publishing a report on deaths of Hispanic origin as one of its top publication priorities. I can think of no more important finding that the Center could publish at this present time.

The Department of Health and Human Services should support the development and financing of training programs for hospital personnel and funeral

directors to inform them of the use of the vital statistics, their importance to health planning and research, and the protocol for completing the ethnic origin item. Many, if not most, of the error and omissions committed by persons who fill out the vital records could be reduced through proper training. They just simply don't know how to go about doing it.

The Department of Health and Human Services also should consider encouraging the State of California to reconsider its recent legislation that specifies the provision of race and ethnicity as optional on the part of the informant. It is ironic that this legislation was proposed by well-meaning persons to protect the privacy and rights of minority group members. Unfortunately, it has adversely affected the data relative to the health needs of minorities, and it has been, I think, counterproductive.

Since the law mandates that it is optional on the part of the informant, we think that funeral directors and hospital staff are interpreting the law as meaning that they do not have to inquire about race and ethnicity, so, in the case of California, we have half the records that don't even have that item completed. Obviously, you can't do anything with those data. They are too unreliable.

California is at present the only State in the Union that makes reporting of race and ethnicity optional. All the others require it.

NCHS should consider encouraging States and other registration areas to adopt one common origin question. Again, with the individuality of States, we have different States asking the question in different ways. Usually, there are no major differences, but it would be a lot better if we could have all of the States using the same question.

NCHS currently is revising the U.S. Standard Certificate of Death proposed to States for their adoption. It would be both easy and appropriate to keep a Hispanic origin item on the new certificate of death.

Finally, NCHS should encourage States that did not incorporate the Hispanic origin item on their certificate to do so in an effort to increase the coverage rate for Hispanics. Florida includes a Hispanic item on certificates of birth but not on certificates of death, making it impossible currently to produce a mortality rate for the Cuban American population. That should be a priority State.

The 1980 census enumerated slightly more than 14.5 million Hispanics. Adding to this the figure for Puerto Rico, which is not included in the census, would yield well over 3 million more Hispanics. If you consider the possibility of some undocumented workers who were probably missed by the census, and allow for the expansion that has occurred in the fastest growing population from 1980 to 1984, it is probable that well over 20 million Hispanics now are living in this country. Furthermore, demographic projections indicate that our population is doubling in size every 25 years. Should social or economic conditions change in Mexico or in Central or South America, a possibility that is not entirely remote, we could absorb an unprecedented number of documented and nondocumented Hispanic immigrants. We must begin to prepare and plan for the inevitable demographic changes we will experience in the United States.

Reference

Trevino, F.M., and Moss, A.J. Health indicators for Hispanic, black, and white Americans. Vital and Health Statistics. Series 10, No. 148, DHHS Pub. No. (PHS) 84-1576. Public Health Service, National Center for Health Statistics. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1984.

Selected Hispanic Health Issues of the Eighties

An Annotated Bibliography

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INTRODUCTION TO THE HISPANIC BIBLIOGRAPHY

As one of its many efforts to bring information about Hispanics to the members and subcommittees of the Task Force on Black and Minority Health, the Hispanic Advisory Group commissioned an annotated bibliography devoted exclusively to research topics in Hispanic health. While no national data on Hispanic mortality and morbidity were available during the tenure of the Task Force, many local and regional studies existed in the scientific and professional literature which addressed important areas in Hispanic health. Gathered from disparate sources, the bibliography brings this information together for the first time.

The Hispanic Advisory Group anticipates that this collection of research material will aid researchers, health care providers, policy-makers, health planners, and other interested persons in determining areas that need further study, applying current research results to the improvement and/or expansion of health services, facilitating collaborative relationships among investigators, and conducting other activities related to improving the health of the various ethnic groups that make up the Hispanic population in the United States.

Articles, monographs, doctoral dissertations, master's theses, and books included in the bibliography constitute the body of available scientific knowledge about the health conditions of Hispanics. Items met criteria established by the Hispanic Advisory Group: current research, conducted in the continental United States, reported during the time period 1980 to 1985, and published in English.

The topics covered in the bibliography were confined to the specific areas in which the Task Force was interested, including: arthritis and lower back pain, cancer, cardiovascular diseases, chemical dependency, dental health, diabetes, digestive diseases, environment, infant mortality, maternity, nutrition, stress, infectious diseases, respiratory diseases, occupational health, and violence relating to accidents, suicide, and homicide.

In compiling the documents reviewed for the bibliography, more than 40 literature sources were searched for relevant material.

- Computer literature retrieval services such as ERIC (Education Resource Information Center), and MEDLINE, the National Library of Medicine's retrieval system that catalogues more than 800,000 biomedical journal articles.

- National clearinghouses, such as those in maternal and child health, and alcohol information.

- Bibliographies such as Dissertation Abstracts.

- University libraries including those of Loma Linda University, Norris Medical Library of the University of Southern California in Los Angeles, University Research Library, Biomedical Library, and Powell Library of the University of California ar Los Angeles, and Fresno Community Hospital Library.

A group of scientific advisors with expertise in specific areas of Hispanic health abstracted the large amount of research material identified for the bibliography. They were: Dr. David Hayes-Bautista, Dr. Amado Padilla, and Dr. Mary Lou de Leon Siantz.

More than 15,300 documents were screened, 1,036 were read and evaluated, and 217 were abstracted for the bibliography. The bibliography listings are classified into three sections:

- Descriptive studies
- Clinical/scientific studies
- Reports in the popular press

The abstracts are formatted as follows:

- Author(s) listed alphabetically by first author, and year of publication
- Complete title of document
- Source: including information about where the document appeared.
- Abstract/summary of the citation, including number of references.

Each citation has been assigned a number. The subject and title indices which follow the abstract section list the number of the citation, not the page number.

A "0 List" section, included as an appendix, consists of documents that were reviewed but did not meet the criteria for inclusion. These articles, listed according to author, title, and source, but not abstracted, might be very useful for researchers interested in background Hispanic health issues.

Data from the Hispanic Health and Nutrition Examination Survey (HHANES), not available when this bibliography was assembled, will be reported by the National Center for Health Statistics.

HISPANIC BIBLIOGRAPHY CONTENTS

Descriptive Studies

1. Author: Bailey, L. B., Wagner, P.A., Christakis, G.J., Davis, C. G., Appledorf, H., Araujo, P. E., Dorsey, E., & Dinning, J. S. (1982).
   Title: Folacin, and iron status and hematological findings in Black and Spanish American adolescents from urban, low-income households.
   Source: The American Journal of Clinical Nutrition, 35, 1023-1032.
   Abstract: The folacin and iron status of 193 adolescents from urban low income households were evaluated. The sample consisted of 161 Black and 32 Spanish Americans, (nationality unknown), drawn from a section of Miami, Florida. Data are not disaggregated for the Spanish American sample. Hematological and biochemical data demonstrates that folacin and iron status is less than adequate in a significant portion of the total sample. This reduced red-blood-cell folacin concentration suggests that tissue stores of this nutrient are being depleted. It is supposed that the ability of an adolescent to maintain normal hematopoiesis under stress such as pregnancy would be compromised. 34 References.

2. Author: Battin, D. A., Barnes, R. B., Hoffman, D. I., Schachter, J., diZerega, G. S., Yonekura, M., & Lynn, M. (1984).
   Title: Chlamydia trachomatis is not an important cause of abnormal postcoital tests in ovulating patients.
   Source: Fertility and Sterility, 42(2), 233-236.
   Abstract: The possible role of chlamydia trachomatis infections in the etiology of infertility is studied in a sample of 63 consecutive patients undergoing midcycle postcoital tests at the Los Angeles County USC Infertility Clinic. The patients came from an indigent population of predominatly Hispanic origin. Results of the endocervical curettage and blood sample testing showed that chlamydial infections of the endocervix are rare and not commonly associated with poor postcoital tests. Data were not broken down by ethnicity. 15 References.

3. Author: Benavides, G., Silva, B., Cervantes, A., Katona, G., & Alvares, V. (1984).
   Title: HLA-DR4 and rheumatoid arthritis in Mexican Mestizos.

Source: Arthritis and Rheumatism, 27(11), 1317-1318.
Abstract: Forty-nine female and three male patients with rheumatoid athritis were studied. Patients were Mexican mestizos ranging from 31 to 72 years with a mean age of 46.9. Control groups consisted of 301 healthy unrelated Mexican mestizos with the same socioeconomic and ethnic background as that of the patients. HLA typing of the lymphocytes isolated was performed using a modification of the National Institutes Health technique. The established frequency of HLA antigens statistically compared between groups compared by chi-square test with Yates correction. In contrast with previous studies on patients with rheumatoid arthritis, a higher frequency of HLA-DR 4 was not demonstrated. Results suggest that the question of association of HLA with rheumatoid arthritis still remains open. Ethnic differences are involved in this association. 4 References.

4. Author: Bonnheim, M. L. & Korman, M. (1985).
Title: Family interaction and acculturation in Mexican American inhalant users.
Source: Journal of Psychoactive Drugs, 17(1), 25-33.
Abstract: Case-control study of 20 Mexican American families in Houston. Ten subjects were families with an inhalant abuser child; 10 controls matched for ethnicity, income and age of child. Structured scales measuring family interaction and acculturation were applied, and open-ended interviews were videotaped and analyzed via a Family Interaction Q-sort. Families with an inhalant abuser child were found to be more disorganized, confused, inconsistent and internally conflicted than control families. The level of acculturation seemed not to explain inhalant abuse. Family coping skills appear to be more important than level of acculturation in the development of an inhalant abusing child. 38 References.

5. Author: Caetano, R. (1984).
Title: Hispanic drinking patterns in Northern California.
Source: Hispanic Journal of Behavioral Sciences, 6(4),
Abstract: Three independent descriptive, probability samples of drinking of the general population in three counties in Northern California were conducted between 1978 and 1980. Of the total sample of 4,510, 634 (about 14%), were self-

identified as Hispanic, most of whom were of Mexican origin. The major instrument was the Quantity-Frequency Index. About 79% of the Hispanics were interviewed in English. For both men and women in the sample, drinking was positively associated with being young, and single, separated or divorced. For women, drinking was also associated with higher income and education. For men it was associated with being Catholic. The major difference in drinking when compared with the rest of the population in the general sample is that Hispanic males were more prone to more quantity and higher frequency; i.e., they drink more often and drink more on each occasion than the general population. Women tended to drink less than the general population and reported higher rates of abstention and lower rates of use when drinking. 28 References.

6. Author: Caste, C. A., Blodgett, J., Glover, J., & Mojica, M. I. (1980).

Title: Alcohol abuse and parental drinking patterns among mainland Puerto Ricans.

Source: In COSSMHO's Hispanic report on families and youth. Washington, D.C.: National Coalition of Hispanic Mental Health and Human Services Organization.

Abstract: A sample 215 Puerto Ricans, half of whom were selected from an alcoholism client population and half of whom were non-alcoholic controls, were questioned about the quantity/frequency, beverage preferences, social drinking habits and reoccurring family problems of their mothers and fathers. Prevalence of fathers' daily drinking in both groups was so high that no relationship between fathers' pattern and offspring alcoholism could be discerned. However, alcoholic children were significantly more likely to have abstaining mothers (60%). Non-alcoholic mothers participated to varying degrees in social drinking. Few respondents in either group associated parental heavy drinking patterns with reoccurring family problems. 276 References.

7. Author: Chase, H. P., Hambidge, K. M., Barnett, S. E., Houts-Jacobs, M. J., Kris, M. S., Lenz, B. A., & Gillespie, J. (1980).

Title: Low vitamin A and zinc concentrations in Mexican American migrant children with growth retardation.

Source: The Journal of Clinical Nutrition, 33(11), 2346-2349.

Abstract: The purpose of this study was to determine serum vitamin A concentrations, which had been low in earlier surveys (1969 and 1972) and to evaluate zinc nutriture, which had not been done previously. Population was 102 Mexican American preschool children (59 male and 43 female) from migrant farm families who were below the 3rd percentile for height, weight, or head circumference. The population for the study was chosen from the first 102 children detected in the migrant health program who were low in growth parameters. Serum A concentrations were low in 36 of 102 children (35%). Hair zinc concentrations were low in 28 of 96 children (29%) and plasma zinc concentrations were low in 35 of 94 children (37%). The results of the biochemical assays performed suggest that a substantial percentage of the children in this population who have low growth percentiles also have poor vitamin A and zinc nutritional status. There was no correlation of height percentiles with plasma zinc, hair zinc, or serum vitamin A. However, further studies are needed to determine if there is a relationship between growth retardation and zinc and/or vitamin A status in the population. 13 References.

8. Author: Chitwood, D. D., & Chitwood, J. S. (1981).
Title: Treatment program clients and emergency room patients: A comparison of two drug-using samples.

Source: The International Journal of the Addictions, 16(5), 911-925.

Abstract: Traditional substance abusers are described as criminally involved narcotic-addicted non-White male youth. To determine if this profile is applicable to both institutionalized drug abusers and acute substance abusers treated in emergency rooms, data was collected in Miami, Florida, interviews with patients prior to institutionalization and from information and emergency room records on acute abuse patients and by age and sex. The underrepresentation of Hispanic clients was related to drug usage patterns, involvement of the family in providing care, cost of medical care, and under utilization of public health services. Females disproportionately used emergency services, whereas drug treatment programs consisted mostly of males. Furthermore, the

largest age group utilizing the emergency and treatment was in the 18-23 age group. Comparing socioeconomic status between drug treatment program clients and emergency room patients revealed lower educational achievement and occupational position among treatment patients. The data on drug treatment program clients supported the traditional profile for drug abusers; however, the data on emergency room drug-related patients did not. The study suggested reevaluation of drug abuse problems and treatment programs and their organization and utilization with emphasis on providing alternative therapies to nontraditional substance abuses. 16 References.

9. Author: Copeland, D. R., Silberberg, Y., & Pfefferbaum, B. (1983).
Title: Attitudes and practices of families of children in treatment for cancer: A cross-cultural study.
Source: The American Journal of Pediatric Hematology/Oncology, 5(1), 65-71.
Abstract: The purpose of this study was to 1) determine the prevalence of use of unproven cancer therapies in a pediatric oncology population, 2) assess parental attitudes about standard and unproven treatments, 3) determine physician awareness of the use of alternative treatments, and 4) to examine the relationship between sociocultural backgrounds and all of the above. Information concerning the use of unproven treatment methods by families of children being treated for cancer was obtained from 66 parents of children with cancer. Information about parental attitudes toward conventional and alternative treatments and their understanding of them was also collected. In addition, physicians were asked about their knowledge of the patient's use of alternative treatment methods and the source of the information about such treatment. Because the population had a fairly large Hispanic group, a Spanish questionnaire was used for Spanish-speaking parents. Cross-cultural comparisons were made to assess the differences between Hispanics and Anglos in their perception of treatment. The results in terms of prevalence of use were comparable to those obtained in an earlier study. No parents reported the use of laetrile. Significant differences were found between Anglos and Hispanics in their perceptions of the treat-

ment administered at the hospital. 9 References.

10. Author: Cox, R. A., Arnold, D. R., Cook, D., & Lundberg, D. I. (1982).
Title: HLA phenotypes in Mexican Americans with tuberculosis.
Source: American Review of Respiratory Disease, 126, 653-655.
Abstract: The purpose of the present study was to extend investigations of HLA phenotypes in tuberculosis patients to include Mexican Americans and to compare phenotype frequencies in patients with those in healthy, tuberculin skin test positive and healthy, tuberculin skin test negative persons. A total of 200 unrelated Mexican Americans, all with Hispanic maternal and paternal surnames, were used in this study. Ninety-nine patients had pulmonary tuberculosis and one had tuberculous meningitis. One hundred healthy subjects were recruited from the hospital staff. HLA-A,-B, and -C phenotype distributions in the 100 active tuberculin skin test positive and 50 healthy tuberculin skin test negative Mexican Americans. Although differences existed in the phenotype frequencies of 5 antigens (Aw30, Aw33,B7,B15, and B17) among the three study groups, these differences were not significant, using p values that were corrected for the number of antigens tested. Therefore, susceptibility (or resistance) to tuberculosis in Mexican Americans does not appear to be linked to a specific HLA-A, B, and -C phenotype. 20 References.

11. Author: Diehl, A. K. (1983).
Title: Gallstone size and the risk of gallbladder cancer.
Source: The Journal of the American Medical Association, 250 (17), 2323-2326.
Abstract: The medical records of ten hospitals (located in San Antonio, Texas) that maintained cancer registries were examined for 1976-1980, to yield a sample of 81 gallbladder cancer cases. These cases were matched with benign gallbladder disease and with non-gallbladder disease controls. Of the cases, 69.1% were Mexican American. A positive correlation is found between size of gallstone and risk of gallbladder cancer. 15 References.

12. Author: Dodge, R. (1983).
A comparison of the respiratory health of Mexican American and non-Mexican American White children.
Source: Chest, 84(5), 587-592.
Abstract: This study compared the rates of respiratory diseases in Mexican American and non-Mexican American White school children (3rd-5th grade) living in three small towns of Arizona. Participating in the study were 315 Mexican American and 281 non-Mexican American children. Parents of these children were asked to respond to a questionnaire based on a standardized questionnaire of the Tucson Epidemiologic Study of Obstructive Lung Disease. Of the participating 596 subjects, 482 completed acceptable testing of pulmonary function with either of two dry rolling-seal spirometers. The findings reported a 6.5% incidence of asthma among non-Mexican American children and 1.9% among Mexican American subjects. The rates of respiratory symptoms were nearly equal in both groups. Initial and serial testing of pulmonary function showed non-Mexican American children had significantly lower maximum expiratory flows in each year of testing. The methods employed in this study prevented the investigation of the cause of differences in rates of asthma and pulmonary function found. If differences in airway size existed between the two groups, a different maximum expiratory flow rate could have resulted. In addition, if the size of the airways determines the risk of asthma in children, then the findings could have stemmed from a single difference between groups, a difference in airway size. However, it is important to realize that without direct comparisons of the size of airways in the ethnic groups, such a hypothesis is only speculation. Further research is therefore needed to explain the results of this study. 16 References.

13. Author: Escobar, J. I., Randolph, E. T., Puente, G., Spiwak, F., Asamen, J. K., Hill, M., & Hough, R. L. (1983).
Title: Post-tramatic stress disorder in Hispanic Vietnam veterans - clinical phenomenology and sociocultural characteristics.
Source: The Journal of Nervous and Mental Disease, 171 (10), 585-596.

Abstract: Forty-one Mexican-origin Hispanic males being seen between 1979 and 1982 at a Veterans Administration Neighborhood Health Clinic in East Los Angeles comprise the sample to explore the symptomatology for post-traumatic stress disorder (PTSD). Scales utilized include the NIMH Diagnostic Interview Schedule, the Combat Stress Scale, the Social Network Questionnaire and the ARSMA Acculturation Scale. Data were compared with a small control group of Hispanic veterans who had no history of mental or physical disorder (N=18). In addition, data from a sample of 29 Hispanic veterans with schizophrenic disorders were compared. Social networks of the non-symptomatic PTSD group were intermediate in size, had less frequency of contact with network members, and network density was greater. Highly symptomatic PTSD veterans reported significantly smaller networks, fewer contacts ouside the family, and more negative emotions were directed toward family members, than the minimally symptomatic veterans. The levels of acculturation in all three groups seemed similar, but the PTSD group appeared more alienated from their cultural heritage than the other groups. The study concludes that "rap" groups alone may not constitute an adequate therapeutic approach, and that more formal psychiatric therapies should be additionally considered. 46 References.

14. Author: Ferrell, R. E., Hanis, C. L., Aguilar, L., Tulloch, B., Garcia, C., & Schull, W. J. (1984).

Title: Glycosylated hemoglobin determination from capillary blood samples utility in an epidemiologic survey of diabetes.

Source: The American Journal of Epidemiology, 119(2), 159-166.

Abstract: As part of an epidemiologic survey to assess the prevalence of non-insulin-dependent diabetes mellitus (Type II), total glycosylated hemoglobin was measured from capillary blood specimens obtained from a sample of 1880 adult individuals (681 males and 1199 females) of Mexican American ancestry residing in Starr County, Texas, between January 1981 and February 1982. Blood glucose was determined using the Eyetone Reflectance Colorimeter. Diabetic history and medication history were determined by interview and confirmed by a review of the subject's medical records when

possible. No significant difference was found between males and females. Diabetics were found to have significantly higher levels of glycosylated hemoglobin than nondiabetics. However, among diabetics, there was no significant difference between newly diagnosed and known diabetics, and known diabetics taking medication did not differ significantly from those not taking medication. An analysis of the specificity and sensitivity of glycosylated hemoglobin, fasting blood glucose, and casual blood glucose determinations as screening devices in a survey of diabetes prevalence reveals that glycosylated hemoglobin is superior to casual blood glucose determination. The conditions under which various screening devices might be more effective are discussed. 25 References.

15. Author: Frerichs, R. R., Aneshensel, C. S., Clark, V. A., & Yokopenic, P. (1981).
Title: Smoking and depression: A community survey.
Source: American Journal of Public Health, 71(6), 637-640.
Abstract: This study dealt with the epidemiology of depression and help-seeking behavior among Anglos (N=887) and Hispanics (N=116). Smoking status and symptoms of mental depression were determined as part of a cross-sectional community survey of adults in Los Angeles county. Nearly 42 per cent of the males and 31 per cent of the females were current smokers. Smokers compared to nonsmokers reported significantly higher levels of depression as measured by the Center for Epidemiologic Studies-Depression (CES-D) Index (10.01 vs 8.79, $p<.05$). The differences were not significant, however, when analyzed by sex. Furthermore, there were no significant differences in the CES-D score when comparing those who had never smoked, ex-smokers, current smokers who wanted to quit, and current smokers who did not want to quit. After controlling in a linear regression analysis for the effects of income, age, employment status, and sex, none of the smoking status variables contributed significantly to explaining the variance of the CES-D score. While both mental depression and smoking are individually major public health problems, the results of this investigation suggest that there is little relationship between the two in the general community. Ethnic comparisons were not reported for any

of the variables investigated. 16 References.

16. Author: Friedman, J. M., Pachman, L. M., Maryjowski, M. L., Radvany, R. M., Crowe, W. E., Hanson, V., Levinson, J. E., & Spencer, C. H. (1983).
Title: Immunogenetic studies of juvenile dermatomyositis HLA-DR antigen frequencies.
Source: Arthritis and Rheumatism, 26(2), 214-216.
Abstract: This experimental study undertakes a multicenter collaborative investigation of immunogenetic factors involved in juvenile dermatomyositis (JDMS). JDMS is a chronic inflamatory disease of unknown etiology that occurs in children and is characterized by a typical rash and symmetric proximal myopathy often associated with soft tissue calcifications. This study reports the results of typing for HLA-DR antigens in 17 patients from Chicago, 18 from Los Angeles, and 16 from Cincinnati. The Terasaki trays defining antigens were used for typing HLA-DR. The HLA antigen frequencies were compared to patients and controls of similar ethnic origin. Data on normal population frequencies of the HLA-DR antigens were obtained from the joint report of the 8th International Workshop which included 11 Whites, 2 Blacks, and 9 Mexicans. The results show the estimated relative risk of JDMS for Whites with HLA-DR 3 (a gene marker) to be 3.8%, for Blacks it was 12.9% and for Latin Americans it was 18.5%. The HLA association report raises the possibility that JDMS may be an "autoimmune disease". 13 References.

17. Author: Fulmer, R., & Lapidus, L. (1980).
Title: A Study of professed reasons for beginning and continuing heroin use.
Source: The International Journal of the Addictions, 15(5), 631-645.
Abstract: In this empirical study, motives drug addicts profess for using heroin (beginning motives as compared with motives for continuing) and general factors underlying the motive professed by addicts are investigated. Eighty adult male ex-heroin addicts (including an undisclosed number of Puerto Ricans) were given a standardized 27-item interview to investigate their reasons for beginning and continuing heroin use. The relative popularity of motives is presented. Changes in popularity of motives at different stages of addiction were found, and a view of the motivational develop-

ment of addiction is discussed. An oblique rotation factor analysis was used to investigate relationships between motives. The three motives for beginning heroin use professed most often by this sample were pleasure, curiosity, and peer pressure. Seven underlying factors were identified for "beginning" motives, and correlations between the factors suggested two contrasting motivational syndromes. Motives for continuing heroin use also yielded seven factors, but with a different hierarchy of importance. "Continuing" factors were generally more complex and more frequently correlated with each other than "beginning" factors, suggesting that continuing heroin use is a more multidetermined phenomenon than beginning, and one in which it is more difficult to identify discrete motivational syndromes. Implications for future research and treatment are suggested.
18 References.

18. Author: Gardner, Jr., L., Stern, M.P., Haffner, S. M., Gaskill, S. P., Hazuda, H. P., & Relethford, J. H. (1984).
Title: Prevalence of diabetes in Mexican Americans: Relationship to percent of gene pool derived from Native American Sources.
Source: Diabetes, 33(1), 86-92.
Abstract: Estimations of the prevalence of non-insulin dependent diabetes mellitus (NIDDM) in adult Mexican Americans and Anglos in three San Antonio neighborhoods are presented. The study design included an initial home interview followed by a medical examination in a mobile clinic. Data was collected from 1979-1981, and the study published in 1984. The age-adjusted NIDDM rates (both sexes pooled) for Mexican Americans were 14.5%, 10%, and 5% for residents of a low-income (N=496) barrio, a middle-income transitional neighborhood (N=285), and high-income suburb (N-642), respectively. In Mexican American women, though not in men, obesity also declined from barrio to suburbs. The authors have previously shown, however, that, although obesity is an imporatant cause of NIDDM in Mexican Americans, there is a two- to fourfold excess in the rate of NIDDM in this ethnic group over and above that which can be attributed to obesity. They therefore speculated that genetic factors might also contribute to excess NIDDM in this ethnic group. The percent Native

American admixture of Mexican Americans as estimated from skin color measurements was 46% in the barrio, 27% in the transitional neighborhood and 18% in the suburbs. The NIDDM rates in Mexican Americans thus paralleled the proportion of Native American genes. Furthermore, the San Antonio Mexican American rates were intermediate between the NIDDM rates of "full blooded" Pima Indians (49.9%), who presumably have close to 100% Native American genes, and the San Antonio Anglo population (3.0%) and the predominantly Anglo HANES II population (3.1%), both of which presumably have few if any Native American genes. The association of genetic admixture with NIDDM rates suggests that much of the epidemic of NIDDM in Mexican Americans is confined to that part of the population with a substantial Native American heritage. 28 References.

19. Author: Gaskill, S. P., Stern, M. P., Hazuda, H. P., Hoppe, S., Kruski, A., Markides, K. S., & Martin, H. (1981).

Title: Sociocultural and genetic influence on plasma glucose: A comparison of Mexican Americans and Anglos in San Antonio.

Source: Diabetes, 30 (Supp. 1), 139A.

Abstract: Adult-onset diabetes is a major health problem among Native Americans. Thirty-five percent of Mexican Americans share a common heritage with the Native American, as well as a high prevalence of adult-onset diabetes. Studies to see whether the onset of diabetes was of genetic or sociocultural origins were undertaken. The first test given was to indicate index of Native American admixture. This was done by testing for skin color with a photoelectric meter: the darker the skin color, the greater the admixture. The second test was to test for plasma glucose levels. There was a 2-hour glucose tolerance test given to 411 Mexican Americans and 383 Anglo Americans living in a low-income bicultural area and in a high-income suburban community. Summary of the findings indicate that plasma glucose levels were lower in the high-income suburban community than in the low-income bicultural community. When height and weight were controlled, the difference between the two communities remained significant, but the ethnic differences were minimized. There seems to be no apparent relationship between Native American admixture and plasma glucose tolerance levels.

Finally, a plasma glucose tolerance seems to be influenced by a sociocultural factor. Abstract.

20. Author: Gilbert, M. J. (1984, November).
Title: Social epidemiological factors underlying contrasts in Mexican American and Anglo American blue- and white-collar drinking patterns.
Source: Paper presented at the Annual meeting of the American Anthropological Association, Denver, Colorado.
Abstract: In this ethnographic study, the alcohol-related practices and patterns of a sample of thirty-six Anglo and Mexican American blue- and white- collar couples in a California city are compared. The study focuses on a comparison of: (1) expression of sex roles in drinking contexts; (2) range and type of drinking setting and companions; (3) range and kind of activities associated with drinking; (4) proportion of public versus private drinking; (5) the presence or absence of life cycle transition that affect drinking behavior. Findings indicate that differences in drinking settings, occasions, and companions are more strongly linked to social class than ethnicity; however, ethnic differences are more visible across blue-collar than white-collar groups. White-collar couples demonstrate a much wider range and greater number of drinking settings, occasions and companions than blue-collar couples, with a greater focus on couple-oriented drinking. Blue-collar Mexican American drinking is predominently sex-segregated, male oriented and confined to a narrow range of settings and intimate companions. Blue-collar Anglo couples' drinking patterns are far less sex-segregated than their Mexican American counterparts', but similar in terms of limited number and range of companions and settings. 13 References.

21. Author: Glynn, T. J., Pearson, H. W., & Sayers, M. (Eds.) (1983).
Title: Research issues 31: women and drugs.
Source: Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse and Mental Health Administration, National Institute on Drug Abuse.
Abstract: This is a compilation of empirical research abstracts and major reviews of theoretical views on female addiction. The report is

divided into two areas of research: psychosocial and physiological. At the beginning of each abstract is a summary of the research indicating drug, sample size, sample type, age, sex, ethnicity, geographical area,methodology, data collection instrument, date(s) conducted and number of references. These areas are indexed at the end of the volume for quick reference. The report is a follow-up to DRUGS AND PREGNANCY, published in 1975, and shows the direction of drug abuse by women in the 1980s. Over half of the patients treated in emergency rooms in 1980 were women. This new era of research provides wider examination of addiction and pays attention to the singular experience of women as drug abusers. Criticism of research in this field is discussed, such as the overemphasis on the effects of drugs on pregnancies and neonates. Suggested are areas for future research such as the effects of drugs on women's health, identifying the problems associated with drawing into and keeping women on treatment programs, identifying personality, attitude, and demographic characteristics which may lead to potential drug use by women and investigating the growing concern of female drug-induced criminality. 561 References.

22. Author: Goldberg, A. S., Heiner, D. C., Firemark, H. M., & Goldberg, M. A. (1981, February).

Title: Cerebrospinal fluid IgE and the diagnosis of cerebral cysticercosis.

Source: Paper presented in part, at the meeting of the Federation of Western Societies of Neurological Sciences San Francisco, California.

Abstract: Cerebral cysticercosis is a common cause of seizures and other central nervous system disorders and is frequently reported in Mexico, Central and South America. It is known that many parasitic diseases lead to an elevation of serum IgE. This led to a study of cerebrospinal fluid and serum IgE in 69 patients diagnosed with cerebral cysticercosis by pathological, radiological, or clinical criteria. Of the sample, drawn from the Harbor-UCLA Medical Center in Los Angeles, there were 35 Mexican-origin patients: 19 had cysticercosis and 16 did not. A paper disc radioimmunoassay was used to measure CSF and serum IgE. The mean CSF level in Mexicans with cysticercosis was 0.44 IU/ml compared to 0.28 IU/ml in Mexicans without cerebral cysti-

cercosis and 0.07 IU/ml in non-Mexicans without cerebral cysticercosis. No socioeconodemographic controls were used. 12 References.

23. Author: Gregory, E. M., Bessman, A. N., Canawati, H. N. & Sapico, F. L. (1981).
Title: Superoxide dismutase levels of E. coli isolated in diabetic gangrene.
Source: Diabetes, 30(Suppl.1), 139 A.
Abstract: A National Institutes of Health supported study of diabetic patients with infested gangrene identified organisms that may be of multiple varieties, show varying degrees of pathogenicity and have the ability to survive in tissue and to destroy tissues in an infected site. Five E. coli strains were isolated from diabetic infested gangrene patients. Cells were extracted by sonic disruption and synthesize superoxide dismutase (SOD) was measured by the McCord-Fridovich method. Independent estimates of clinical pathogenicity and invasiveness were made and compared with the SOD studies. The preliminary reports indicate that the invasiveness of the E. coli is related to the ability of the organism to SOD. (Journal abstract modified).

24. Author: Gunby, P. (1980).
Title: San Antonio heart study compares ethnic groups.
Source: The Journal of the American Medical Association, 244(3), 225.
Abstract: The University of Texas Heart Science Center, San Antonio, is conducting comprehensive studies of diabetes, high blood pressure, and other cardiovascular risk factors of a broad cross section of the Mexican American population. Individuals of Mexican ancestry make up about 60% of the total United States Hispanic population and San Antonio has a greater proportion of persons of Mexican descent than any other United States city. The study began September, 1979, and will continue until 1982. Interviews were conducted in middle-class neighborhoods of more than 4,000, and are currently being conducted in high-income neighborhoods. In October, 1980, interviewing will begin in low income neighborhoods. Households are selected by random sample and notified in advance by mail. All adults (25-64)in the household are invited to participate. Interviews are conducted about health

knowledge, eating, excercise, smoking habits, family background, attitudes and beliefs, and use of health resources. Individuals are then given a free physical examination in a mobile unit. Those who participate receive the results of their examination, have the results sent to their physicians, and are given general and personalized information about good health habits. Early findings indicate that Anglo Americans have a higher prevalence of diabetes and hypertension, abnormal ECGs and a slightly lower prevalence of high blood cholesterol levels than Mexican Americans. The San Antonio study is supported by grants from the National Heart, Lung, and Blood Institute and the U.S. Department of Agriculture's human nutrition program. O References.

25. Author: Gutgesell, M., Terrell, G., & Labarthe, D. (1981).
Title: Pediatric blood pressure: Ethnic comparisons in a primary care center.
Source: Hypertension, 3(1), 39-46.
Abstract: To determine the age of onset of hypertension, many investigators study childhood patterns of blood pressure. This study reviews the blood pressure (BP) determinations previously recorded in a primary care center serving a low socioeconomic population and compares the systolic blood pressure (SBP) and diastolic blood pressure (DBP) distributions within the clinic population among the three major ethnic groups represented, and also between this clinic population and a recently reported standard population (Task Force for Blood Pressure Control in Children, NHLBI). The study group consisted of 2,810 children 3-17 years of age from the Houston area, of whom 49.2% were of Spanish surname, 23.4% Black, and 27.4% White. As a standard clinic procedure, BP readings were obtained from the right arm with the subject seated. Comparisons of the average SBP by 3-year age groups, by sex, within the clinic population showed that Blacks had higher SBPs than children with Spanish surnames or Whites in all of the five male subgroups and in four of the five female subgroups. Black males had higher DBPs than Spanish or Whites in four of the five subgroups; Black females had higher DBPs in three of the five subgroups. In comparison with the standard population, the overall 95th percentile values for both SBP and DBP were lower. Proportionately,

elevated (BP) readings were most common among Blacks and least common among Whites, but this difference is largely related to body size. These differences between ethnic groups could be accounted for statistically, to a great extent, by adjusting for height and weight, since Blacks were the tallest and heaviest of the three groups. 42 References.

26. Author: Haffner, S. M., Rosenthal, M., Hazuda, H. P., Stern, M. P., & Franco, L. J. (1984).
Title: Evaluation of three potential screening tests for diabetes mellitus in a biethnic population.
Source: Diabetes Care, 7(4), 347-353.
Abstract: This study, published in July, 1984, tested the ability of three potential screening tests for (non-insulin-dependent) diabetes melitus (fasting plasma glucose value > 140mg/dl, 1-h postglucose (PG) load value > or = to 200 mg/dl, and 2-h PG value > 200mg/dl) among 130 diabetic Mexican Americans (MAs) and 50 diabetic Anglo Americans (AAs) using the National Diabetes Data Group criteria as the standard. The subjects, ages 25-64 years, were participants in the San Antonio Heart Study, a population-based survey of diabetes risk factors. The sensitivity of the fasting plasma glucose (FPG) cutpoint in detecting diabetes was low in both AAs (36.0%) and MAs (59.3%) and was related to the age-adjusted prevalence rates of diabetes in the two ethnic groups (AAs, 4.9%; MAs, 10.9%). The 2-h PG load cutpoint had good sensitivity (> 93%) and specificity (>99%) in both ethnic groups. The ethnic difference in the sensitivity of the FPG cutpoint appeared to be related to the greater hyperglycemia of diabetic MAs and their development of diabetes at an earlier age, when compared with diabetic AAs. Nearly 30% of diabetic MAs had FPG value > 200 mg/dl as contrasted with only 10% of diabetic AAs. The difference in severity of hyperglycemia between the ethnic groups appears to be unrelated to ethnic differences in adiposity, pharmacologic treatment, or delay in diagnosis, although longer disease duration in MAs may explain part of the difference. Current investigation is considering whether the greater hyperglycemia in diabetic MAs as opposed to AAs may be related to greater consumption of sucrose and/or certain types of complex carbohydrates. 22 References.

27. Author: Haffner, S. M., Gaskill,S. P., Hazuda, H. P., Gardner, L. I., & Stern, N. P. (1982).
Title: Saturated fat and cholesterol avoidance by Mexican Americans and Anglos: The San Antonio Heart Study.
Source: Clinical Research, 30(2), 237A.
Abstract: A study to assess whether Mexican Americans and Anglos have similar patterns of fat consumption. Data was collected from 388 Anglos and 915 Mexican Americans living in lower, middle, and upper class neighborhoods. Fat avoidance scores among Mexican Americans increased dramatically from low-income barrio to high income suburb. This suggests that fat avoidance in different groups is not a major factor in explaining the similarity between Anglos and Mexicans in the decline in ischemic heart disease. Abstract.

28. Author: Hanis, C. L., Ferrell, R. E., Barton, S. E. Aguilar, L., Garza-Ibarra, A., Tulloch, B. R., Garcia, C. A., & Schull, W. J. (1983).
Title: Diabetes among Mexican Americans in Starr County, Texas.
Source: American Journal of Epidemiology, 118(5), 659-672.
Abstract: A study of Type II (non-insulin dependent) diabetes in a county in south Texas that is 97.9% Spanish ancestry. A random household survey of 2,498 persons was tested for the symptoms of diabetes mellitus. Age-specific prevalence of diabetes for males ranged from 0% in age 15-24 to 17.6% in those over 75 years. Rates for females ranged from 0.4% for those age 15-24 to a high of 19.0% in the 55-64 cohort. In both sexes, the rates are relatively low for those under 45 years, with a sharp increase in those over 45. The sample data are compared with national data and show that Starr County residents have two to five times greater risk. This is compatible with mortality data from Texas showing a high rate of death due to diabetes in counties with 75% or more Spanish ancestry population.
13 References.

29. Author: Hansen, V. E. (Ed.). (1984).
Title: Cardiovascular diseases in Los Angeles, 1979-1981.
Source: Los Angeles, California: American Heart

Association-Greater Los Angeles Affiliate, Inc.

Abstract: This report is on the current status of the major cardiovascular diseases among males and females in Los Angeles County. It is the seventh in a series prepared for the American Heart Association-Greater Los Angeles Affiliate Inc., (AHA-GLAA) by the Division of Epidemiology, School of Public Health, University of California, Los Angeles. Statistics for this report were derived using tapes prepared by the California Department of Health Services and the Los Angeles County Department of Health Services. The mortality patterns described are divided into two chronological sections: 1) 1979-1981 and 2) 1981, the date of most recent mortality information currently available. Maps, tables, and graphs present mortality patterns by sex and race-ethnicity, income, deaths occurring in and out of health facilities, and mortality statistics in the six communities served by the AHA-GLAA. Findings from the 1981 first edition of the report were: 1) heart disease is the leading cause and strokes are the third leading cause of death in Los Angeles County, 2) higher death rates due to all major cardiovascular diseases were for males, 3) Black males had the highest risk of heart disease, followed by White males with Japanese males having the highest mortality rates of both heart disease and strokes in the Asian group, 5) heart disease rates were higher in poor neighborhoods and 6) heart disease deaths among the poor were more likely to occur outside of a health facility. Findings from the 1984 edition of the report were: 1) crude death rates for heart disease declined by 4.4% since 1980 and death by strokes by 10.5%, 2) heart disease remained the most common cause of death during 1981 among all major race-ethnic groups, 3) premature deaths from acute heart attacks accounted for 19,000 potential years of life lost. 0 References.

30. Author: Hazuda, H. P., Hoffner, S. N., Stern, M. P., Rosenthal, M., & Franco, L. J. (1984).

Title: Effects of acculturation and socioeconomic status on obesity and glucose intolerence in Mexican American men and women.

Source: American Journal of Epidimiology, 120, 494A.

Abstract: This study examined whether increasing differences in socioeconomic status and acculturation among Mexican Americans are associated

with differences in obesity and glucose intolerence. A total of 1,241 Mexican American men and women, ages 25-64 years, were randomly selected from three socio-culturally distinct neighborhoods in San Antonio, Texas. Socioeconomic status was measured with the Duncan Socioeconomic Index. Acculturation was measured with a multidimentional scale reflecting adoption during adulthood of Anglo American behaviors, attitudes, and values. Analysis were done using multiple regression with age adjustment. Socioeconmic status was inversely related to obesity in both sexes, but was significant only for women. After adjustment for socioeconomic status, acculturation was inversely and significantly related to obesity in both men and women. Socioeconomic status was inversely related to glucose intolerance in both sexes, but significant only for women. After adjustment for socioeconomic status, acculturation was inversely related to glucose intolerance in both sexes. This relationship was not significant in women, but was highly significant in men, and remained significant even after adjusting for obesity. Findings suggest that in women socioeconomic status is more important than acculturation for obesity and glucose intolerance. For men, acculturation appear to be the most important factor, especially for glucose tolerance. (Abstract modified).

31. Author: Hazuda, H. P., Stern, M. P., & Gaskill, S. P. (1982).
Title: Ethnic and social class differences related to CHD mortality decline: The San Antonio Heart Study.
Source: Clinical Research, 30(2), 237A.
Abstract: A study to determine what factors have led to the decline in coronary heart disease among Hispanics. Data was collected from a random sample of 937 Mexican Americans and 400 Anglos in a higher, middle, and lower class San Antonio neighborhood. The three factors examined were: 1) knowledge of preventive behaviors, 2) knowledge of the major heart attack symptoms, and 3) awareness of the need for prompt action. Three times as many Mexican Americans scored zero on Point 1. Four times as many Mexican Americans scored zero on Point 2. Smallest ethnic difference was in Point 3: 73% for Mexican Americans compared to 80% for Anglos. These differences

fail to explain the similarity in the decline of coronary heart disease between Mexican Americans and Anglos. (Journal abstract modified).

32. Author: Hazuda, H. P., Stern, M. P., Gaskill, S. P., Haffner, S. M., & Gardner, L. I. (1983).
Title: Ethnic differences in health knowledge and behavior related to the prevention and treatment of coronary heart disease: The San Antonio Heart Study.
Source: American Journal of Epidemiology, 117(6), 717-728.
Abstract: A sample of 1,925 Mexican-origin Hispanics was sampled between 1979 and 1981, as part of the San Antonio Heart Study. A special algorithm was developed to screen out both non-Hispanics, and non-Mexican origin Hispanics. This algorithm utilized interviewer identification, surnames of parents and reported ethnicity of grandparents. The sample was stratified by being carried out in three neighborhoods of distinct socioeconomic characteristics: low-income barrio, a transitional neighborhhood, and a suburb. An Anglo sample was simultaneously taken in a transitional and suburban area. Questions were asked regarding knowledge of coronary heart disease (CHD) and preventive behavior. When controlled for the three income strata, knowledge was not particularly high, but it was somewhat higher among the Anglo than the Mexican American of similar socioeconomic background. Preventive behavior was also some what low, but higher for Anglos than for Mexican Americans. There was a high awareness of the need for prompt medical attention in both groups, prompting speculation that prompt access to treatment when coronary emergencies occur may have made a relatively greater contribution to CHD mortality decline in both Mexican Americans and Anglos than did changes in lifestyle. 17 References.

33. Author: Hettig, J. L. (1982).
Title: The relationship between levels of information about uterine cancer and pap smear usage in low-income Hispanic population.
Source: Ann Arbor, MI: University Microfilms International No. 1320252.
Abstract: The purpose of this study was to establish if a relationship existed between level of infor-

mation about uterine cancer and the utilization of pap smears in a low-income, Hispanic population. Seventy-three Hispanic women attending a prenatal clinic were administered a 10-item questionnaire. Data were analyzed utilizing a chi square. A statistically significant relationship between uterine cancer information level and pap smear use was found. The findings indicated that while this relationship exists, a majority of women had no such information. Therefore, a target group must be reached with pap smear information. This is an important consideration for health care providers, especially nurses.
31 References.

34. Author: Holck, S. E., Warren, C. W., Smith, J. C., & Rochat, R. W. (1984).
Title: Alcohol consumption among Mexican American and Anglo women: Results of a survey along the U.S.-Mexico Border.
Source: Journal of Studies on Alcohol, 45(2), 149-154.
Abstract: A review of U.S. alcohol consumption literature reveals two recurrent points: 1) Mexican American women are more likely than both Mexican American men and Anglo women to be abstainers or light drinkers, and 2) the acculturation of Mexican American women into the Anglo American culture seems to add stresses that are associated with increased alcohol use. In this study, a household probability survey was conducted of 1233 Mexican American women and 798 Anglo women residing along the U.S.-Mexico border. A higher proportion of abstainers was found among the Mexican Americans than among the Anglos in almost every social and demographic category examined (age, marital status, education and employment status). Because the level of alcohol consumption increased markedly with the years of education completed, most of the overall ethnic differences observed could be accounted for by the generally lower level of education among the Mexican Americans. However, ethnic subgroups of Mexican American women reported different levels of alcohol consumption that could not be accounted for by differences in education, suggesting that additional ethnic factors contribute to drinking patterns. 16 References.

35. Author: Hsu, K. (1984).

Title: Thirty years after isoniazid: Its impact on tuberculosis in children and adolescents.

Source: The Journal of the American Medical Association, 25(10), 1283-1285.

Abstract: This is the final report of 30 years of observation of isoniazid prophylaxis and chemotherapy of tuberculosis in children. It includes 2,494 patients of whom 51% were Black, 30% White, and 19% Hispanic who completed a course of prescribed therapy in Houston and who had been under observation for a total of 15,943 person-years. The effectiveness of isoniazid prophylaxis which refers to treatment of subclinical infection for prevention of covert disease was best demonstrated in those children infected before 4 years of age, because none of them have experienced overt disease. Chemotherapy refers to treatment of overt pulmonary tuberculosis and was effective for existing disease in all ages and prevented dissemination. Of those treated for pulmonary tuberculosis during childhood, the striking absence of adolescent reactivation points to the likelihood of a permanent cure. Adequate drug therapy is the key to successful treatment. 10 References.

36. Author: Humble, C. G., Samet, J. M., Pathak, D. R., & Skipper, B. J. (1985).

Title: Cigarette smoking and lung cancer in "Hispanic" Whites and other Whites in New Mexico.

Source: American Journal of Public Health, 75(2), 145-148.

Abstract: A case-control study comparing White and Hispanic lung cancer patients with smoking causes. Of a total sample of 1,290, 362 were Hispanic. The total of 521 lung cancer cases were those reported from the New Mexico Tumor Registry for 1982. 156 cases were Hispanic. Controls were selected from randomly generated telephone numbers and from Medicare lists for those age 65 and over. In the male controls, the prevalance of current and previous cigarette usage was similar in the two ethnic groups, but Hispanics smoked fewer cigarettes daily. In the female controls, a lower percentage of Hispanics had ever smoked, and their usual consumption was less than that of other White women. Analysis of the data showed comparable risks of cancer in Hispanic and White smokers. There was no evidence of interaction between ethnicity and cigarette

smoking. The data imply that the differences in lung cancer incidence between Hispanics and Whites are largely explained by the patterns of cigarette smoking of the two groups. 19 References.

37. Author: Joos, S. K., Mueller, W. H., Hanis, C. L., & Schull, W. J. (1984).
Title: Diabetes alert study: Weight history and upper body obesity in diabetic and non-diabetic Mexican American adults.
Source: Annals of Human Biology, 11(2), 167-171.
Abstract: A multidisciplinary study of Type II (non-insulin dependent) diabetes was carried out in 1983. The target sample was Mexican Americans in south Texas. A household survey of 10% of all adults over 15 was completed in one county, yielding 59 male and 109 female diabetics. These were matched with non-diabetics by sex and age. Diabetics differed little from non-diabetics in overall body fatness at the time of examination. History of fatness was different. Diabetics were heavier than non-diabetics at age 18, and continued to gain more weight faster and at an earlier age, than non-diabetics. Diabetics tend to have more trunk fat, especially in the subscapular fold, and less lower extremity fat. Fat patterning in this population does not appear to be influenced by age when weight gain occurred, but is related to diabetic status, especially in women. 9 References.

38. Author: Jorquez, J. (1984).
Title: Heroin use in the barrio: Solving the problem of relapse or keeping the tecato gusano asleep.
Source: American Journal of Drug Abuse, 10(1), 63-75.
Abstract: This empirical study describes how Southern California "tecatos" or Chicano heroin addicts solved the relapse problem and formed nonaddict lives at peace with "square society" and interestingly in some cases, with both square society and the tecato world. Also incorporated into this paper are field data and clinical observations of active and inactive heroin addicts during the period of 1972-1980 at a major Chicano drug abuse program in the Los Angeles harbor area. Life-history interviews with a subsample of 18 ex-tecatos who were abstinent from 2.3 to 24.5 years revealed that tecatos employ the metaphor of an indestructable junkie worm or "tecato gusano"

living in their vicera to explain heroin relapse and abstinence in a manner essentially consistent with learning theories of opioid addiction. The study showed that ex-tecatos use a variety of coping mechanisms for maintaining abstinence and for avoiding "dangerous situations" which could trigger heroin craving and relapse. The research also revealed that being an ex-tecato does not necessarily imply living a crime free or nondeviant lifestyle, and that the process of working out of an addiction involves two complementary social adjustment processes termed (a) extrication (from the tecato subculture) and (b) accommodation (to square society). Suggestions for utilizing these findings for treatment intervention purposes are offered. 29 References.

39. Author: Klatsky, A. L., Sieglaub, A. B., Landy, C., & Friedman, G. D. (1983).
Title: Racial patterns of alcholic beverage use.
Source: Alcoholism, 7(4), 372-377.
Abstract: Among 59,766 persons who had routine health examinations in the years 1978 through 1980, the proportion reporting drinking among self-classified racial groups were: White, 89.5%; Latin, 84.8%; Japanese, 81.9%; Black, 79.8%; Chinese, 68.1%; Filipino, 63.9%. Reported use of three or more drinks daily was similar for Whites, Latins, and Blacks but was much lower in the Asian groups. Men of all races reported more drinking than women. A large proportion of drinkers in all race-sex subgroups reported use of small amounts of alcohol, and most non-drinkers reported lifelong abstinence. Wine drinking (2+days a week) was favored over spirits or beer by Whites of both sexes and women of most races; beer use was favored by men of all races except White. All race-sex groups reported a strong alcohol-cigarette smoking association. Comparison with data collected 15 years earlier showed a substantial decline in reported proportions of abstainers and heavier (3+) drinkers as well as apparent narrowing of race-sex differences. 18 References.

40. Author: LeBlanc, D. M. (1983).
Title: Quality of maternity care in rural Texas.
Source: Ann Arbor, MI.: University Microfilms International No. 8408511.

Abstract: The purpose of the study was to describe regionalized systems of perinatal care serving predominately low income Mexican American women in rural underserved areas of Texas. The study focused upon ambulatory care and allowed for examination of the state health care system. The questions posed at the onset of the study included: 1) How well do regional organizations with various patterns of staffing and funding levels perform basic functions essential to ambulatory perinatal care? 2) Is there a relationship between the type of organization, its performance, and pregnancy outcome? 3) Are there specific recommendations which might improve an organization's future performance? A number of factors--including maldistribution of resources and providers, economic barriers, inadequate means of transportation, and physicians resistance to transfer of patients between levels of care --have impeded the development of regionalized systems of perinatal health care, particularly in rural areas. This study has examined the "system" of perinatal care in rural areas, utilizing three basic regional models--preventive care, limited primary care, and full primary care. Information documented in patient clinical records was utilized to compare the quality of ambulatory care provided in the three regional models. The study population included 390 women who received prenatal care in one of the seven study clinics. They were predominately Hispanic, married, of low income, with a high proportion of teenagers and women over 35. Twenty-eight percent of the women qualified as migrants. Results indicate that women usually initiated prenatal care early in pregnancy with almost half doing so in the first trimester of pregnancy. Further, 75% of the women had or exceeded the recommended number of prenatal visits. There was, however, a low rate of clinical problem recognition. Data indicate that basic screenings, such as lab tests and blood pressure readings, were done but that providers were not recording a recognition of common clinical problems. Numerous recommendations are offered to remedy this problem. The findings also showed that only 60% of mothers had post-partum follow-up, but on the positive side 90% of their newborns received care. Differences between the various clinic sites was also an integral part of the findings reported. There were clinic differences in both prenatal and post partum care of

mother and infants. Suggestions were offered for increasing the services of clinics that had lower clinical service ratings. 118 References.

41. Author: Linn, M. W., Linn, B. S., & Harris, R. (1981).
Title: Stressful life events, psychological symptoms, and psychosocial adjustment in Anglo, Black, and Cuban elderly.
Source: Social Science & Medicine, 15(E), 283-287.
Abstract: The psychological status of high and low stress groups in Anglo, Black, and Cuban cultures are compared. A total of 280 elderly subjects living in Florida were given the Social Readjustment Scale. The group included 78 Cubans, 100 Black, and 102 Anglo respondents, all with an average age of 73.1 years. Findings indicate that high and low stress produce greater differences on psychological variables than does culture. High and low stress groups were significantly different, particularly in regard to symptoms of somatization, depression and anxiety. The three cultural groups differed significantly in social participation and social dysfunction. The fact that symptoms differentiated high and low stress groups similarly in each culture suggests that reactions to such stress as death and illness, which occurred frequently among these older persons, may be a common response that transcends cultural differences. 31 References.

42. Author: Malina, R. M., Little, B. B., Stern, M. P., Gaskill, S. P., & Hazuda, H. P. (1983).
Title: Ethnic and social class differences in selected anthropometric characteristics of Mexican American and Anglo adults: The San Antonio Heart Study.
Source: Human Biology, 55(4), 867-883.
Abstract: This study examines age, ethnic, and social class differences in the anthropometric characteristics of body size, fatness, and estimated muscularity in a cross-sectional sample of 1,328 randomly selected Mexican American and Anglos adults, ages 25-64, from San Antonio, Texas. The study is designed to clarify the extent to which ethnic differences in cardiovascular risk factors are due to factors of life style as opposed to genetic background. The Mexican Americans resided in three socioeconomically distinct areas:

(1)low income barrio, (2) middle income transitional area, and (3) high income suburban area. Anglos resided in only the latter two areas. Among the Mexican Americans, stature increases with socioeconomic status in both sexes. Mexican American men from the three social strata do not differ significantly in weight, relative weight, Quaetelet's Index and subcutaneous fatness. Mexican American women from the lowest social stratum are heavier and have thicker skinfolds and larger arm circumference than women from the transitional and suburan areas. Suburban women are smaller in all dimensions except stature. Social class differences in Anglos from the transitional and suburban areas parallel those for Mexican Americans in the same area. Ethnic comparisons within the same socioeconomic level show Mexican Americans as shorter, relatively but not absolutely heavier, and fatter at the subscapular but not the triceps skinfold site than Anglos. The thicker subscapular skinfolds of Mexican Americans, coupled with the lack of an ethnic difference at the triceps skinfold site, suggests an ethnic difference in fat patterning. These findings have implications for the definition of obesity in epidemiologic surveys using anthropometric techniques, since the sites chosen for skinfold measurement may not be equally diagnostic of obesity in different ethnic groups. 35 References.

43. Author: Mascola, L., Pelosi, R., Blount, J.H., Binkin, N.J., Alexander, C. E., & Cates, W. (1984).
Title: Congenital syphilis: Why is it still occurring?.
Source: The Journal of the American Medical Association, 252(13), 1719-1722.
Abstract: The purpose of this report was to analyze 50 reported cases of congenital syphilis occurring in Texas out of 159 documented cases in the United States. These 50 cases were reviewed to identify the most important characteristics on which to focus control efforts. Twenty-seven infants were Hispanic and 23 Black. The mothers were young in general with a mean age of 22.7 years. Thirty-three were unmarried. Thirty-seven of the mothers had another living child. All were from minority groups. Among women of reproductive age in Texas, the rate of syphilis was seven times higher among Blacks than Hispanics. However,

pregnant Black women were only twice as likely than Hispanics of being delivered of an affected infant. The ratio of congenital syphilis to early lesion syphilis among women of reproductive age was four and one-half times higher in Hispanics than Blacks. Foreign-born Hispanic women were three times as likely to deliver an infected child than Hispanics born in the United States. Prenatal care significantly affected the risk for delivering an infected child in both Black and Hispanic women. The findings suggested that in Texas congenital syphilis can be reduced by improving prenatal care for high-risk populations and by refining case finding efforts to control infectious syphilis in the community. 25 References.

44. Author: Menck, H. R., & Mack, T. M. (1982).
Title: Incidence of biliary tract cancer in Los Angeles.
Source: National Cancer Institute Monogram, (62), pp. 95-99.
Abstract: Incidence of biliary tract cancer data in four ethnic groups in Los Angeles county are consistent with previous reports of a similarity between the ethnic-sex distribution of gallbladder cancer and bile lithogenicity, as well as that of other biliary cancer and free bilirubin. The highest excess of biliary cancer was found to be in females of those ethnic groups which had the highest average parity. Parity correlates such as martial status and religion were related to risk. A migration effect in Spanish-surnamed and other White females was present for both diseases. (Author's abstract modified).

45. Author: Mueller, W. H., Joos, S. K., Hanis, C. L., Zavaleta, A. A., Eichner, J., & Schull, W. J. (1984).
Title: The diabetes alert study: Growth, fatness, and fat patterning, adolescence through adulthood in Mexican Americans.
Source: American Journal of Physical Anthropology, 64, 389-399.
Abstract: Diabetes Alert is a study of Type II (non insulin-dependent) diabetes in Mexican Americans of Texas. A sample of 1,155 individuals were randomly selected in Starr County, Texas, an agricultural area that is 95% Mexican American by population. The age range was from

ten to 70 years and over. Fifteen body measurements were taken of each subject. The children (141 pre-adult males and 17 pre-adult females) were growing at about the 50th percentile of the national HANES sample for height, weight/height^2, and triceps and subscapular skinfolds. Adults were below median height but above median Wt/Ht^2 and skinfolds. Diabetics compared to non-diabetics, matched for age and sex, were more likely to have short sitting heights, more upper body fat, less lower body fat and were heavier at maximun weight and at age 18. Overall results show a precipitous weight gain after maturity and an association of diabetes with differences in anatomical fat patterning. 26 References.

46. Author: Nanjundappa, G., & Friis, R. (1984, April).
Title: Impact of diabetes upon depression among Mexican Americans.
Source: Paper presented at Annual meeting of the Western Sociological Association, San Diego, California.
Abstract: A case-control sample comparing diabetic and non-diabetic patients. Fifty-six cases were matched with 57 controls. This number included 22 Mexican American cases and 21 such controls. The 20 item CES-D depression scale was administered, as was the Social Network Index. Diabetic persons had significantly higher depression levels than non-diabetics. Mexican Americans, diabetics and non-diabetics were more depressed than Anglos, both diabetic and non-diabetic. Diabetes, insulin dependency, and Mexican American ethnicity were associated positively with depression, while social connectedness and full-time employment were negatively associated with depression. Study was conducted in Orange County, California. 17 References.

47. Author: Noble, D. R. (1983).
Title: Prenatal care and infant outcome in Mexican women.
Source: Ann Arbor, MI.: University Microfilms International No. 1321097.
Abstract: The purpose of this study was to assess the influence of early prenatal care on the Apgan score and birthweight of infants born to 120 mothers of Mexican origin receiving prenatal care at a community clinic in a Los Angeles

County tax supported medical center. Mothers were divided into two groups, based on the gestational age at the initiation of prenatal care. The sample was non-randomized. Group One had gestational ages of 20 weeks or less, while Group Two had gestational ages greater than 20 weeks. The Prenatal and Intrapartum High Risk Screening System (Hobel, Hyvarinen, Okada, & Oh, 1973; 1978) was used in this study. Correlation coefficients were determined between the criterion variables of birthweight, Apgar score at one minute, and Apgar score at five minutes and the predictor variables of gestational age, parity, number of visits, maternal age, risk factor I and risk factor II. It was found that both groups were similar in respect to age, parity, number of prenatal visits, initial, prenatal, and intrapartum risk factors. However, 24.1% of the first group had infants with Apgar scores less than 7 at one minute compared to 3.4% for the second group. The first group infants had 10% birthweight less than 2,500 grams, compared to 0% for the second group. The results did not support other studies in this area. 91 References.

48. Author: Panepinto, W., Galanter, M., Bender, S. H., & Strochlic, M. (1980).
Title: Alcoholics' transition from ward to clinic: Group orientation improves retention.
Source: Journal of Studies on Alcohol, 41(9), 940-945.
Abstract: Alcoholics who have been released from in-patient care require out-patient care afterwards. To increase the percentage of former in-patients receiving care in an out-patient setting, an orientation program was devised at the Bronx Municipal Hospital. The approximately 600 patients were 35% Black, 35% Hispanic and 30% White. No information about identification of Hispanics is given. The orientation for Hispanics was conducted in Spanish. A control group was not given the orientation. In the experimental group, Hispanics and Blacks were much more likely to return for out-patient care than Whites. 10 References.

49. Author: Penk, W. E., Robinowitz, R., Roberts, W. R., Dolan, M. P., & Atkins, H. G. (1981).
Title: MMPI differences of male Hispanic American,

Black, and White heroin addicts.

Source: Journal of Consulting and Clinical Pychology, 49(3), 488-490.

Abstract: Multivariate analyses of the Minnesota Multiphasic Personality Inventory, administered to 41 Hispanic American (nationality unspecified), 161 White, and 268 Black heroin addicts. The results show differences between White and minority addicts. Both Black and Hispanic better adjusted males were more likely to be- come addicted, than the less well-adjusted males. By contrast, among White males the less well-adjusted were more likely to do so. Hispanic males differed from Blacks and Whites in demonstrating a greater reluctance to admit psychological symptoms and a higher degree of defensiveness. 4 References.

50. Author: Perez, R., Padilla, A. M., Ramirez, A., Ramirez, R., & Rodriguez, M. (1980).

Title: Correlates and changes over time in drug and alcohol use within a barrio population.

Source: American Journal of Community Psychology, 8 (6), 621-635.

Abstract: The purpose of this study was to investigate the abuse of various chemical substances by adolescents within several public housing projects in the Mexican American East Los Angeles Community. In particular this study examined alterations in the extent and type of drugs presently abused emphasizing the exploration of sociodemographic, cultural, and personality variables relevant to drug abuse. In addition, this study examined the extent and determinants of the use of phencyclohexyl piperidine HCL (PCP), alcohol, marijuana, and inhalants. The sample was composed of 339 children and adolescents 9 to 17 with 160 males (47.3%) and 179 females (52.9). The median age was 15.51 years with 17.5% being between 9 and 12 years of age. The remainder were 13 to 17 years old. The sample reflected variation in acculturation common to the area. New data were collected through a questionnaire which included a self-concept scale, various items relating to cultural and sociodemographic factors, and a number of questions relating to the educational experiences and goals. The questionnaire was administered by 10 bilingual/bicultural adolescents from the same area as the respondents. Results from the study were compared to those from a similar survey conducted two years

previously. The use of inhalants had declined when compared to the earlier survey. However, use of alcohol and marijuana had increased across all age and sex cohorts. The use of PCP was found to be extremely high. In general, the use of all drugs was predicted by age, sex, and number of peers reporting use. Self-concept factors, particularly one's self-evaluation with respect to others, were also significant predicators of marijuana use, inhalants and PCP. Alcohol, on the other hand was not related to any self-concept factors. Language (Spanish-English) used both in the home and with peers was related to the use of all substances studied. The limitations of the study were also discussed, particularly due to sampling problems. 14 References.

51. Author: Perez, R. (1982).
Title: Stress and Coping as determinants of adaptation to pregnancy in Hispanic women.
Source: Ann Arbor, MI.: University Microfilms International No. 8219749
Abstract: The effect of stress, social support, and coping styles on both prepartum anxiety and intrapatum processes (labor and delivery complications, intrapartum analgesia requirements) were explored in a study of a sample of Hispanic women. Stress, whether indexed in terms of life changes or the women's prepartum estimate of labor and delivery pain, was significantly related to prepartum anxiety. More interesting was the manner in which stress, especially in interaction with prepartum use of medical personnel for information and reassurance, affected both prepartum anxiety and intrapartum analgesia requirements. Obtaining information from medical personnel was associated with reductions in prepartum anxiety only among women experiencing moderate or low amount of life change stress. Women reporting high amounts of life change stress experienced increases in anxiety levels to the extent they sought information from medical personnel. This interaction was discussed in terms of the ability of a largely English-speaking staff to respond to the psychosocial concerns of Spanish-speaking patients. The significance of these findings was tempered by the fact that the social support and coping style failed to consistently predict the intrapartum criterion variables. Further, many stresses by social support or coping

style interactions were non-significant. These failures were attributed to the fact that predictor variables did not bear a direct relationship with the subject's actual intrapartum behavior and emotions. 168 References.

52. Author: Rada, R., Knodell, R. G., Kellner, R., Hermanson, S. M., & Richards, M. (1981).
Title: HLA antigen frequencies in cirrhotic and noncirrhotic male alcoholics: A controlled study.
Source: Alcoholism: Clinical and Experimental Research, 5(2), 188-191.
Abstract: Although epidemiological data suggest that the development of cirrhosis in alcohol abusers is related to the duration and amount of ethanol intake, the fact that only a small percentage of alcohol abusers develope cirrhosis remains unexplained and suggests a possible predisposing genetic factor. Several previous studies have reported an association between various human leucocyte antigens (HLA) and alcoholic cirrhosis. The purpose of this study was to examine the relationship between HLA antigens and the presence or absence of cirrhosis in alcoholics. HLA antigen frequencies in Anglo and Spanish American alcoholic patients were determined and the frequencies of these antigens were compared between those alcoholic patients who have developed cirrhosis and those who have not. In addition, HLA antigen frequencies in the alcoholic patients were compared with a concomitant control group of nonalcoholic patients without liver disease. This empirical study employed adult males in New Mexico and consisted of 68 nonalcoholics, 74 alcoholics with cirrhosis, and 40 alcoholics without cirrhosis. A personal interview was conducted with each subject about their drinking patterns, and the Michigan Alcoholism Screening Test was also administered. Diagnoses of alcoholism were consistent with the criteria established by the Criteria Committee, National Council on Alcoholism. No statistically significant differences in HLA frequencies among the ethnic groups were found. Comparisons of HLA frequencies between cirrhotic and noncirrhotic alcoholic patients do not support the hypothesis that individual susceptibility to the development of alcoholic cirrhosis is genetically determined. 18 References. (Author abstract modified).

53. Author: Ramirez, A. G., Herrick, K. L., & Weaver, F. J. (1981).
Title: El asesino silencioso: a methodology for alerting the Spanish-speaking community.
Source: Urban Health, June, 44-48.
Abstract: The purpose of this survey was to establish a data base for Baylor's National Heart Center in order to design future community health education programs in Houston, Texas. On the basis of the survey, existing knowledge, attitudes, practices related to cardiovascular disease and its associated risk factors, as well as media habits of Houston area adults 18 and older were evaluated. A random sample of 2,322 subjects, including 69% Anglo, 23% Black, and 8% Mexican American was surveyed. Data revealed that a substantial portion of the Mexican American community does not possess fundamental knowledge necessary for adopting health risk reducing behaviors. In particular, there was little knowledge about cardiovasular disease. A need to supplement this information was identified. As a result, a community health information program was designed. Its purpose was to demonstrate the effectiveness of appropriate methods and media that increase awareness to the problems of high blood pressure among Mexican Americans in Houston, Texas. Based on the findings, it was concluded that stimulating high interest in target groups is a prerequisite to subsequent adoptive behavior. In this sample, interest was a function of personal health experience and behavior which determined the importance and relevance of advocated behaviors. When interest was high, corrective behavior was more likely when exposed to appropriate media and messages, such as the program designed for this target group. 0 References.

54. Author: Rosenbaum, M., & Murphy, S. (1981).
Title: Getting the treatment: Recycling women addicts.
Source: Journal of Psychoactive Drugs, 13(1), 1-13.
Abstract: In this ethnographic study differences experienced by women addicts in treatment are examined. A sample of 100 women in San Francisco and New York City were interviewed, focusing on their drug-using careers. The interviews were voluntary and respondents were paid $20. Interviews lasted two to three hours. The group was 43% White, 38% Black, 14% Latina,

and 5% other. Findings indicate that although the treatment goal is to eliminate the use of heroin this goal is seldom met. Problems encountered by the female heroin addict are limited space, inadequate facilities, physiological problems in relation to detoxification by methadone maintenance programs which lead to disillusionment, self-treatment, and a high rate of recidivism. 43 References.

55. Author: Rosenbaum, M. (1981).
Title: Sex roles among deviants: The woman addict.
Source: The International Journal of the Addictions, 16(5), 859-877.
Abstract: This comparative study of the effect of sex roles on the careers of women addicts examines women committed to the California Rehabilitation Center for drug-related crimes. Data were gathered by means of questionnaires and individual life histories. Each of the 180 women was matched to a man with identical demographic characteristics. One half of the women were White, one fifth Chicana, and one fifth Black. The comparisons indicate that 78% of the women that had husbands who were addicts, began using heroin later than men. Fifty percent started using after their spouses and only one third have shot heroin alone. Women had larger, more costly habits than men. White and Chicana women volunteered for treatment more often than men; however Black men and women had similar rates of volunteering. Two thirds of the Chicana and White women had low self-concepts. Two thirds of Black women had high self-concepts. Women's self-image decreases as the size of the habit increases. Self-sufficiency and a manageable habit resulted in a high self-concept for women but not for men. 11 References.

56. Author: Rosenbaum, M. (1981).
Title: When drugs come into the picture, love flies out the window: Women addicts' love relationships.
Source: The International Journal of the Addictions, 16 (7), 1197-1206.
Abstract: This retrospective survey examines the relationship between heroin use and love relationships. A sample of 100 female addicts (43% White, 38% Black, 14% Latino and 5% other) from New York and San Francisco was obtained

by posting notices in high drug use areas, the city prison and a variety of treatment facilities. The women were primarily active, non-institutionalized heroin users. The data was collected by in-depth interviews, personal histories and observations. Interviews were voluntary and usually lasted 2-3 hours. Findings suggest that female addicts had mates who were addicts or ex-addicts, that the heroin world was the communality shared, that the fixing routine and the sharing aspect of taking heroin together replaced intercourse, that ultimately the relationship was undermined by conflicts over the heroin, and that the treatment of female addicts should focus on developing job and career skills conducive to an independent life style rather than establishing traditional sex-role orientations. 6 References.

57. Author: Rosenbaum, M. (1981).
Title: Women addicts' experience of the heroin world: Risk, chaos, and inundation.
Source: Urban Life, 10 (1), 65-91.
Abstract: This ethnographic study looks at female heroin addicts, including their lifestyle, adjustment to risk and chaos, and the effects of risk and chaos on identity. The sample interviewed consisted of 100 female addicts (43 White, 38 Black, 14 Latinas, 1 Asian, 1 Native American, and 3 Filipinas). The age of the women ranged from 10 to 53 years with a median age of 28 years. Of these, 34% were single, 23% were married, 24% divorced, 15% separated, and 4% widowed. The study consisted of interviews and personal histories and was conducted in New York and San Francisco. All interviews were voluntary and a $20 remuneration fee was paid each respondent. Findings indicate that the life of a female heroin addict is centered around the taking of heroin. The study compares male and female heroin activity and findings indicate that in women the risk aspects lead to a lower status than in men. 54 References.

58. Author: Samet, J. M., Skipper, B. J., Humble, C. G., & Pathak, D. R. (1985).
Title: Lung cancer risk and vitamin A consumption in New Mexico.
Source: American Review of Respiratory Disease, 131 (2), 198-202.

Abstract: This paper reports on the association between dietary intake of vitamin A and lung cancer risk. A population-based, case control study of Hispanics and Anglos (477 patients and 759 control subjects) was done in New Mexico. Data was collected through a food frequency interview which measured usual intake of total vitamin A retinal, preformed vitamin A, and carotene. Combining all respondents, the odds ratios for lung cancer were greater as intakes of total vitamin A and carotene declined, but did not vary with intake of performed vitamin A. Stratifying the subjects by ethnic group revealed that the significant effects of vitamin A consumption were limited to Anglos. While the protective effects of total vitamin A and carotene intake were present in men and women, they varied greatly with cigarette smoking habits. Only former smokers who had stopped smoking for 6 to 15 years showed significant effects of total vitamin A and carotene consumption. This limitation of the protective effect of vitamin A and carotene intake to past smokers has important implications for developing clinical trials and cancer control strategies.(Author's abstract modified).

59. Author: Samet, J. M., Young, R. A., Morgan, M. V., & Humble, C. G. (1984).
Title: Prevalence survey of respiratory abnormalities in New Mexico Uranium miners.
Source: Health Physics, 46 (2), 361-370.
Abstract: One-hundred-ninety-two miners in New Mexico with long-term (approximately ten years) experience in uranium mines were given a prevalence survey. 105 of the subjects were White Hispanic. Total duration of underground uranium mining was used as the exposure index. Hispanics were more likely to have never smoked, or to smoke less, than White non-Hispanics. Of the major respiratory symptoms, only the prevalenced dyspnea increased significantly with duration of uranium mining. Small, but statistically significant effects of mining were found for two spirometric measures, the forced expiratory volume, and the maximal midexpiratory flow. Twelve of 143 participants with x-rays available for interpretation had at least category 1/0 pneumoconiosis. 35 References.

60. Author: Samet, J. M., Schrag, S. D., Howard, C. A., Key, C. R., & Pathak, D. R. (1980).

Title: Respiratory disease in a New Mexico population sample of Hispanic and non-Hispanic Whites.

Source: Review of Respiratory Disease, 125 (2), 152-157.

Abstract: To characterize the epidemiologic features of respiratory diseases among Hispanics a prevalence empirical survey was conducted in Bernalillo County, New Mexico. The ATS-DLD-78 respiratory symptoms questionnaire was completed by 633 Hispanics and 1,038 Anglos with an overall response rate of 72%. Bilingual questionnaires were initially mailed to subjects with Hispanic surnames. Three age groups were analyzed between Hispanic and Anglo female and male smokers: less than 40 years, 40-59 years, and greater than or equal to 60 years. Anglo reported more physician-confirmed asthma, chronic bronchitis and/or emphysema than Hispanics. Anglos also reported more wheezing attacks with dyspnea, hay fever, and pneumonia. Adjusting for cigarette smoking status and age showed a similar smoking status in both groups, although more Anglo males over age 60 were ex-smokers. Hispanic males tended to use filter-tip cigarettes more often, while Anglo males smoked cigars and pipes more frequently. A greater number of Hispanic females age 40-59 years were lifelong smokers of filter-tip cigarettes than other female age groups. Current and cumulative cigarette consumption was significantly lower in Hispanics. A multiple logistic regression analysis revealed ethnicity as a predictor of dyspnea, with Hispanics exhibiting a greater prevalence. Educational level was also a predictor of dypsnea. A significant predictor of respiratory disease was lifelong smoking consumption. Present smokers exhibited a persistent wheeze and chronic cough and phlegm. Ethnicity had an effect on the occurrence of physician-diagnosed asthma, with a greater risk to Anglos. Risk factors for physician-confirmed chronic bronchitis and/or emphysema included cigarette consumption, age, and female sex. These data demonstrate differences in the epidemiologic features of respiratory disease among the Hispanic and Anglo populations in New Mexico. Many of the differences resulted from lower cigarette consumption by the Hispanics. The extent to which these results can be generalized to other Hispanic populations is unclear. 32 References.

61. Author: Siantz, M. L. (1984).
Title: The effect of stress on maternal depression and acceptance/rejection of Mexican migrant mothers.
Source: Ann Arbor, MI: University Microfilms International No. Pending.
Abstract: This empirical study sought to determine if response to problems in life conditions varied in the presence of total social supports. Responses to problematic conditions included depression and maternal acceptance/rejection. One hundred Mexican migrant mothers of preschoolers were interviewed for this study through the Texas Migrant Council's Headstart program. Instruments used were the Inventory for Socially Supported Behaviors (Barrera, 1983), the Stress and Support Family Functioning Interview (Colletta, 1981), the Center for Epidemiologic Studies Depression Scale (Radloff, 1979), and Parental Acceptance-Rejection Questionnaire (Rohner, 1975). Factors thought to affect the relationship between problems of life conditions and the dependent variables were entered into multiple regression analysis. Total social supports accounted for 75% of the explained variance in maternal acceptance/rejection in the presence of depression. To explain why social supports did not account for variance in depression, problems with reliability and methodology were ruled out. Total task support, a subcategory of total social support, with the most variance was disaggregated into kinds of task support through a factor analysis having a verimax rotation. A Pearson Moment correlation was done to identify if any statistical relationship existed between these factors and the dependent variables. It was concluded that in the presence of child care support, migrant mothers are less likely to become depressed and are warmer toward their children. If a mother's problems are not taken seriously, they are more likely to become depressed. When mothers can share their private feelings and be distracted from their problems, they are less likely to neglect their children. If mothers are provided tangible assistance, they are more likely to be accepting of their children. 222 References.

62. Author: Staff. (1981).

Title: Use of lead tetroxide as a folk remedy for gastrointestinal illness.

Source: U.S. Department of Health and Human Services, PHS, Morbidity and Mortality Weekly Report, 30 (43), 546-547.

Abstract: The purpose of this article is to discuss the use of Azarcon as a folk remedy for gastrointestinal illness among Hispanics. Azarcon is a lead tetroxide with a total lead content of 86%. The distribution of this substance as a cure for gastrointestinal illness is of great concern. It is recommended that authorities in areas with Hispanic populations should be aware of this potential health hazard. Parents are often reluctant to admit the use of folk remedies, especially to physicians. Children with lead poisoning are usually asymptomatic, or have non-specific symptoms. Because of this and the estimated high prevalence rates of the disease, the Center for Disease Control recommends that all children 1 to 5 be screened for lead toxicity. Medical examiners should consider lead exposure when examining young children. 0 References.

63. Author: Stern, M., Haffner, S., Hazuda, H. & Rosenthal, M. (1984, December).

Title: Cadiovascular disease in Mexican Americans.

Source: Paper presented at The Woodlands Conference on Chronic Diseases Among Mexican Americans.

Abstract: Data from large scale epidemiological health studies conducted with Mexican American samples are reviewed in an effort to explain the low cardiovascular mortality rate found within this population. Numerous cardiovascular risk factor studies suggest that most risk factors are the same or worse among Mexican Americans than Anglo Americans. The authors suggest that the cardiovascular risk factor pattern of Mexican Americans is hard to reconcile with the lower rate of cardiovascular mortality found for males. Also difficult to explain is the lower male-to-female ratio in cardiovascular mortality in Mexican Americans compared to Anglo Americans. The authors conclude that additional research is needed to examine whether conventional cardiovascular risk factors have the same impact on cardiovascular disease in Mexican Americans as in their Anglo American counterparts. 28 References.

64. Author: Stern, M.P., Gaskill, S. P., Allen, Jr., C.R., Garza, V., Gonzales, J.L., & Waldrop, R. H. (1981).

Title: Cardiovascular risk factors in Mexican Americans in Laredo, Texas. I. Prevalence of overweight and diabetes and distribution of serum lipids.

Source: American Journal of Epidemiology, 113(5), 546-555.

Abstract: The purpose of this study was to investigate the distribution of cardiovascular risk factors in a low-income, Mexican American population living in Laredo, Texas. The prevalence of overweight and diabetes and the distribution of plasma lipid concentrations were also presented. A randomized sample of 389 subjects from two low-income, almost exclusively Mexican American census tracts were chosen. The sample included 127 men and 262 women. The subjects were administered a brief questionnaire concerning prior diagnosis of diabetes during a home visit and blood pressures were taken three times. Appointments were then given for repeat blood pressure measurement and fasting blood work at the Health Department. The prevalence for overweight was determined according to criteria developed in the Health and Nutrition Examination Survey (HANES I). The prevalence of overweight in Laredo was compared with the national estimate from HANES I and with the rates reported for Pima Indians. The prevalence of overweight was found to be intermediate between U.S. national estimates and the rates recorded for Pima Indians. Fasting hyperglycemia was intermediate between the rates observed in the sample of predominantly Caucasian individuals and those observed in Pima Indians. Excess hyperglycemia in the Laredo Mexican American population compared to a predominantly Caucasian population does not reflect a lower level of medical control of diabetes in the study population, but a true excess in the prevalence of diabetes. Serum cholesterol and triglyceride concentrations were also higher in the sample than in a Caucasian comparison population. This may be due to the fact that Mexican Americans are of mixed European and Native American ancestry. Native Americans have high rates of diabetes which could be genetically determined. On the other hand, sociocultural determinants could also need consideration since they are thought to influence obesity, a major precur-

sor to diabetes. 28 References.

65. Author: Stern, M. P., Relethford, R. E., Ferrell, R., Gaskill, S. P., Hazuda, H. P., Haffner, S. M., & Gardner, L. I. (1982).
Title: Diabetes and genetic admixture in Mexican Americans: The San Antonio Heart Study.
Source: Diabetes, 31(Suppl. 2), 45A.
Abstract: The prevalence of diabetes was determined in 963 randomly selected Mexican Americans: 469 from a low income barrio, 178 from a middle income transitional neighborhood, and 276 from a high income suburb. There was a marked decline in the prevalence of diabetes from barrio to suburb, ranging in men from 15.7% in the barrio to 6.9% in the suburb. The women ranged from 18.3% in the barrio to 1.4% in the suburb. It was suggested that in addition to the sociocultural factors mediated by obesity, the amount of Native American admixture might also play a role in increased diabetes in the Mexican American communities. Native American admixture was estimated by using skin color as measured by a reflectance meter and previously validated model and by using gene frequencies at eight blood group loci. The studies indicate that diabetes prevalence decreases as Native American admixture decreases, suggesting a genetic component to diabetes in Mexican Americans. Abstract.

66. Author: Stern, M. P., Gaskill, S. P., Hazuda, H. P., Gardner, L. I., & Haffner, S. M. (1983).
Title: Does obesity explain excess prevalence of diabetes among Mexican Americans? Results of the San Anotnio Heart Study.
Source: Diabetologia, 24, 272-277.
Abstract: The purpose of this study was to determine if the excess rate of Type II diabetes in Mexican Americans could be entirely attributed to their high prevalence of obesity or whether other factors such as genetics or nutrition explain the overweight. Genetic susceptibility was considered due to the mixed ancestry of Mexican Americans that includes both Native Americans and European ancestry. Native Americans have a genetic predisposition to Type II diabetes which Mexican Americans could share. Nine hundred and thirty-six Mexican Americans and 398 Anglo Americans were randomly selected from three socially and culturally distinct neighborhoods in San Antonio, Texas.

Obesity categories included: lean, average, and obese based on skin-fold measurements. Mexican Americans were two to four times as likely to fall into the obese category as Anglo Americans. Within the categories, two ethnic groups were closely matched in terms of sum of skinfolds. The prevalence of Type II diabetes was significantly greater in Mexican Americans than Anglo Americans, even when comparisons were made within the three obesity categories. The summary prevalence ratio when obesity was controlled was found to be 2.54 ($p = 0.004$) for males and 1.70 ($p = 0.036$) for females. This indicated that lean Mexican Americans were still at greater risk for Type II diabetes than equally lean Anglo Americans. In addition, while Type II diabetes risk increases with obesity, obese Anglo Americans are somewhat protected when compared with equally obese Mexicans. Plasma glucose was found to be significantly higher in Mexican Americans than in Anglo Americans, even when obesity was controlled. This finding indicated that while obesity contributes to Type II diabetes among Mexican Americans, it does not alone explain the entire excess prevalence rate. 18 References.

67. Author: Stern, M. P., Pugh, J. A., Gaskill, S. P., & Hazuda, H. P. (1984).
Title: Knowledge, attitudes, and behavior related to obesity and dieting in Mexican Americans and Anglos: The San Antonio Heart Study.
Source: American Journal of Epidemiology, 115(6), 917-927.
Abstract: The San Antonio Heart Study is a comprehensive epidemiologic investigation of life styles as they relate to obesity, diabetes, and cardiovascular risk factors in Mexican Americans and Anglos living in San Antonio, Texas. The study is designed to clarify the extent to which ethnic differences in these health variables are due to life style factors as opposed to genetic factors. The purpose of the study reported in this article is to present data on knowledge, attitudes, and behavior related to obesity and dieting on an initial group of participants representing both ethnic groups and two levels of social class. Two socioeconomically and culturally distinct target areas in San Antonio were used in the sample. These included a middle-income ethnically integrated area (transitional) and an upper-

income predominantly Anglo area (suburbs). Two behavioral scales were created: the "sugar avoidance" scale and the "dieting" behavior scale. Pearson and Spearman correlation coefficients between relative weight and the various dependent variables were calculated. Statistical analysis was done using the Biomedical Computer Programs (BMDP). The results showed that while suburbanite Mexican Americans were leaner than their lower-income counterparts, they were still more overweight than suburbanite Anglos. Even after adjusting for these differences in relative weight, Mexican Americans were more likely than Anglos to communicate that Americans are overly concerned about weight loss. Mexican American women in transitional neighborhoods in particular were less concerned about weight. While no ethnic differences in the two behavioral scales were found in the more affluent suburbs, the implications for public health concern in general was ascertained since the majority of Mexican Americans in the United States are of low socioeconomic status. 23 References.

68. Author: Stern, M. P., Rosenthal, M., Haffner, S. M., Hazuda, H. P., & Franco, L. J. (1984).
Title: Sex difference in the effects of sociocultural status on diabetes and cardiovascular risk factors in Mexican Americans: The San Antonio Heart Study.
Source: The American Journal of Epidemiology, 120(6), 834-851.
Abstract: It is hypothesized that as Mexican Americans became more affluent and/or acculturated to "mainstream" United States life-style they will progressively lose their "obesity-related" pattern of cardiovascular risk factors which were defined as: obesity, diabetes, hypertriglyceridemia and low levels of high-density lipoprotein cholestrol. This hypothesis was tested in 1979-1982 in the San Antonio Heart Study, which is a population-based study of 1,288 Mexican Americans and 929 Anglos living in three San Antonio neighborhoods: a low income barrio, a middle-income transitional neighborhood, and a high income suburb. The study population comprised 25 to 65-year-old men and non-pregnant women. In Mexican American women, all the "obesity-related" risk factors fell sharply with rising socioeconomic status. In Mexican American men by contrast,

diabetes was the only "obesity related" risk factor which fell with rising socioeconomic status. Moreover, it fell less steeply, there being an approximately twofold difference in diabetes prevalence between the barrio and the suburbs in men compared to a fourfold difference in women. Also, total and low-density lipoprotein cholesterol rose with rising socioeconomic status in Mexican American men, but not in Mexican American women. "Obesity-related" risk factors were generally higher in Mexican Americans of both sexes than in their Anglo neighbors who were of similar socioeconomic status. These results suggest that cultural factors exert a stronger influence on diabetes and cardiovascular risk factors in Mexican Americans than do purely socioeconomic factors. 33 References.

69. Author: Texas Migrant Council,Inc., & Minority Resource Center on Child Abuse and Neglect for Mexican Americans (1982).

Title: A study of attitudes toward child abuse and child rearing among Mexican American migrants in Texas.

Source: Laredo,Texas: Texas Migrant Council, Inc.

Abstract: Three major goals underlie this study: 1) to provide a descriptive profile of migrants with young children,2) to investigate the migrants' attitude toward child rearing, and 3) to examine attitudes towards child abuse. A total of 500 Mexican American parents utilizing Head Start programs in Texas were interviewed in six general areas: migrant lifestyle, education of the child, socialization, childrearing practices, attitudes toward child abuse and neglect issues, and awareness and usage of social services and child protective services. Analyses are presented in percentages providing information on the demographic profile and attitudes toward childrearing and child abuse. Not surprisingly, demographic results depict the Mexican American migrants as poor, low-skilled individuals with large extended families, and with low levels of education and low mobility outside of their migration patterns. Respondents' childrearing patterns tend to follow those of their parents and their interaction with their offspring is limited. A variety of rewards and punishments are used with the children and obedience is considered an important lesson for children to learn. There is low tolerance for abuse and

neglect, although if it goes on in the community, it tends not to be reported. Socioeconomic status and education did not appear to be related to tolerance of abuse and neglect. In comparison to the general population of Texas, the migrants' attitudes toward abuse and neglect represent less willingness to tolerate such practices than those of the general population. It is concluded that more work needs to be done in this area. 6 References.

70. Author: Tulloch, B.R., Hanis, C., & Schull, W.J.(1982).
Title: Homo diabeticus Rio Grande: Epidemiology in Starr County, Texas.
Source: Diabetes, 31 (Suppl. 2), 45A.
Abstract: Review of diabetic mortality in Texas revealed a death rate of 3.1 to 64.5 per 1,000, with the higher rates occurring in counties with 80% Spanish origin population. A National Institutes of Health supported study was conducted to assess the prevalence of diabetes in the adult Mexican American population. A random sample of 2,445 people over 14 years of age was selected in Starr County, Texas (98% Mexican American). Histories taken indicated that rates for males were: 17-44 years, 2.3%; 45-64, 10.7%; and over 64, 12.6%. Rates for women were: 17-44 years, 1.2%; 45-64, 14.0%; and 13.1% for females over 64. Age and sex prevalence rates when compared with the National Commission on Diabetes Report (1976) suggest that women between 17 and 44 and over 64 years of age are substantially at higher risk. (Journal abstract modified).

71. Author: Ueno, Y., Iwaki, Y., Terasaki, P.I.,Park, M.S., Barnett, E. V., Chia, D., & Nakata, S. (1981).
Title: HLA-DR4 in Negro and Mexican rheumatoid arthritis patients.
Source: The Journal of Rheumatology, 8(5), 804-807.
Abstract: The purpose of this research was to determine whether rheumatoid arthritis patients of other races have a higher incidence of DR-4 or possibly a different antigen. HLA-DR antigen was tested in 38 Caucasians, 18 Negro, 17 Mexican and 5 Japanese patients with rheumatoid arthritis. HLA-A, -B, -C and DR lymphocyte alloantigens were tested by the standard microcytotoxicity test. Coefficients of linkage disequalibrium (>) were obtained. Significantly high HLA-DR4 were observed in all

races. This included 61% for Caucasians, 39% for Negroes, 77% for Mexicans, and 100% for Japanese. No clinical correlations with the DR4 antigen were found. This may indicate that the clinical features are not specifically related to the genetic susceptibility factor, but are instead features in the progression of the disease. 17 References.

72. Author: Van den Tweel, J. G., Dugas, D.J., Loon, J., & Lukes, R. J. (1982).
Title: HLA typing in non-Hodgkins lymphomas: Comparative study in Caucasoids, Mexican Americans and Negroids.
Source: Tissue Antigens, 20, 364-371.
Abstract: The purpose of this study was to examine whether an association between HLA and the functional subgroups of non-Hodgkin's lymphomas could be detected. Over 200 cases of non-Hodgkin's B, C, and DR antigens was typed for HLA-A, B, C, and DR antigens. Typing was correlated with morphologic diagnosis according to the Lukes-Collins classification system of non-Hodgkin's lymphomas. The major racial groups represented were Caucasian, Mexican and Negroid. Significant associations were between HLA-AW33 and Caucasoid B-cell lymphomas, and for HLA-AW24, HLA-B37 and HLA-B40 and B cell lymphomas in Negroids. No significant correlations were found within the Mexican American population. The number of T cell lymphomas was not enough to make any conclusions. The DR antigens were not significantly associated with any of the diagnostic subgroups. 17 References.

73. Author: Weiss, K. M., Ferrell, R. E., Hanis, C. L., & Styne, P. N. (1984).
Title: Genetics and epidemiology of gallbladder disease in New World native peoples.
Source: American Journal of Human Genetics, 36 1259-1278.
Abstract: In most populations of the world, the rise in gallbladder disease has resulted from "westernization, "including consumption of high-calorie, high-fat, low-fiber and insufficient excercise. Gallbladder disease rates are very high among persons of Amerindian descent, suggesting a genetic linkage. Studies were conducted in Laredo and Starr County in South Texas. The Laredo study focused on 42,864 hospital in-patient discharge records for the

years 1910-1945, and cholecystectomy records for 1980. The Starr County study (97.7% Mexican American) was a household survey of 10% of the county, yielding 617 male and 1,050 female respondents. Data from the study show that the risk that a genotypically susceptible Mexican American female will undergo a cholecystectomy by age 85 can approach 40%, and the risk of gallbladder cancer can reach about 3% percent. A genetic susceptibility may be as "carcinogenic" in New World people as a known environmental. Data showing gallbladder cancer rates for other Latin American nationalities and American groups are also given for comparison. 92 References.

74. Author: Zavaleta, A. N. & Malina, R. M. (1980).
Title: Growth, fatness, and leaness in Mexican American children.
Source: The American Journal of Clinical Nutrition, 33, 2008-2020.
Abstract: A sample of 1,269 Spanish-surnamed children (619 boys and 650 girls, age 6 through 17 years) was taken in Brownsville, Texas. These are almost exclusively Mexican-origin children. The families were from schools located in areas classified as lower socioeconomic. Height, weight, arm circumference, and triceps skin fold were measured. The arm circumference was corrected for triceps skinfold to estimate midarm muscularity and fatness. The triceps skinfold was also used to estimate obesity and leanness. The heights and weights of the sample are comparable for other Mexican American samples, but fall at about the 25th percentile of the nationally based Health Examination Survey (HES). Compared to the national norm, there is less muscle mass in the midarm areas for the sample than national norms, suggesting a correlation with a diet that is sufficient in calories, but low in protein. This lessened muscle mass may also reflect the generally smaller stature of Mexican American children. The rate of obesity is about the same for Mexican girls as in the HES sample, but the rate for Mexican American boys is about twice that of the national sample. 34 References.

75. Author: Ziedler, A., Frasier, S. D., Kumar, D., & Loon, J. (1982).
Title: Histocompatibility antigens and immunoglobu-

lin G insulin antibodies in Mexican American insulin-dependent diabetic patients.

Source: Journal of Clinical Endocrinology and Metabolism, 54 (4), 569-573.

Abstract: A study of the associational histocompatibility antigens (HLA) with insulin-dependent diabetes (IDD) in Mexican Americans. The sample is persons born in Mexico, or first generation born in the U. S. of Mexican-born parents. 112 such persons, using an outpatient diabetic clinic in Los Angeles, diagnosed as having IDD, were typed for HLA-A, -B, and -C. An additional typing for HLA-DR was performed on 85 persons of this sample. Controls for the first typing were 332 and for the second, 209. IDD patients have a significant increase in HLA-DR4 compared to the control population. HLA-DR2 was not detected in any IDD patient. There was a significant association between HLA-Aw30 and HLA-B18 in IDD patients as to the controls. IgG insulin antibody formation was increased in HLA-DR3- and DR4-negative patients compared to that in patients positive for both antigens. The findings support observations in Caucasian and Black Americans and indicate that HLA-DR specificities are associated with IDD and may play a role in determining its mode of inheritance, and perhaps of its pathogenesis, independent of ethnic difference. 29 References.

76. Author: Ziedler, A., Fraser, S.D., Penny, R., Stein, R. B., & Niciloff, J. T. (1982).

Title: Pancreatic islet cell and thyroid antibodies, and islet cell function in diabetic patients of Mexican American origin.

Source: Journal of Clinical Endocrinology and Metabolism, 54(6), 949-954.

Abstract: A study of the presence of pancreatic islet cell antibodies (ICA) and thyroid microsomal antibodies (TMA) in Mexican American patients. The study group of 236 diabetic persons was taken from patients utilizing a diabetes clinic in Los Angeles. 131 subjects were insulin-dependent diabetics (IDD) and 105 were non-insulin dependents (NIDD). A control group of 79 normal subjects was used. In the Mexican American IDD patients, the prevalence of ICA and TMA is lower than in a similar Caucasian population in Europe or the U.S. The persistence of ICC in IDD patients is related to the duration of the disease. The presence of ICA is not related to pancreatic

islet cell functions, as C- peptide levels were found to be similar in IDD patients with and without ICA. The suggested lower frequencies of ICA and TMA in Mexican American IDD can be explained by a reduced susceptibility to organ-specific autoimmunity in this popula tion. This may indicate ethnic differences and heterogeneity in IDD populations. 36 References.

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77. Author: Abeyta-Benke, M. A. (1981).
Title: A nutrition profile of the Hispanic elderly.
Source: In P. Vivo & C. D. Votaw (Eds.), The Hispanic Elderly: La Fuente de Nuestra Historia, Cultura Y Cariño (pp.114-120). Rockville, MD: U. S. Department of Health and Human Services, Public Health Service (Spanish Heritage Public Health Service Workers).
Abstract: The author presents a nutrition profile of the Hispanic elderly and at the same time draws our attention towards avoiding stereotyping the nutrient needs of the elderly. Eighty percent of the general elderly Hispanic population is characterized by one or more chronic diseases which may result in secondary malnutrition if untreated. Natural changes occuring with age mandate a qualitative change in nutrients due to changes in lifestyle, socioeconomic status, psychological changes and the presence of chronic diseases which alter nutrient intake. Recommendations of nutrient needs are tentative and based on current understanding of the natural physiological changes occuring with the aging process such as decreased renal function, nutrient-drug interaction, gastrointestinal changes, skeletal changes, increased blood pressure, neuromuscular changes, deteriorating vision, decline in muscular strength, and gradual reduction in performance of many organ systems. Aging and physiological changes associated with it are highly individual. Among different people, aging occurs at different rates and time, but through adequate nutrition the integrity of renewable cells and the preservation of the integrity of non-renewable cells may be achieved thereby reducing the rate of aging. 0 References.

78. Author: Adelman, J. D. (1983).
Title: Staff awareness of Hispanic health beliefs that affect patient compliance with cancer treatment.
Source: In Progress in Cancer Control III: A Regional Approach. (pp.85-86). New York: Alan R. Liss, Inc.
Abstract: The Columbia University Division of Cancer Control is developing a unique approach for improving the compliance with clinic appointment for chemotherapy of Hispanic patients. They are developing open-ended standardized interviews to be administered to Dominicans, Puerto Ricans and Cubans in either Spanish or

English to ascertain culturally derived beliefs and behaviors about compliance and noncompliance with chemotherapy treatment. These culturally derived beliefs and behaviors, together with the sociodemographics of these patterns, will be identified, compared, and analyzed. These patterns of behavior and attitudes will then be incorporated into training sessions with the health care staff to improve clinician/patient relationships. Patient compliance rates before and after this program will be compared. 0 References.

79. Author: Arfaa, F. (1981).
Title: Intestinal parasites among Indochinese refugees and Mexican immigrants resettled in Contra Costa County, California.
Source: The Journal of Family Practice, 12(2), 223-226.
Abstract: Stool samples of 186 Indochinese refugees and 99 immigrants from Mexico, all of whom had been referred by physicians to the Public Health laboratory of Contra Costa County, were examined. Rates of infection varied with age and sex. The Indochinese had an overall infection rate with one or more parasite(s) of 60%, with a rate of 80% in the age of 10-14 group. Infection rates were much lower overall in the Mexican group, at 39%. Among the Mexican group specific parasites and rates were: whipworm, 12%; Ascaris, 12% Giardia lamblia, 11%; dwarf tapeworm, 9%; Entamoeba histolyica, 4%; hookworm 2% Strogloides, 1%. 9 References.

80. Author: Banker, C.A., Berlocher, W.C., & Mueller, B. H. (1984).
Title: Primary dental arch characteristics of Mexican American children.
Source: Journal of Dentistry for Children, (May-June), 200- 212.
Abstract: To gain baseline information on the primary dentition of Mexican American surname children 36-60 months were examined. Maxillary and manibular alginate impressions and centric occulusion waxbite registrations were taken. The main arch configuration found among the children was ovoid, overbite ranged from 2 to 5 mm and an overjet of 0-2 mm was found frequently. The maxilla had a higher percentage of primate and generalized space than the mandible. Class I canine relationship was

present and the majority of children exhibited a straight second molar terminal plane relationship. 14 references.

81. Author: Baranowski, T., Bee, D. E., Rassin, D. K., Richardsen, C. J., Brown, J. P., Guenthur, N., & Nader, P. R. (1983).
Title: Social support, social influence, ethnicity, and the breastfeeding decision.
Source: Social Science and Medicine 17(21), 1599-1611.
Abstract: The purpose of this study was threefold: 1) to establish whether the decision to breastfeed was related to the social support received for breastfeeding, 2) to determine which individual or combination of individuals providing support were most influential in promoting breastfeeding, and 3) to ascertain if a difference existed between social influence and social support processes. In order to answer these questions, a survey was conducted of all mothers delivering infants at a medical center hospital in Galveston, Texas. The survey was conducted within 48 hours of delivery during the month of July 1981. An instrument which included questions on the decision to breastfeed, social support, and social influence was utilized. A chi-square test for independence was used to study the relationship of decision to demographic, social support, and social influence variables. The pattern of bivariate relationships between person's supportiveness and breastfeeding varied across ethnic and marital status groups. Single and multiple logistic analyses were also conducted in order to determine who was most supportive of initiating breastfeeding. It was found that among Black Americans, a close friend was the most important source of support. For Mexican Americans, support from one's mother was the most important social support variable. With Anglo Americans, the male partner's support was the most valued. It was concluded that the key person to reach in order to increase support for breast feeding varies among ethnic groups. Therefore programs aimed at increasing Anglo American breastfeeding behavior should include male partners. For Black Americans, including friends is important. On other hand, among Mexican American mothers, social supportive targets ought to include the physician, mother of the index mother, friend, and grandmother in that order. 43

references.

82. Author: Barnett, P. G., Midtling, J. E., Velasco, A. R. Romero, P., O'Malley, M. Clements, C., Tobin, M. W., Wollitzer, A. O., & Barbaccia, J. R. (1984).

Title: Educational intervention to prevent pesticide-induced illness of field workers.

Source: The Journal of Family Practice, 19(1), 123-125.

Abstract: In response to a lack of knowledge regarding the potential health threat of working with pesticides among migrant Mexican field workers, a project was initiated to meet the health educational needs of these farm workers. Methodology included the development of a slide show with recorded narration featuring an interview with a member of a poisoned crew and its presentation to 16 groups of farm workers, students in adult English classes, parent advisory committees to migrant education programs, those attending meetings at a migrant labor camp, and parents at a community farm workers' clinc. The sample included 566 people. Of these, 166 agricultural workers were interviewed with a multiple-choice survey instrument in Spanish. Pre- and post-tests were given. Those surveyed before the presentation gave an average of 10.2 correct answers to the 14 questions asked in the questionnaire. Those surveyed immediately after gave an average of 11.6 correct answers. A third group was followed up after the presentation and averaged 11.3 correct responses. An analysis of the variance and Scheffe comparison showed the mean score of the post-test group to be significantly greater than the pre-test group. A striking observation was that after every educational presentation, someone in the audience volunteered an anecdote of past exposure to pesticide and resultant illness. The slide show augmented knowledge of pesticides. Because of the attention focused on this public health program, Monterey County became the first agricultural area in the United States to require that warning signs be posted in fields of pesticide-treated vegetable crops. 3 References.

83. Author: Black, J. R., Cahalin, C., & Germain, B. F.(1982).

Title: Pedal morbidity in rheumatic diseases: A clinical study.
Source: Journal of the American Podiatry Association, 72(7), 360-362.
Abstract: The purpose of this clinical investigation was to identify the pedal morbidity in a general rheumatic disease clinic. One hundred patients were sequentially selected over a six-week period from a general rheumatic disease clinic at the Veterans Administration Hospital in Tampa, Florida. Ninety-five percent of the subjects were male with an age range of early 20's to late 70's. Ninety-four percent were Caucasian, 3% Hispanic, and 3% Black. Disease entities were identified within the survey pool. The incidence of pedal morbidity in the cross section of rheumatic diseases was 82%. Seven of the 17 identified rheumatic diseases presented pedal morbidity at a 90% level or greater. It was concluded that patients with rheumatic diseases are at high risk for pedal morbidity. Therefore, in the management of the needs of patients with rheumatic diseases, the medical team needs to focus on this hidden part of the body. In this sample, rheumatoid arthritis was the most common rheumatic disease. 15 References.

84. Author: Bose, A., Vashista, K., & O'Loughlin, B. J. (1983).
Title: Azarcon por empacho--another cause of lead toxicity.
Source: Pediatrics, 72(1), 106-108.
Abstract: This study consisted of case reports of three Mexican American children who had been given azarcon, a folk remedy containing 86 to 95% lead. The treatment was to cure indigestion or any digestive symptoms known as empacho. Notes on the beliefs about empacho, including causes and cures are given. For example, Azafran, another orange folk remedy for empacho, is largely American Saffron and is harmless. However, greta, another remedy for empacho contains a mercury derivative that can also be harmful. 9 References.

85. Author: Brandt, Jr., E. N., & McGinnis, J. M. (1984).
Title: Nutrition monitoring and research in the Department of Health and Human Services.
Source: Public Health Reports, 99(6), 544-549.
Abstract: This paper is based on the testimony of Dr. Edward N. Brandt, Assistant Secretary for

Health before the Subcommittee on Science, Research and Technology. The paper reviews the status of current nutrition research and monitoring describing elements of activity and progress central to both nutrition monitoring and human nutrition research. In particular this report highlights a special survey of the health and nutritonal status of Hispanics. Data for this project was completed in 1984. The Public Health Service plans to release the first data tapes for analysis on the Mexican American sample in December, 1984. The policy implications for human nutrition within the Department of Health and Human Services is also highlighted. 0 References.

86. Author: Brinton, L. A., Hoover, R., Jocobson, R. R., & Fraumeneni, Jr., F. (1984).

Title: Cancer mortality among patients with Hansen's disease.

Source: Journal of National Cancer Institute, 72 (1), 109-114.

Abstract: For the evaluation of cancer risks associated with immunodeficiencies experienced by patients with Hansen's disease (Leprosy) and for the assessment of possible adverse effects of dapsone therapy, a follow-up study was conducted of 1,678 patients admitted to the National Hansen's Disease Center in Carville, LA, between 1939 and 1977. A total of 709 Hispanics most of whom were of Mexican descent were included in the follow-up study. To obtain expected mortality for the Hispanic sample, actual mortality rates for New Mexico Hispanics were used. Overall, no substantial cancer mortality was observed (standard and mortality ratio=1.3) nor was there any excess among patients exhibiting defects in cellular immunity by virtue of Lepromatous forms of the disease. Notable was the absence of any significant excess of lymphoma (5 observed vs. 2.3 expected), despite the predominance of the tumor in certain other immundeficiency states. Several cancer sites (oral, bladder and kidney) occurred excessively, but reasons for the observations were obscure. For example, Hispanics showed higher rates of cancers of the liver and gallbladder. In sum, this follow-up study did not reveal a substantially increased cancer risk among patients with Hansen's disease. There were certain other cancer sites (oral, bladder, and kidney) with elevated

risks, although these were probably related to various confounding factors in Hansen disease patients. 29 References.

87. Author: Bryant, C. A. (1982).
Title: The impact of kin, friend and neighbor networks on infant feeding practices. Cuban, Puerto Ricans and Anglo families in Florida.
Source: Social Science and Medicine, 16(20), 1757-1765.
Abstract: The study examines the impact of social networks as a tool to determine the effect of kin, friend and neighbor networks on infant practices. The study population consisted of Cuban, Puerto Rican and Anglo families in Dade County, Florida. Inter-ethnic differences in network members were noted in connection with giving assistance and advice on infant care. These influences on specific feeding practices were discussed. The decision to breastfeed, bottle-feed, use of sucrose supplements and when to add solid foods to the baby's diet were significantly affected by the social network. Findings were that members of the network by offering advice did contribute to a successful lactation experience. However, the application of Fisher's exact test to a small subsample did not show a significant correlation between presence or absence of network support and the outcome of lactation. (Author's abstract modified).

88. Author: Caetano, R. (1983).
Title: Drinking patterns and alcohol problems among Hispanics in the U.S.: A review.
Source: Drug and Alcohol Dependence, 12, 37-59.
Abstract: A review of the epidemiological literature available as of 1981, regarding Hispanic drinking. Data was derived from studies utilizing indirect measures, such as participation in treatment programs, arrest records and mortality patterns. These investigations have inherent biases and do not seem very useful. Survey research promises a wider scope. As of the date of this article there has been a paucity of research targeted to the Hispanic population. Rather, Hispanics that happened to be included in larger samples have been the cases utilized for analyses. Unfortunately this has resulted in fairly small sample sizes. Given this previous type of research based on small, possibly biased samples, the

conclusions from different studies are often contradictory. A special caution is added that intra-Latino differences between Puerto Ricans, Mexicans and Cubans are likely to be great. 18 References.

89. Author: Caetano, R. (1984).
Title: Ethnicity and drinking in Northern California: A comparison among Whites, Blacks, and Hispanics.
Source: Alcohol and Alcoholism, 19(1), 31-44.
Abstract: This research reports the drinking patterns and alcohol problems in three ethnic groups: Whites (N=2327), Blacks (N=1206) and Hispanics (N=634). Respondents were surveyed randomly from the general population of three counties surrounding San Francisco, California. One respondent, between the age of 19-59 years was randomly selected from each household for interviewing. Both Black and Hispanic females have higher rates of abstention than White females. Male drinking patterns are similar across ethnicities and prevalence of alcohol problems change dramatically according to age. Among White males, ages 20-30 years, drinking and associated problems decrease abruptly. Among Black males the trend is exactly the opposite of that for Whites, while among Hispanic males there is also a decrease but not quite so large as that for Whites. The frequency of Hispanic heavy drinking and problems is always higher than for the other two groups. The types of problems reported by respondents do vary by ethnicity, but the sociodemographic correlates of both number of drinks consumed per month and number of alcohol problems do differ among ethnic groups. Both Hispanics and Blacks have more liberal attitudes towards alcohol use than Whites. Whites, Blacks and Hispanic have different groups of people at risk for developing alcohol problems and prevention should be planned accordingly. 30 References.

90. Author: Caetano, R. (1984).
Title: Self-reported intoxication among Hispanics in Northern California.
Source: Journal of Studies on Alcohol, 45(4), 349-354.
Abstract: Self-reported intoxication among Hispanics in Northern California was studied through three independent surveys of the general popu-

lation conducted between 1977 and 1980 in three counties of the San Francisco Bay Area. All of the surveys followed the same sampling plan and only probability techniques were employed. A total of 634 adult who identified themselves as Hispanics served as subjects. In the sample, 20% of the men and 5% of the women reported becoming intoxicated at least once a month, rates twice as high as in the general U.S. population. Intoxication was more frequent among the young and among heavier drinkers, and it was also a significant predictor of alcohol-related problems. It is suggested that intoxication be studied carefully because of its association with alcohol related problems. 7 References.

91. Author: Caracci, G., Migone, P., & Dornbush, R. (1983).
Title: Phencyclidine in an East Harlem psychiatric population.
Source: Journal of the National Medical Association, 75(9), 869-874.
Abstract: The purpose of this study was to investigate the use of phencylidine (PCP) in a psychiatric population of an East Harlem hospital. The hospital provides services to a community that is 58% Hispanic, 21% Black, and 21% White. The Hospital is used by 48% Hispanics, 32% Blacks, and 20% Whites. The population served is a low socioeconomic one. Sixty-eight consecutive PCP users admitted to the hospital were interviewed through a 77 item questionnaire. The majority of the subjects were Black (86%), single (72%), and living with their parents (79%). Based on the findings, it was concluded that either more Blacks use PCP or non-Black PCP users seek psychiatric help less frequently than Black users. In addition, the findings pointed to the many problems affecting the respondents and the risk for developing psychiatric problems which exist in the population. 15 References.

92. Author: Carpenter, J. L., Obnibene, A. J., Gorby, E. W., Neimes, R. E., Koch, J. R., & Perkins, W. L. (1983).
Title: Antituberculosis drug resistance in South Texas.
Source: The American Review of Respiratory Diseases, 128, 1055-1058.
Abstract: The purpose of this report was to study drug-

resistant patterns in South Texas. Age, sex, and ethnic group were not found to significantly affect the incidence of resistance. Four drugs were considered in this analysis. These included isoniazid, ethambutal, rifampin, and streptomycin. There was a 7.3% rate of resistance to isonized and/or ethambutal or rifampin for any individual organism. Based on the findings, it was concluded that the incidence of single and multiple antituberculosis drug resistance in South Texas was found to be higher than previously documented. 8 References.

93. Author: Carrillo, R. A. & Marrujo, R., (1984).
Title: Acculturation and domestic violence in the Hispanic community.
Source: Denver, Colorado: Servicios de la Raza, Inc.
Abstract: The purpose of this paper was to report on the exploratory study of ten couples experiencing domestic violence. The study sought to establish a relationship between acculturation, stress and domestic violence in a Hispanic community in Denver, Colorado. Acculturative stress was defined as "psychological distress or discomfort in daily events experienced by an individual or group attempting to adopt a new culture," (Padilla, et al, 1983). In treating ten battered couples, the investigators found that differing levels of acculturation and acculturative stress produced marital conflicts in several areas. These included: sex role expectations, family obligations and relationships, and the permissible amount of the type of contact with persons/institutions associated with the host culture (U.S.). In particular, women who were more acculturated than their spouses tended to be more nontraditional in their attitudes toward women's roles and therefore clashed with males having more traditional sex role expectations. Based on the findings of this exploratory study, the authors recommended further research on the relationship of acculturative stress and domestic violence among Hispanic couples and well adjusted Hispanic couples should also be formulated. Finally, it was recommended that practitioners need to understand current models of acculturation to comprehend an individual's particular level of acculturative stress and its impact on the individual's psychological process. 5 References.

94. Author: Castro, F. G., Baezconde-Garbanati, L., & Beltran, H. (1985).
Title: Risk factors for coronary heart disease in Hispanic population: A review.
Source: Hispanic Journal of Behavioral Sciences, 7(2), 153-175.
Abstract: Epidemiological studies of coronary heart disease (CHD) risk factors among Hispanics were examined. Hispanics as compared with Anglo Americans and Blacks appear to have somewhat lower mortality rates of CHD. This suggests that Hispanics may have lifestyle patterns which reduce CHD risk in the areas of: stress, diet, exercise, hypertension and smoking. However, independent studies report that their samples of Mexican American subjects, but not Puerto Rican subjects, had higher blood lipid levels, greater rates of being overweight and participate in less aerobic exercises as compared with same sex and aged Anglo American cohorts. By contrast, adult Mexican Americans and Puerto Ricans tend to smoke less than do Anglo American cohorts, although some evidence suggests that Hipanic adolescents may smoke more than do their Anglo American peers. The CHD risk status of Hispanics is summarized and recommendations for future research and health promotion programs are made. Author's abstract. 72 References.

95. Author: Chin, J., & Roberto, R. R. (1985, March-April).
Title: Cysticercosis in California.
Source: Border Epidemiological Bulletin, pp. 1-2.
Abstract: A report on the problem of beef (Taenia saginata) and pork (Taenia solium) tapeworms. The two-stage life cycle of the parasites is charted. The conditions under which cysticercosis infestation by tapeworm can be acquired and passed on are described. Areas in which the affliction is endemic are listed. The behavior of the parasites, once ingested, is described, including sites of infestation and accompanying symptoms. Also discussed are methods of diagnosis and their relative effectiveness. From 1979 to 1983, 214 cases were reported in California. A CDC survey of 4 major Los Angeles Hospitals serving large Hispanic populations found 458 cases between 1973 and 1983. Possible factors leading to an increase in cysticercosis should be considered as a diagnosis when seeing patients from endemic areas who have neurological findings such

as unexplained seizures and headaches. 3 References.

96. Author: Collado, M. de L., Kretshmer, R. R., Becker, I., Guzman, A., Gallardo, L., & Lepe, C. M. (1981).
Title: Colonization of Mexican pregnant women with group B streptococcus.
Source: The Journal of Infectious Diseases, 143(1), 134.
Abstract: The purpose of this study was to document the incidence of Group B streptococcus (GBS) in 200 lower, middle class Mexican American women in their last prenatal vist. Single rectal and endocervical swabs were done for identification of GBS. A 1.5% rate of endocervical colonization with GBS was found. This was statistically less than the rate found by previous research. The lower rate of GBS colonization in Mexican women in Los Angeles and Mexican women in Mexico City than in White and Black women in Los Angeles City may reflect not only differences in genetic constitution but also differences in sexual practice and environmental factors such as hygiene and nutrition. Since the single most important factor in GBS infection in the neonate is the presence of microorganism in the maternal genital tract at birth, the low colonization rates among Mexican women may explain the low and sporadic incidence of sepsis due to GBS in neonates in Mexico. 1 Reference.

97. Author: Coreil, J. (1984).
Title: Ethnicity and cancer prevention in a tri-ethnic urban community.
Source: Journal of the National Medical Association, 76(10), 1013-1019.
Abstract: This paper, published in 1984, presents the findings of ethnic awareness and naturally occurring behavioral changes needed to reduce cancer risk, with special attention to knowledge of recommended safeguards and dietary factors in cancer prevention. Most of the frequency differences of cancer among ethnic groups may be attributable to behavioral, social, and enviromental factors rather than biological or genetic characteristics. A household survey of 64 residents of Galveston, Texas, including 20 Blacks, 20 Mexican American, and 24 White adults was conducted during the winter of 1982. A 45-item interviewer-

administered questionnaire was given to all subjects. Knowledge of smoking and dietary risk factors was substantial (78% and 36%, respectively), but awareness of cancer safeguards involving reduced sun exposure and mouth and proctological examinations was very low. One of five respondents had taken measures to prevent cancer, and these persons tended to rate their own risk higher than respondents who made no life-style changes. Self-motivated behavior change focused primarily on avoidance of cancer-promoting foods. Blacks had a lower awareness of cancer causes and prevention measures particularly regarding dietary factors and behavior modification than Whites and Mexican Americans. The findings reaffirm the need to consider ethnic background when targeting health information to particular audiences. Television, magazines and radio were the major cancer information sources. 25 References.

98. Author: Cuellar, J. B. (Ed.), (1983).
Title: A la brava--frankly speaking about drug,alcohol and substance abuse in the Chicano experience.
Source: San Diego, CA: San Diego State University.
Abstract: This syllabus for a college course seeks to give the student a basic understanding of abuse in the Mexican American coummunity, especially the tecato subculture. Part one provides an overview of the drugs and substances used and abused by Hispanics. Part two presents an analysis of the historical, political, and cultural perspectives involved in the development of drug abuse policies and treatment models which have directly affected the Hispanic addict. Part three examines the status of the Chicano addict in the tecato subculture and in correctional institutions from an insider's perspective. Part four is designed to increase the students awareness of basic characteristics of the tecato subculture as well as the contrasting values of counselor and addict, the different types of counselors, programs and treatment from the tecato perspective and the most effective treatment approaches for the tecato. 0 References.

99. Author: Dawkins, R. L., & Dawkins, M. P. (1983).
Title: Alcohol use and delinquency among Black, White, and Hispanic adolescent offenders.

Source: Adolescence, 18(72), 799-809.
Abstract: This study, published in winter 1983, examines the relationship between drinking and criminal behavior among adolescent male and female offenders in a northeastern state. Data were collected by means of questionnaires administered to 342 residents of a public juvenile facility. Analyses were performed separately for each racial subgroup including, Blacks, Whites and Hispanics. The results of the present study provide evidence which may help clarify the inconsistent findings of previous research on alcohol, delinquency and ethnicity. Based on simple correlations, the results show that among each subgroup, drinking is strongly associated with minor (victimless) juvenile offenses. However, the correlation between drinking and serious offenses is strong only for Blacks and Whites, but not for Hispanics, which suggests that other sociocultural experiences must be considered when attempting to assess the likelihood that will lead to serious criminal involvement among this group. Multiple regression analysis further reveals that relative to other background and behavioral factors, drinking is the strongest single predictor of criminal offenses among Blacks, with less importance for Whites and little importance for Hispanics. Implications for prevention are discussed. 24 References.

100. Author: Delano, B. G., Lundin, A. P., & Friedman, E. A. (1982).
Title: Successful home hemodialysis in purportedly unacceptable patients.
Source: Nephron, 31, 191-193.
Abstract: Presentation of four cases of successful home hemodialysis experience by patients that could easily have been excluded from consideration for this type of therapy because of age, marital status, intelligence, economic status and language proficiency. One of the cases included a 27-year-old Hispanic father of unspecified nationality living in downstate new York. 11 References.

101. Author: Delgado, M. (1980).
Title: Consultation to a Puerto Rican drug abuse program.
Source: American Journal of Drug and Alcohol Abuse, 7(1), 63-72.

Abstract: A case study of one consultant's experience working with a drug abuse program serving a Puerto Rican community in Massachusetts. The various steps taken to win staff confidence and cooperation are detailed, along with the substantive program suggestions. 35 References.

102. Author: Desmond, D. P., & Maddux, J. F. (1984).
Title: Mexican American heroin addicts.
Source: American Journal of Drug and Alcohol Abuse, 10(3), 317-346.
Abstract: Mexican Americans are the second largest ethnic minority group amongst visible opioid addict population in the United States. This study looks at previous research on historical background and indicates that socioeconomic problems: poverty, under education, poor command of English, limited vocational skills and discrimination may be more important than cultural change. The difference between Mexican Americans and other Hispanic groups is discussed. Comment is made of the lack of research into the above areas prior to 1970. Clinical and research literature is reviewed, as well as presenting new data from studies in San Antonio. Prior research on heroin addiction, clinical and psychological studies is described and results compared. Findings are summarized and the authors state that, in their opinion, the drug dependence itself, and the physical, mental, and social changes which go with it, represent common features among heroin users which outweigh the ethnic differences. 90 References.

103. Author: Desmond, D. P., & Maddux, J. F. (1981).
Title: Religious programs and careers of chronic heroin users.
Source: American Journal of Drug and Alcohol Abuse, 8(1), 71-83.
Abstract: The purpose of this paper is to review the literature and report on the religious program participation of 248 San Antonio addicts, 87% of whom are Mexican American and have been followed from 1966 through 1980. All subjects were males residing in San Antonio who were treated for opioid dependence at the former U.S. Public Health Service Hospital in Fort Worth, Texas, between 1964 and 1967. For 95%, heroin was the principal drug used. During a twelve year period, 11% of the 248 entered

religious programs. While only 33 admissions occurred, the percent followed by a year or more of abstinence (44%) exceeded that of conventional treatment or correctional interventions. It was concluded that the ability of religious programs to attract large numbers of clients is limited. However, major changes in attitudes and lifestyle occur among some participants. Successful participation is related possibly to a special motivational state at admission. The authors contended that religious programs may be viewed as sociotherapy and similiar to traditional therapeutic communities and other self-help programs. Factors thought to lead to success of religious programs among Mexican Americans may be: their unique religious orientations, their tradition of non-medical healing rituals, such as curanderismo and their positive expectation of religious programs. 50 References.

104. Author: Dewey, K. G., Chavez, M. N., Gauthier, C. L., Jones, L. B., & Ramirez, R. E. (1983).
Title: Anthropometry of Mexican American migrant children in Northern California.
Source: The American Journal of Clinical Nutrition, 37 (May), 828-833.
Abstract: The objective of this study was to evaluate the growth of a sample of migrant children in the Sacramento Valley of California, and to compare results to those found in studies in the previous decade. Anthropometric data were obtained from 209 Mexican American migrant children, 0-7 years of age. Physical examinations were completed on the preschool children by trained medical personnel. Hematocrit measurements for 170 children revealed that only 13 children (7.6%) had hematocrits below acceptable levels. Growth standards from the National Center for Health Statistics (NCHS) were used to determine the weight-for-height, height-for age, and weight-for-age growth percentiles of each child at each exam. Only 15% of the children were at or below the 10th percentile of height-for-age, only 7% were above the 95th percentile of weight-for-height, and the weight-for-age distribution was very close to the NCHS standard, in contrast to results obtained by earlier nutrition survey studies of Mexican American children. The mean percentile of weight-for-height increased significantly with age, while height-

for-age decreased. Growth rates for weight and height accelerated during their summer residence in the U.S., indicating that the adequate growth status of these children may be related to improved conditons for growth while in the U.S. 12 References.

105. Author: Deyo, R. A. (1984).
Title: Pitfalls in measuring the health status of Mexican Americans: Comparative validity of the English and Spanish Sickness Impact Profile.
Source: American Journal of Public Health, 74(6), 569-573.
Abstract: A sample of 120 patients utilizing a walk-in clinic in San Antonio, Texas, was chosen to assess the internal consistency of English and Spanish versions of the same instrument. The Sickness Impact Profile (SIP) was translated, and applied in a clinical study of low back pain. Respondents were divided into three groups: Group I, Non-Hispanic (N-23); Group II, Mexican Americans who used the English version (N-54); Group III, Mexican Americans who used the Spanish version (N-43). The internal consistency of responses of all three groups was excellent. However, when the construct validity was tested by correlating the SIP scores with clinically observed measures of disease severity, differences emerged. Group I responses appeared to be highly valid, while Group III were not. Group II responses were intermediate. Although both Groups II and III were Mexican American, there is reason to believe that those who speak only Spanish are different. They are generally less well educated, less fluent in English, and generally appear to be less "acculturated" than Group II respondents. The study concludes that Hispanics are very heterogeneous. 19 References.

106. Author: Dicker, L., & Dicker, M. (1982).
Title: Occupational health hazards faced by Hispanic workers: An exploratory discussion.
Source: Journal of Latin Community Health, 1 (1), 101-107.
Abstract: A study addressing occupationally related health problems of Hispanic Americans. Using 1980 statistics from the Bureau of the Census and the Department of Labor, the placement of Hispanics across the United States and in the occupational and industrial order is des-

cribed. Based on 1980 Department of Labor statistics, the relative health hazards in each industry are listed. The major findings are that 47% of all Hispanics work in the five highest categories in terms of overall health risk and that 64% of Hispanics are blue-collar workers. This report focuses on broad industrial and occupational categories and related risks associated with them, thereby laying the groundwork for further study of particular problems. 5 References.

107. Author: Diehl, A. K., Stern, M. P., Ostrowers, V. S., & Friedman, P. C. (1980).
Title: Prevalence of clinical gallbladder disease in Mexican American, Anglo and Black women.
Source: Southern Medical Journal, 73(4), 438-441, 443.
Abstract: A study to determine the status of gallbladder disease in ambulatory Mexican American women, in comparison to that of Black and White women. The records of 1,018 women patients of the Family Health Center of the University of Texas Health Science Center were retrospectively reviewed. They were all of low socioeconomic background, aged 15 to 59. Of these, 551 were Mexican American, 111 Anglo, and 356 Black. A variety of factors relating to medical history were noted. The presence of gallbladder disease was determined by a hospital record of surgery for gallstones, a history of cholecystectomy, or a record of abnormal results of an oral cholecystogram. These categories were tested for statistical significance using the chi squared test and differences in continuously distributed variables were evaluated, using the student's t test. The five variables tested in the analysis of variance model were: presence or absence of gallbladder disease, age decade, presence or absence of diabetes, ethnic group, and degree of adiposity. Mexican American women were found to have a prevalence of gallbladder disease three times that of Black women, with Anglo rates falling in between. Gallbaldder disease was also positively associated with increasing age and diabetes. An association with obesity was shown but could not be shown to be independent of other risk factors. Multivariate analysis showed ethnic/racial background to be an important contributor to gallstone prevalence even after age, adiposity, and diabetes had been considered. The researchers suggest that Mexican American

heritage and diabetes mellitus are risk factors for gallbladder disease which should be taken into account by the examining physician when making a diagnosis. References.

108. Author: Dominquez, S. (1980, Fall).
Title: Tuberculosis in the Chicano communities of Los Angeles: is there an epidemic? What is being done about it?
Source: (Available from UCLA Chicano Studies Research Library, 3121 Campbell Hall, UCLA, Los Angeles, California 90024).
Abstract: This document attempts to provide an answer to the question of a possible tuberculosis epidemic in the Latino community. Area data indicate that while the number of cases is rising, they are occurring in the Black and Asian areas of Los Angeles: cases are dwindling in the Latino areas. Anecdotal data from interviews with provider are furnished. 12 References.

109. Author: Domino, G. (1981).
Title: Attitudes toward suicide among Mexican American and Anglo youth.
Source: Hispanic Journal of Behavioral Sciences, 3(4), 385-395.
Abstract: Suicide rates for Mexican Americans are lower than for Anglos, but are accelerating quite rapidly. This study decribes the attitudes Mexican Americans have towards suicide. A suicide opinion questionnaire (SOQ) was administered to 76 Mexican Americans and 76 Anglos from three Arizona communities, equated on several demographic dimensions. An item analysis yielded statistically significant differences on 35 of the 100 SOQ items. Twice as many Mexican Americans believe that the higher incidence of suicide is due to the lesser influence of religion. The present results fully support earlier observations indicating that while the incidence of ritualistic expression of Catholicism among Mexican Americans may be low, religious beliefs do play a major role in their daily lives. On the psychopathological aspects of suicide, Mexican Americans were more likely to label suicidal persons as mentally ill but less likely to consider them under stress. Anglos tend to accept suicide more as a possibility to end incurable illness. Also a greater proportion of Mexican Americans believe that

those who threaten to commit suicide rarely do so and mention that it's more of a "cry for help." Finally, the results show that suicide has a greater emotional impact upon Mexican Americans. The implications of these finding are briefly discussed. 19 References.

110. Author: Fortmann, S. P., Williams, P.T., Hulley, S.B., Maccoby, N., & Farquher, J. W. (1982).
Title: Does dietary health education reach only the privileged?
Source: The Stanford Three Community Study, 66(1), 77-82. (Stanford Heart Disease Prevention Program and the Department of Medicine and Communication, Stanford University School of Medicine).
Abstract: The Stanford Three Community Study is a quasi-experimental field study to determine if a community-directed health education program could reduce the risk of cardiovascular disease among a cross-cultural adult population ages 35-59, and to determine the responses of different social groups to the educational efforts. The relationship of selected social factors to diet, weight and plasma cholesterol was studied in one control and two treatment towns before and after a 3-year, bilingual, mass-media health education program. Spanish-speaking persons reported higher dietary cholesterol and saturated fat than English-speaking participants at baseline, and this remained true after adjusting for the confounding influence of socioeconomic status (SES). Obesity was also more prevalent in Spanish-language and low-SES groups, but plasma cholesterol was not related to these sociodemographic factors. Over the 3 years of the education program, all groups reported 20-40% decreases in dietary cholesterol and saturated fat. These decreases were as large in low-SES groups as in high-SES groups; Spanish-speaking participants reported significantly greater decreases in dietary saturated fat ($p=0.02$). Weight change was not related to either SES or language group, but change in plasma cholesterol was marginally more favorable in Spanish-speaking subjects ($p=0.06$). 31 References.

111. Author: Gibson, G., & Torres, A. M. (Eds.). (1981).
Title: Child abuse and neglect: The Mexican American community.

Source: Proceedings of the First Annual Conference on Child Abuse and Neglect in the Mexican American Community. Texas Migrant Council, Laredo, Texas.

Abstract: The First Annual Conference on Child Abuse and Neglect in the Mexican American Community, sponsored by the Texas Migrant Council and the National Resource Center on Child Abuse and Neglect for Mexican Americans, met in Laredo, Texas. The conference focused attention on the severe problems of abuse and neglect among Mexican American children in general and among those whose families are migrants in particular. Ten papers were presented in two categories: 1) Child abuse and neglect and the Mexican American community: issues and approaches to problems; 2) Child abuse and neglect research and the Mexican American. Topics of discussion included lack of staff members who speak Spanish or understand the culture of Mexican American families in child protective agencies, and the fact that lack of all adult members of the family must work leads to children being left in care of their siblings. The importance of recognizing the differences between Mexicans, Mexican Americans, and other Latinos was stressed. Discussed was the lack of accurate demographic information as well as a need for in-service training to minimize problems of insensitivity. Consensus was that problems of child abuse and neglect among migrant families are serious, but there were ideological variations as what was considered the "best" solution. 18 References.

112. Author: Gilbert, M. J. (In Press).

Title: Intracultural variation in attitude and behavior related to alcohol: Mexican Americans in California.

Source: In L. Bennett and G. Aimes. (Eds.) The American Experience with Alcohol. New York, NY: Plenum Press.

Abstract: A paper based on ethnographic work in three heavily Mexican American areas: Los Angeles, Fresno and San Jose. Drinking in private (weddings, baptisms, birthdays) and public is studied qualitatively. Differences are noted between foreign and nativeborn drinking patterns. Foreign born tend to drink in singles sex situations, native born tend to drink in mixed sex situations. Class differences compound the nativity differences. Rising class females tend to drink more than lower class;

still, significant sex differences in drinking patterns exist. The effect of alcohol use on kinship and marriage interaction is examined. Alcohol consumption is seen as deviant only when it impairs social relations or performance of role-related obligations. 24 References.

113. Author: Glick, R. (1983).
Title: Dealing , demoralization and addiction: Heroin in the Chicago Puerto Rican community.
Source: Journal of Psychoactive Drugs, 15(4), 281-292.
Abstract: This article reports findings from ethnographic research on heroin addiction. The subjects interviewed were Puerto Rican drug dependents and/or ex-addicts from the Chicago area. The results emphasize the relationship among social barriers, family demoralization and addiction to escape life's problems. These findings support a sociological interpretation which suggests that among the lower-class, addiction is used to escape from the sense of failure brought on by lack of opportunity. The analysis of the results emphasizes the influence of social inequality that has impacted heavily on many families, thus frustrating achievement of life goals, bringing discouragement and addiction. Although addiction for many of the Chicago Puerto Rican respondents was motivated by the need to escape life problems, this does not mean that respondents were passive. In fact, out of necessity respondents pursued an active lifestyle including affiliation with gangs. Also discussed are the dilemmas confronting female Puerto Rican addicts. The problem of heroin addiction does not rest so much with the addicts, but rather in the lack of opportunity. Judging from research among Chicago's Puerto Ricans, these reports may indicate both the extent of drug dealing and the extent of demoralization these communities are experiencing. 19 References.

114. Author: Gonzalez, D. H., & Page, J. B. (1981).
Title: Cuban women, sex role conflicts and the use of prescription drugs.
Source: Journal of Psychoactive Drugs, 13(1), 47-51.
Abstract: This is an ethnographic study of 100 Cuban immigrant women residing in Dade County. The purpose of the study was to analyze prescription drug use among Cuban immigrant women. It

was hypothesized that the use of prescription drugs was an adaptive strategy to relieve the stress originating from the discrepancies between Cuba and the U.S. in the respondents' socioeconomic status, sex roles, cultural background and lifestyle in general. A brief screening interview was given that requested information on drug use patterns of all respondents. Results indicated that almost three-fourths of these women had used pills (usually minor tranquilizers). Of these, 30% use them daily or more frequently. Also, half of the interviewed women used sleep aids (sedatives and tranquilizers) on a regular basis. The relationship between presence or absence of sources of stress and patterns of intensive drug use was not shown to be significant. However, subjects did state that exile uncertaintly (i.e., anxiety about fate of relatives, income, employment, repatriation) and acculturation problems were the two most important reasons for their drug use. 16 References.

115. Author: Gordon, A. J. (1981).
Title: The cultural context of drinking and indigeneous therapy for alcohol problems in three migrant Hispanic cultures.
Source: Journal of Studies on Alcohol, 9 (Supplement), 217-240.
Abstract: An ethnographic study of drinking and treatment patterns among three Latino groups in a small "New England" town: Dominicans, Guatemalans and Puerto Ricans. No statistical analysis is provided. Dominicans were upwardly striving immigrants with families, who drink little and in moderation. The Guatemalans were largely males without families, who evidenced much drinking, rapidly and in great quantity. They tended to use an Alcoholics Anonymous group composed almost entirely of Guatemalans. Puerto Ricans were poly drug users, and seemed not to be striving for upward mobility. They used pentecostal, evangelical churches for treatment via being "born again." 13 References.

116. Author: Guerra-Ellis, I. (1984, September).
Title: Hansen's disease in Hispanic patients.
Source: Paper presented at the meeting of the National Association of Hispanic Nurses, Los Angeles, California.

Abstract: The states in which Hansen's disease is endemic have large Hispanic populations. The highest prevalence is found in Texas. Approximately 45% of the residents in the National Hansen's Disease Center are Hispanic, suggesting that this disease may be somewhat more prevalent in this group than in others. This paper presents a protocol of etiology, symptoms and treatment, which are applicable to all Hansen's disease patients. Some psychosocial aspects are noted which are applicable to all populations. This is not a survey or clinical study, but rather a protocol for sensitization of professionals. 0 References.

117. Author: Haider, S. Q., & Wheeler, M. (1980).
Title: Dietary intake of low socioeconomic Black and Hispanic teenage girls.
Source: Journal of the American Dietetic Association, 77(6), 677-681.
Abstract: The present study was undertaken to assess and compare the 1974 Recommended Dietary Allowances (RDAs) with the nutrient intake of teenage girls in Black and Hispanic families residing in the Bedford-Stuyvesant section of Brooklyn, New York. Comparison was also made with the intake of their mothers. The site has a population of 75% Blacks and 23% Hispanic. Systematic random selection was used to select 75 Black and 75 Hispanic teenage girl-mother pairs. The instruments of data collection were: (a) a 24-hour dietary recall and a 2-day record, (b) a foodbuying and preparation questionnaire, and (c) anthropometric measurements. Private interviews were conducted by the authors and five specially trained advanced nutrition college students. Results were compared to the 1974 RDAs. It was found that the intake of all nutrients was either below or close to the RNA levels for all ages, the exception being that protein and ascorbic acid intake was considerably higher. Vitamin A intake of both Blacks and Hispanics were within or higher than recommended levels. The findings on caloric intake suggest a relatively high consumption of bacon and fatty meats and low intake of fruits and vegetables. There was no significant differences between the pooled mean nutrient intakes of Black and Hispanic girls. Anthropometric data indicated a prevalence of overweight, particularly in the Black population. Comparison of mothers and daughters showed similar intakes. Poverty

was a more significant factor than race for the data of this study. Conclusions were that any effective nutritional program must include proper selection, buying and meal preparation of food for the entire family as well as an emphasis on regular eating habits. 27 References.

118. Author: Hasir, H. E. (1982).
Title: The relationship between vitamin B-6 levels in the diet and breast milk of ten Mexican American women.
Source: Ann Arbor, MI: University Microfilms International, No. 1319547.
Abstract: The purpose of this study was to analyze the diets of ten lactating low socioeconomic women to determine if vitamin B-6 ratios met the Recommended Dietary Allowances of 0.02mg vitamin B-6:protein ratio, and to determine if dietary vitamin B-6 levels were correlated with breast milk levels in these women. The Saccharomyces carlsbergensis microbiological assay was utilized to measure vitamin B-6 in the milk samples. It was found that vitamin B-6 levels were within the suggested range according to the National Research Council. A statistically significant, positive correlation was found between dietary vitamin B-6 and breast milk among 8 subjects. It was concluded that despite marginal maternal intakes of vitamin B-6, the breast milk levels of low socioeconomic Mexican American women seemed to be adequate to fulfill the needs of their infants, based on the National Research Council. 26 Reference.

119. Author: Hazuda, H. P., & Haffner, S. M. (1984).
Title: Acculturation as a protective factor against diabetes in Mexican Americans: The San Antonio Heart Study.
Source: Diabetes, 33(5), 30A. (No. 117).
Abstract: Non-insulin dependent diabetes mellitus (NIDDM) is a major health problem of Mexican Americans, the largest Hispanic subgroup in the U.S. Authors recently reported that relative to Anglo Americans, Mexican Americans have a two to threefold excess of diabetes, even after adjusting for differences in obesity. This study examined whether higher levels of acculturation (adoption of Anglo American behaviors, attitudes and values) are associated with lower NIDDM prevalence among Mexican

Americans. Subjects were a random sample of Mexicans (532 men, 707 women), ages 25-64, selected from three socioeconomically distinct neighborhoods. Levels of acculturation in adulthood were measured using scales which evidenced excellent construct validity and internal consistency. NIDDM was diagnosed using the NDDG criteria. Tests for linear trend across levels of acculturation were run separately for men and women, using multiple logistic regression with adjustments for age and SES. Increased levels of acculturation were consistently associated with a reduction of NIDDM prevalence for both men and women. After an additional adjustment for obesity, results suggested that the effect of acculturation on NIDDM is largely mediated through obesity for women but is largely independent of obesity for men. (Journal abstract modified.)

120. Author: Hazuda, H. P. (1984), November 30).
Title: Differences in socioeconomic status and acculturation among Mexican Americans and risk of cardiovascular disease.
Source: Paper presented to the Task Force on Black and Minority Health, Bethesda, MD.
Abstract: The purpose of this paper is to review the available literature to assess the extent to which increasing differences in socioeconomic status and acculturation among Mexican Americans are associated with differences in cardiovascular risk factors and to make public health recommendations based on the findings. The author reviews education, occupation, and income among Mexican Americans. Cardiovascular disease as a cause of death among Mexican Americans is discussed, focusing on studies done in this area. Twenty-one research reports between 1966 and 1984 concerning socioeconomic status and acculturation among Mexican Americans are next discussed. The evidence contained in these reports deals with six risk factors: lipids and lipoproteins, blood pressure and hypertension, cigarette smoking, exercise, obesity, and diabetes. The studies indicate that within the Mexican American population, those in the lowest socioeconomic group and those who are the least acculturated have a significantly worse profile of cardiovascular risks than those in higher socioeconomic groups and those who are more acculturated. Obesity and noninsulin

dependent diabetes mellitus rank as major health problems in Mexican Americans of both sexes. For Mexican American males, hypertension and cigarette smoking rank as significant health problems as well. Greater hypertriglyceridemia and lower levels of high density lipoprotein cholesterol in both sexes exist along with greater hypercholesterolemia and higher levels of low density lipoprotein. Cholesterol in males relative to non-Hispanic Whites should also be recognized as a public health concern. Public Health recommendations included: research on genetic and life-style factors related to insulin dependent diabetes mellitus in Mexican Americans, public health education concerning hypertension and smoking among Mexican American males, the monitoring of lipids and lipoproteins in Mexican Americans, and focusing on the lower levels of socioeconomic status in order to lower the profile of coronary risk among Mexican American. 43 References.

121. Author: Heisel, M. A., Siegel, S. E., Falk, R. E., Siegel, M. M., Carmel, R., Lechago, J., Skaff, G., Roessel, T., Nielsen,P. G., & Cummings, P. (1984).

Title: Congenital pernicious anemia: Report of seven patients, with studies of the extended family.

Source: The Journal Pediatrics, 105(4), 565-568.

Abstract: The purpose of this paper is to describe seven cases of congenital pernicious anemia in an extended family which included seven children ranging from 1 1/2 to 12 years. All of the affected children had megaloblastic anemia accompanied by low serum B12 and normal serum folate levels. Normal gastric acidity along with normal serum folate levels was revealed by gastric fluid analysis. Serum antibodies to intrinsic factor or parietal cells were also absent. Schilling tests were done on six of the patients and produced abnormal results. A gastric biopsy was done on 3 of the patients with two having normal histologic finding and one with mild atrophy. All patients responded to parenteral administration of vitamins B12. One hundred and seventy extended family members were screened for the defect with complete blood counts and serum B12 levels. Doing such screening detected two of the children. No other abnormalities that could be attributed to pernicious anemia were detected. Long term studies in these patients, as well

as surveillance of the other family members will be necessary to rule out the possibility of additonal cases developing with time. Detection of the carrier will probably require careful quantification of the levels of intrinsic factor secreted into the gastric juice. Based on the family pedigree, autosomal recessive inheritance is likely. The variability of age presentation in this family is noteworthy and suggests that expression may be modified by still undefined factors. 33 References.

122. Author: Hoft, R. H., Bunker, J. P., Goodman, R. I., & Gregory, P. B. (1981)
Title: Halothane hepatitis in three pairs of closely related women.
Source: The New England Journal of Medicine, 304(17), 1023-1024.
Abstract: The purpose of this study was to investigate if a genetic component may be involved in halothane hepatotoxicity. In this study, three pairs of closely related women developed hepatitis following anesthesia with halothane. Two of the patients were mother and daughter, two were sisters, and two were first cousins. All reported either Mexican Indian or Mexican Spanish origin. No ancestors were shared by the three pairs. All lived in California. The authors contended that based on their observations of post-halothane hepatitis in these closely related women with a common origin, familial susceptibility to halothane-induced hepatotoxicity may exist since the probability that this could occur by chance alone is very small. The authors postulated that if a familiar basis for some cases of halothane hepatitis exists, it may have not been reported because most surveys of this conditon have been performed in the United States and Europe where persons of Hispanic origin are in the minority. 14 References.

123. Author: Holland, T. R., Levin, M., & Beckett, G. E. (1983).
Title: Ethnicity, criminality, and the Buss-Durkee Hostility inventory.
Source: Journal of Personality Assessment, 47(4) 375-378.
Abstract: A small-scale survey to apply the Buss-Durkee Hostility Inventory (BDHI) scale to the prediction of violent and non-violent crime in a

multi-ethnic sample. One hundred fifty-one offenders in a California correctional facility were utilized. There were 40 Whites, 53 Mexican Americans, and 48 Blacks. The BDHI tested for two hostility scales (Resentment and Suspicion) and five aggression scales (Assault, Indirect Aggressiveness, Irritability, Negativism, and Verbal Aggression. The rankings on these scales were then compared with violent or non-violent nature of the most recent offenses. There was no statistically significant association between the scale scores and the violence of the most recent offense. When the ethnic groups are compared, Whites have higher Indirect Aggression, Irritability and Verbal Aggression scores than Blacks, and lower Suspicion. Mexican-Americans occupied a place between the two other groups. The study concludes that violent criminal conduct is more likely a product of situational, sociocultural, and physiological variables, rather than of the psychological characteristics of offenders. 14 References.

124. Author: Honig, G. R., Seeler, R. A., Shamsuddin, M., Vida, L. N., Mompoint, M., & Valcourt, E. (1983).
Title: Hemoglobin Korle Bu in a Mexican family.
Source: Hemoglobin, 7(2), 185-189.
Abstract: The purpose of this report is to discuss the identification of the Hb Korle Bu in a Mexican Indian family from Durango. Second, this paper describes a method for confirming the presence of this variant. The index case involved a 23-month-old Mexican child in Cook County Hospital Chicago, Illinois, who demonstrated a "AS" pattern with a negative sickling test based on hemoglobin electrophoresis. Studies of this distribution of abnormal hemoglobins in Mexico have demonstrated a high incidence of Hb S, especially in coastal areas formerly active in African slave trade. Surveys among various Indian populations of Mexico have demonstrated an absence of abnormal hemoglobins. The family described in this report was from an isolated rural area of West Central Mexico and of Indian heritage. The possibility that this hemoglobin in this family may have resulted from an independent mutation was considered. 15 References.

125. Author: Horton, P. A. (1981).
Title: Utilization of alcoholism services by Mexican Americans: A case study in social networks and ethnic marginality.
Source: Ann Arbor, MI: University Microfilms International, No. 8215857.
Abstract: The goal of this doctoral dissertation was to document the process of a specialized health care delivery system as a case study in the dynamic of urban assimilation and/or marginality of Mexican Americans. This work attempts to delineate a unifying system model of social prevalence of alcohol problems among Mexican Americans as well as the failure of appropriate health care systems to respond adequately. The ethnographic study was conducted in Santa Barbara, California. Information about treatment and prevention programs was obtained while the author was on the staff of the National Council of Alcoholism. This provided him with access to a wealth of information about 1) agencies involved in treatment and prevention of alcohol problems, 2) governing bodies of treatment agencies and 3) related service groups for outreach and community interface. The findings suggest that underutilization of treatment facilities by Mexican Americans is not a matter of cultural fit, but of structural marginalization which works to exclude Mexican Americans from the flow and distribution of resources. The irony of this is that the processes of marginalization which play a fundamental role in generating excessive alcohol use are replicated by the very urban subsystems controlling modern treatment resources for alcohol problems. Most resources immediately accessible to these troubled families are equipped with neither the knowledge or organizational resources to deal with alcohol dependence. Agencies providing alcohol treatment are generally not accessible and are not equipped to deal with the specific needs of the Mexican Americans and the urban environment (or the inability to interact) maintain a disequilibrium leading to increasing alcohol dependence, and the process of social marginalization is sustained vis-a-vis the treatment delivery system. 185 References.

126. Author: Howard, C. A., Samet, J. M., Buechley, R., W., Schrag, S. D., & Key, C. R. (1983).

Title: Survey research in New Mexico Hispanics: some methodological issues.

Source: The American Journal of Epidemiology, 117(1), 27-34.

Abstract: In order to explain differing pattern of respiratory disease epidemiology in Hispanic and Anglos, a prevalence survey was done in Albuquerque, New Mexico. Population for the survey was randomly selected from the 1978 R. L. Polk & Co. Directory. Ethnicity of the study population was obtained by self-reporting by respondents, 1980 Census list of Spanish surnames and a computer system known as Generally Useful Ethnic Search System (GUESS). Comparison of the methods of obtaining ethnicity indicated, when compared with self-reporting, that the census list was more specific (97%) and GUESS was more sensitive (90% sensitivity). Intermarriage reduced the accuracy in females. Emphasis of this paper was on the methodological issues raised during the conduct of the study: respondent rates, potential language barriers and bias, and identification of Hispanic by surnames. Approaches to obtain adequate response rates were mail, telephone, and personal interviews. Highest response (78%) was from Anglo females: lowest from Hispanic males (60%), with 22% refusing to be interviewed. Less Hispanics returned mailed questionnaires than responded to telephone interviews and as the respondents age increased, preference was for the Spanish language. (Author's abstract modified).

127. Author: Hunt, I. F., Murphy, N. J., Cleaver, A. E., Faraji, B., Swenseid, M. E., Coulson, A. H., Clark, V. A., Browdy, B. L., Cabalum, M. T., & Smith, Jr., J. C. (1984).

Title: Zinc supplementation during pregnancy: Effects on selected blood constituents and on progress and outcome of pregnancy in low-income women of Mexican descent.

Source: The American Journal of Clinical Nutrition, 40 (September), 508-521.

Abstract: The effects of oral zinc supplementation on levels of various blood constituents and the outcome of pregnancy in 213 women of Mexican descent with low-incomes who attended a prenatal clinic in Los Angeles was assessed in this double-blind experimental study published in September, 1984. The women were randomized into either a control (C) or a zinc-supplemented (Z) group and received similar

vitamin mineral supplements except that 20 mg zinc was added to the Z group's capsules. At the final interview, women (C+Z) with low serum Zn levels (53 ≤ ug/dl) had higher ($p<0.01$) mean ribonuclease activity and lower ($p<0.01$) mean delta-aminoluvulinic aid dehydratase activity than women with acceptable serum zinc levels. The incidence of pregnancy-induced hypertension (PIH) was higher ($p<0.003$) in the C than in the Z group but PIH was not associated with low serum zinc levels at either the initial or final interview. Two factors, absence of zinc supplement and unmarried status, were found to be predictive of PIH. The expected increase in serum copper levels was greater ($p<0.001$) in women with PIH (C+Z) than in normotensives. Women with PIH, in contrast to normotensive women, reported diets that provided a lower energy value and less protein and carbohydrate at the final than at the initial interview. Except for PIH there was a higher incidence of abnormal outcomes of pregnancy in the non-compliers than in the compliers (C+Z) and not between control and zinc-supplemented groups. The incidence of spontaneous abortion, preterm delivery and low-birth weight infants was higher among noncompliers. 42 References.

128. Author: Judson, F. N., Sbarbaro, J. A., Tapy, J. M., & Cohn, D. L. (1983).
Title: Tuberculosis screening: Evaluation of a food handler's program.
Source: Chest, 83(6), 879-882.
Abstract: All applicants for a food handler license in Denver, Colorado, were skin tested for tuberculosis. Of the total 6,090 applicants, 1,209 were classified as Hispanic (nationality unknow). Hispanics had the highest rate of positive reaction (14.6%), Whites the lowest (4.7%) and Black intermediate (11.0%). A risk benefit analysis is performed, showing cost effectiveness of this type of screening program. 26 References.

129. Author: Kalter, D. C., Goldberg, L. H., & Rosen, T. (1984).
Title: Darkly pigmented lesions in dark-skinned patients.
Source: The Journal of Dermatologic, Surgery and Oncology, 10(11), 867-881.
Abstract: This report begins with a case study of two

male Latin American adult patients with skin lesions suspected of being malignant melanoma (MM). The case studies illustrate the problems associated with determining the nature of darkly pigmented, suspicious lesions in dark-skinned patients. Furthermore, there is little information available to help the practitioner in the diagnosis of pigmented skin lesions in dark-skinned patients. One of the major problems is that the basal-cell epitheliomas appear to be darkly pigmented in dark-skinned people, thus, leading to erroneous diagnosis and treatment as melanomas. The incidence of MM in Whites, Blacks, and Hispanic in New Mexico and Texas are also discussed. The findings indicate that Blacks have an incidence of MM from 5-18 times less than Whites, while Hispanics have a higher incidence than Blacks, but 3.5 to 4.5 times less than Whites. 40 References.

130. Author: Kasim, S., & Bessman, A. (1984).
Title: Thyroid autoimmunity in Type II (non-insulin-dependent) diabetic patients of Caucasoid, Black and Mexican origin.
Source: Diabetologia, 27 59-61.
Abstract: Four hundred and forty-nine subjects with Type II (non-insulin-dependent) diabetes mellitus were selected from patients who regularly attended a diabetic outpatient clinic at a Los Angeles County facility for the medically indigent, to be screened for the presence of thyroid microsomal antibodies. These were matched with 270 control subjects for age, sex, and ethnicity. Of those selected, 134 were Mexican as were 70 of the control subjects (method of identification was not specified). Mexican female controls had a significantly higher frequency of thyroid microsomal antibodies when compared with Black female controls. Type II diabetic patients did not have a higher frequency when compared with their matched control counterparts. A subgroup of patients who required insulin for control of their blood glucose did not have a higher frequency of thyroid microsomal antibodies when compared with noninsulin-requiring diabetic patients. Autoimmunity against thyroid gland is not more common in Type II patients when compared with matched control subjects. 11 References.

131. Author: Kayaalp, O., Muller, C., Forman, M., & Kaplan, D. (1981, November).
Title: Health Status and Service Utilization of Hispanic Patients with Arthritis.
Source: Paper presented at the meeting of the American Public Health Association's 109th Annual Meeting, Los Angeles, California.
Abstract: This paper reported on the health status and service utilization of patients with arthritis at a comprehensive health care center in Brooklyn, New York, and the activities developed to improve outpatient care to them. Hispanics and non-Hispanic adult arthritis patients health status and service utilization were compared. Of the patients with joint disease, 69% were Hispanic, 62% were on Medicare, Medicaid, or both; 35% qualified for minimum fee on the basis of income, and 3% had private insurance. The population was urban and low income. Spanish language was used at intake by trained bilingual interviewers and in the field by field workers. 0 References.

132. Author: Keane, J. R. (1984).
Title: Death from cysticercosis--seven patients with unrecognized obstructive hydrocephalus.
Source: The Western Journal of Medicine, 140(5), 787-789.
Abstract: Case reports of seven patients at Los Angeles County USC Medical Center are reported in detail. Although cysticercosis has been largely eliminated in the U.S., it is pandemic in Mexico, Central, and South American. With increased immigration from those regions, cysticercosis is becoming a common disease in the Southwest. The seven cases were Latin American patients. Most had repeatedly sought medical attention because of severe headache and vomiting. Until irreversible brain-stem compression occurred, most were considered to have benign vascular headaches. Occasional symptoms of syncope, fleeting diplopia and transient unilateral numbness were reported. 5 References.

133. Author: Kerr, G. R., Amante, P., Decker, M., & Callen, P. W. (1982).
Title: Ethnic patterns of salt purchase in Houston, Texas.
Source: American Journal of Epidemiology, 115,906-916.
Abstract: An indirect measure of sodium intake for Black, White, and Hispanic populations of

Houston, Texas, was derived from an examination of warehouse orders received over a six-month period from a chain of 52 stores in the area. For each store, both direct salt purchases and the salt content of 20 dietary staple items were recorded. The ratios between the sales of salt and each food commodity in each store were then examined in relation to the ethnic characteristics of the census tracts in which the store was located. Stores located in census tracts that had more than 50% of any of the Black, White, or Hispanic population were compared. The mean ratios between salt and the food staple commodities in the predominantly Black and Hispanic census tract supermarkets were 148% and 202%, respectively, of that in predominantly White census tract supermarkets. Sales of table salt are 50-100% higher in Black and Hispanic census tract supermarkets than in those of White census tracts. It is not known if the increased sales of table salt have causal relationship to the prevalence of hypertension in those communities, but this study indicates higher salt usage. 64 References.

134: Author: Kerr, G. R., Amante, P., Decker, M., & Callen, P. W. (1983).

Title: Supermarket sales of high-sugar products in predominately Black, Hispanic, and White census tracts of Houston, Texas

Source: The American Journal of Clinical Nutrition, 37 (April), 622-631.

Abstract: The purpose of this study was to analyze supermarket sales of sweet foods in comparison to staple foods to determine if changes in nutrient consumption are related to changes in socioeconomic and demographic factors. Records of sales of 488 sweet foods (SE) and 21 staples (C) were examined in 48 supermarkets located in predominately Black, Hispanic, and White census tracts in Houston, Texas. The mean sweet energy/commodity food sales ratios in the Black (122%) and Hispanic (108%) were higher than those in the White census tracts. Although ethnic differences in sweet energy/commodity sales ratios were almost always significant, variations within ethnic supermarkets remained large, indicating nonethnic factors also influenced food purchase patterns. High sucrose products (SE) were aggregated into six categories: dry sugars, liquid

sugars, fruit preserves, candy, sucrose- or fructose-containing beverages, and miscellaneous sweet products. The energy content of each sweet product was analyzed and calculated separately for each supermarket. Total sales of SE of each supermarket were examined in relation to sales of each of 20 staple food commodities (C), and SE/C ratios calculated for each of the three ethnic groups of supermarkets. It is suggested by the authors that supermarket sales records offer an inexpensive source of data for comparative or longitudinal studies of community purchase of food products which may play a role in the development of nutrition associated with health problems. The major problems in interpreting the data are a need to use ratios and lack of a valid measure of the population consuming the food purchased. 56 References.

135. Author: Langrod, J., Alksne, L., Lowinson, J., & Ruiz, P. (1981).

Title: Rehabilitation of the Puerto Rican addict: A cultural perspective.

Source: The International Journal of the Addictions, 16(5), 841-847.

Abstract: Drug dependence ranks among the leading causes of death among Puerto Ricans of all ages. This study describes 162 Puerto Rican patients in a drug rehabilitation program in a New York city clinic of the Albert Einstein College of Medicine Substance Abuse Service. A questionnaire was self-administered. Two social factors perceived as relating to rehabilitation efforts are the patient's employment status and educational levels at the time of admission. Only 3% were employed and 17% were High School graduates. Seventy one percent of the Puerto Rican group were retained in treatment over a 2-year period; this is comparable with retention in treatment for non-Hispanic patients in the program. Also, Methadone maintenance treatment was found to be beneficial in the reduction of criminal behavior after entry into treatment. Moreover, if Hispanic addicts are to be rehabilitated, treatment personnel must understand not only the key values of dignity and respect inherent in the culture, but also the circumstances which threaten that culture. These circumstances include geographic mobility making extended family ties difficult to maintain, the confusion created by challenges to the traditional

authority vested in the male head of a Hispanic household and stress caused by pressure to conform to American customs which often denies or contradicts their own cultural values. 6 References.

136. Author: Lawlis, G. F., Achterberg, J., Kenner, L., & Kopetz, K. (1984).
Title: Ethnic and sex differences in response to clinical and induced pain in chronic spinal pain patients.
Source: Spine, 9(7), 751-754.
Abstract: There is widely held clinical opinion and some tentative research justification for stereotypic or ethnic and sex differences in response to pain. To more adequately test this notion, 60 Texas chronic spinal pain patients (Black, Mexican American, and Caucasian, with ten men and ten women per group), all having persistent spinal pain for over 1 year, were studied. They were administered the ischemic pain test (a psychophysiologic scaling technique used to approximate clincal pain and pain tolerance), a numerical estimate of spinal pain, and two independent rates scaled the amount of pain emphasis, based upon the patient's physical condition and pain behaviors. Results showed that when pain was assessed by multiple measures in a sample of spinal pain patients, Mexican Americans tended to identify their spinal pain as being significantly greater than did Caucasians when the ischemic pain match was used. Women of all ethnic groups tended to be judged as emphasizing their pain more than men, based upon judgment of their pain behaviors, and upon their own numerical estimates of pain. They also indicated that they more nearly approached their pain tolerance. It was concluded that while ethnic and sex differences were found, stereotypic responses were not uniform, and tended to be related to the manner in which the pain was assessed. These results are discussed in light of cultural differences. 23 References.

137. Author: Leland, J. (1984).
Title: Alcohol use and abuse in ethnic minority women.
Source: In S. C. Wilsnack & L. J. Beckman. (Eds.), Alcohol Problems in Women, (pp. 69-96). New York: The Guilford Press.
Abstract: This is a review of the available alcohol-

related literature comparing women of various U. S. minority groups, primarily, Black, Hispanic, and Indian, with women in the general population. Topics covered in the review include: prevalence of alcohol use and abuse, youth and adult drinking patterns, adult drinking contexts, health and social consequences, support systems, sex roles and utilization of and response to treatment. The author notes difficulties engendered by small sample sizes, lack of comparable measurement criteria, and absence of data, especially for Hispanic and Asians. 99 References.

138. Author: Levenson, P. M., Pfefferbaum, B. J., Copeland, D. R., & Silberberg, Y. (1982).
Title: Information preferences of cancer patients ages 11-20 years.
Source: Journal of Adolescent Health Care, 3(1), 9-13.
Abstract: A written questionnaire was used in this study to determine sources of information preferred by 63 adolescent cancer patients 11-20 years old. The most common source was the private physicians. More than half preferred private discussion with a health professional, while 68% wanted physicians as the preferred choice. Parents were included in the discussion by 68%, while only 35% indicated that additional information might be helpful. That families (42%) and friends (45%) should have more information was indicated by the respondents. Findings showed no apparent relationship between diagnosis or sex and the patients' answers. Physicians as their main information sources or additional information was not the wish of newly diagnosed patients. Those who were actively ill also were not as interested in additional information. Younger patients tended to avoid group discussion, wanted the information only from their parents, and did not want their friends to receive additional information. Hispanics were most likely to request additional information for parents and that their parents be included in discussions. (Authors abstract modified.)
I.D.No.: 22G

139. Author: Lindholm, K. J., & Willey, R. (1983).
Title: Child abuse and ethnicity: Patterns of similiarities and differences. (Occasional paper No. 18).
Source: Spanish Speaking Mental Health Research Center, Los Angeles, California: UCLA.

Abstract: A total of 4,132 cases of child abuse that were reported to the Los Angeles County Sheriff's Department were analyzed to determine whether there were differences related to the ethnic group status of the victim or suspect. Results demonstrated that there were a number of significant differences attributed to ethnic group status. Comparing the ethnic group distribution of reported cases with that of the population in the county showed that Anglos and Hispanics were underreported with respect to their representation in the population whereas Blacks were overrepresented. Among suspects, males (especially fathers) were the more frequent suspects in Anglo and Hispanic families, although females (and mothers) were the suspects most often in Black families. Physical abuse was highest in Black families, with discipline most often given as the reason for the abuse. On the other hand, physical abuse was nearly equivalent for Hispanic and Anglo families. There were also differences in the types of physical injuries that the children suffered as a result of the abuse. Black children were most likely to be whipped/beaten and to receive lacerations/scars, whereas Anglo children most often obtained bruises. Hispanic and Anglo children, especially females, were much more likely to be sexually abused than were Black children, with sexual preference more frequently given to Anglo and Hispanic male suspects as the reason for abuse. Finally, there were also differences in the informant of the abuse, with schools more often reporting Hispanics, hospitals informing on Blacks, and family members informing on Anglos. It was concluded that cultural differences need more systematic research attention in studies of child abuse. (Author abstract.) 17 References.

140. Author: Lopez, L. (1985, February 17).
Title: The Mexican American with non-insulin dependent diabetes mellitus-an epidemiological report.
Source: Paper presented to the Task Force on Black and Minority Health, Bethesda, Maryland.
Abstract: The purpose of this paper is to present an epidemiological perspective of diabetes among Mexican Americans. The author discusses the incidence of diabetes and the accumulating evidence of its being a major health problem for this population. The effect of socio-

economic status on diabetes prevalence as well as that of acculturation are factors further mentioned. Health beliefs among family members are also thought to contribute to the incidence. Risk for diabetes is presented particularly in San Antonio, Texas. The implications for nursing include: further research needed, acknowledgement and understanding of cultural practices and beliefs, health education, in particular the development of materials for teaching in Spanish that are culturally sensitive to the specific needs of Mexican Americans. 9 References.

141. Author: Lopez-Aqueres, W., Kemp, B., Plopper, M., Staples, F. R., & Brummel-Smith, K. (1984).
Title: Health needs of the Hispanic elderly.
Source: Journal of the American Geriatrics Society, 3 (March), 191-198.
Abstract: The purpose of this paper was to review the health needs of the Hispanic elderly in Los Angeles County. The sample included 1,000 noninstitutionalized elderly persons 60 years and older. The study used a multistaged area probability sample stratified by city and Hispanic population density. The instrument used in the study was the Comprehensive Assessment and Referral Evaluation, a multidisciplinary, semistructured personal interview guide that covered psychiatric, medical, functional, nutritional, economic, and social problems of older adults. A total of 704 interviews were obtained: 299 male and 404 female. The findings indicated that older Hispanics were affected by cognitive impairment (13.8%), depression/demoralization (30.8%), heart disorders 12.8%), stroke effects (11.5%), arthritis (28.3%), hypertension (23.7%), financial hardship (28.0%), fear of crime (38.4%), ambulation problems (17.2%), or activity limitation (24.7%). They also needed assistance (19.3%) or used social services (22.0%). Additional analysis demonstrated that the prevalence of many of these problems varied significantly according to the age, sex, language and income of respondents. The indicators of health care needs that this study utilized were different from the more traditional measures based on the person's own perception of his or her health. 25 References.

142. Author: Lorig, K. R., Cox, T., Cuevas, Y., Kraines, R. G., & Britton, M. C. (1984).
Title: Converging and diverging beliefs about arthritis: Caucasian patients, Spanish speaking patients, and physicians.
Source: The Journal of Rheumatology, 11(1), 76-79.
Abstract: A sampling of arthritis patients undergoing treatment at Stanford Arthritis Center was taken, consisting of 98 Caucasians,46 Spanish-speaking patients and 50 physicians (mainly rheumatologists). Caucasian patients were asked about beliefs regarding arthritis and its treatment. The physicians were given the same items. There was a great degree of similarity between the two sets of responses. However, when physicians perceptions of Caucasian patients' beliefs were matched against the patients' actual responses, there was a great divergence. The authors summarize that for Caucasian patients and physicians the beliefs are similar: Physician generally underestimate the knowledge and beliefs of their patients in traditionally proven treatments; physicians overestimate patient beliefs in non-traditional therapies. The Spanish-speaking sample was quite heterogeneous, 45% born in Mexico, 27% in Central America, 10% from South America, and 16% U.S. born. The foreign born had been resident in the U.S. from one to more than 20 years. This sub-sample's responses were compared only to the Caucasian patients': physicians were not asked about their perceptions of Spanish-speaking patients' belief. Spanish-speaking patients differed from Caucasian in reporting inflammation as a problem caused by arthritis, and in the use of massage as treatment. While equal numbers of both groups mentioned diet, the Spanish-speaking responses were uniform that pork and red meats caused problems, whereas there was no such pattern in Caucasian responses. 7 References.

143. Author: Maddux, J. F., & Desmond, D. P. (1981).
Title: Opioid use in San Antonio.
Source: Careers of opioid users. (pp.31-46), New York: Praeger Press.
Abstract: This article is a historical view of the growth and development of San Antonio, the evolvement of the Mexican Americans in San Antonio, and the evaluation of the drug trade in this geographic area. The author begins by describing the founding of San Antonio and the

growth of the city. The influence of the Mexican Revolution of 1910 and two world wars is presented. The mixed Indians, European, and Mestizo background is introduced. Historical conditions which influenced status and attitudes toward Mexican Americans is included. The Bracero Program and the effects of the civil rights movement of the 1960s are discussed. The author next describes the development of opioid use in San Antonio. Subjects and police officials interviewed reported that heroin use began during the 1930s in San Antonio and was initially associated with the red-light district and the race track. During the 1950s and early 1960s, Mexican American juvenile gangs in the westside had serious group fights. While gangs engaged in drinking beer and smoking marijuana, heroin use was not approved. However, by 1956, ten years after the end of World War II, San Antonio had become a center for illicit heroin traffic. By the 1970s, the heroin traffic from Mexico to the U.S. had become organized into an extensive and complex criminal business. Several large Mexican families with relatives and friends in San Antonio, Los Angeles, Chicago and other cities managed production and distribution networks. After 1950, an increase effort by federal, state and local law enforcement agencies occurred in order to try to reduce the drug traffic. The final section of this report discusses street heroin and treatment programs. Variations in heroin potency and packaging for distribution are described. Since 1966, availability of treatment programs has increased. Programs currently available are introduced. 29 References.

144. Author: Marcus, A. R., & Crane, L. A. (1984).
Title: Smoking behavior among Hispanics: A preliminary report.
Source: In P. E. Engstrum, H. Anderson, & Mortenson (Eds.). Advances in Cancer Control: Epidemiology and Research (pp 141-151). New York: Alan R. Liss, Inc.
Abstract: The purpose of this review was to report on available data concerning the smoking patterns of Hispanics. An analysis was made of smoking rates by race and ethnicity, sex, age, and smoking behavior among Hispanic youth. Findings indicated that Hispanics appear to have a lower smoking rate (32.%) than either

White/Anglo (37.1%) or Blacks (39.4%). When stratified by sex, smoking rates among males appear similar across groups. Hispanic men have a slightly higher rate (41.5%) than White/Anglo (39.3%) and Blacks (40.0%). Hispanic women have lower rates (27.4%) than either White/Anglos (35.2%) or Black women (39.0%). Thus, it appears that the lower prevalence of smoking among Hispanics is due to the smoking behavior of Hispanic women. Hispanic men seem to be smoking at least as much as White and Black men. When both sexes and all ages are combined, smoking rates are slightly lower for Hispanics than for White/Anglos or Blacks. When stratified by age and sex, a different view is characterized. For all females under 65, Hispanic smoking rates are 5 to 10 percentage points lower than rates for White/ Anglos. The difference is greater between Hispanic and Black women. Hispanic men between 35 and 64 have slightly higher smoking rates than White/Anglo men and slightly lower than Black men. Among Hispanic youth, the data shows a higher rate of "ever smoked" and "currently smoking" for Hispanics when compared to Anglo and Black children. The results of the data reviewed suggest a hypothesis that runs counter to current thinking. The authors believe that rates of Hispanic lung cancer may sharply increase within this decade and continue to increase into the next century. 13 References.

145. Author: Marcus, A. C., & Crane, L. a. (1985).
Title: Smoking behavior among U.S. Latinos: an emerging challenge for public health.
Source: American Journal of Public Health, 75(2), 169-172.
Abstract: The purpose of this review was to discuss evidence on smoking and lung cancer among Latinos in California, Texas and New Mexico. Data reviewed included findings from several unpublished studies and technical reports. Latino males were found to smoke as frequently as White males. Latina females smoked at a lower rate than White females. An analysis of 1979 and 1980 National Health Interview Survey corroborated these findings and further indicated that the pattern held for Latino subgroups. Based on the findings, it was suggested that rates of lung cancer and other cigarette-linked diseases among Latino males may increase within this decade and continue

to increase into the next century. 14 References.

146. Author: Merritt, R. J., Coughlin, E., Thomas, D. W., Jariwala, L., Swanson, V., & Sinatra, F. R. (1982).
Title: Spectrum of ambeiasis in children.
Source: American Journal of Diseases in Children, 136 (September). 785-789.
Abstract: The purpose of this article is to document the need for considering amebiasis in the differential diagnosis of infants and children with hematochezia or hepatomegaly, especially in endemic areas. In eleven patients with childhood amebiasis, only two exhibited dysentery. Additonal clinical symptoms included hematochezia without diarrhea (4 patients), dysentery with appendicitis (one patient), exacerbation of ulcerative colitis (2 patients), and disseminated infantile amebiasis (2 patients). All patients who manifested hematochezia when examined by proctosigmoidoscopy exhibited colitis. Amebiasis was diagnosed by microscopic examination of fresh stool specimens, pathologic findings, and/or serologic titers. All but one of the patients had a Spanish surname or at least one Spanish-speaking parent. None of the children had a history of recent foreign travel. The one non-Hispanic patient had been exposed to a maid who had recently returned from Central America. Since the Southwest and Central America are know endemic areas for amebiasis, the suspicion for this condition must be high in patients with Spanish surnames who have hematochezia. The disease is particularly frequent in the Mexican American population. Amebiasis is the fourth most common cause of death in Mexico City. Based on the findings among the cases discussed, the authors recommended that if routine stool cultures and at least three stool examinations for ova and parasites are negative, all such patients should have a proctosigmoidoscopic examination and a fresh stool specimen examined for E histolytica. An amebic titer by IHA should be obtained if colitis is present and the stool examination and cultures are negative. 21 References.

147. Author: Miller, B. L., Goldberg, M. A., Heiner, D., & Myers, A. (1983).
Title: Cerebral cysticercosis: An overview.

Source: Bulletin of Clinical Neurosciences, 48, 2-5.
Abstract: The purpose of this paper is to briefly discuss the epidemiology, parasitology, and clinical features of cysticercosis. Currently available immunologic lists and those presently under investigation are also presented. Cysticercosis is becoming increasingly important to medical doctors in the United States, particularly those working with Mexican Americans. With the increasing number of immigrants from endemic areas arriving in Southern California, it is possible that native Californians will become infected by eating food contaminated with eggs from the stool of infected patients. The clinical diagnosis of this condition depends on a combination of clincal suspicion, radiographic studies, and immunological confirmation. 10 References.

148. Author: Miller, B. L. Heiner, D., & Goldberg, M. A. (1981).
Title: The immunology of cerebral cysticercosis.
Source: Bulletin of Clinical Neurosciences, 48, 18-23.
Abstract: While cysticercosis has been a rare disease in the United States, it is prevalent in Mexico, Central and South American. The recent immigration from those areas has resulted in many cases of cysticercosis in the U.S. A protocol for examination of suspected cysticercosis cases is presented, including a description of the life cycle, a clinical course, and a listing of immunological tests. Protocol was developed from Mexican patients in Los Angeles. 22 References.

149. Author: Miller, B., Goldberg, M. A., Heiner, D., Myers, A., & Goldgerg, A. (1984).
Title: A new immunologic test for CNS cysticercosis.
Source: Neurology, 34(5), 695-697.
Abstract: This study carried out in the Los Angeles area sought improved techniques for diagnosing cerebral cysticercosis. The manifestations of this disease can be classified under three pathologic entities: (1) cortical cysts, (2) ventricular cysts, and (3) meningitis. Cerebral cysticercosis is endemic in Mexico and throughout Central and South America and is being noted with increasing frequency in immigrant populations throughout the Southwest. The new radioimmunoassay for cerebral cysticercosis was studied in 70 patients almost all

of whom were Mexican American. The assay showed nearly 100% sensitivity for ventricular cysts or meningitis, 86% sensitivity for multiple parenchymal cysts, and a false-positive rate of 7%. Both serum and CSF antibody levels were useful diagnostically, and the contribution of both improved accuracy. In some patients, there was endogenous CNS production of IgG against the cysticercus antigen, which leads to elevated CSF levels and normal serum levels. Patients with high CSF total IgG levels may show false-positive CSF antibody elevation with normal serum levels. Although a formal study is needed the new radioimmunoassay is an improvement over earlier diagnostic tests. 9 References.

150. Author: Miller, B., Grinnell, V., Goldberg, M. A., & Heiner, D. (1983).
Title: Spontaneous radiographic disappearance of cerebral cysticercosis: Three cases.
Source: Neurology, 33(10), 1377-1379.
Abstract: Cerebral cysticercosis is prevalent throughout Mexico and has become more prevalent in clinics in the Southwest serving Mexican immigrants. This article illustrates the spontaneous resolution of three cases of cerebral cysticercosis. The patients were 2 Mexican adult women and one Mexican adult male. A short history on the evolution of the disorder is provided. The authors emphasize the need for controlled studies on the benign course of cerebral cysticercosis. Furthermore, they indicate that the benign course of the disease should be considered prior to surgical intervention or institution of other treatments. 7 References.

151. Author: Nace, R. P. (1984).
Title: Epidemiology of alcoholism and prospects for treatment.
Source: Annual Review of Medicine, 35, 293-309.
Abstract: This article reviews current epidemiological studies of alcoholism among five subgroups within the American population: older adults, adolescents, women, Blacks and Hispanics. Also, prospects regarding treatment outcome are discussed. The epidemiological methodology provides data that a) document national drinking practices across decades and indicate no marked changes in drinking practices for the past decade; b) allow a quantification of

the frequency of alcohol related problems; and c) illustrate the relationship between quantity, frequency, and pattern of alcohol use and the symptoms of alcohol dependence. Among adults who drink, an alcoholism prevalence rate of nearly 8% is expected. When subgroups within the population are examined, women are found to have a lower rate of alcoholism than men. There are indications that Blacks and Hispanics exceed the general population in prevalence of alcoholism, although the data was incomplete in this regard. About a third of Hispanic women are abstainers, a rate three times that of Hispanic men. Among Hispanics being young, single or divorced is associated with more drinking for both sexes. The prospect for treatment for all of the above subgroups is highly favorable. Among Hispanics, though, a major problem is the underutilization of treatment facilities. Cultural factors are offered as a means to explain the underutilization. 60 References.

152: Author: Navarro, J. D. (1981).
Title: The family and child abuse in a Latino Community.
Source: California: J. W. Gaterman & Associates.
Abstract: The purpose of this study was to compare factors which cause child abuse that occur within a culturally unique low socioeconomic community with established criteria in order to describe the characteristics of families prone to child abuse. The study population was predominantly Mexican American from East Los Angeles. The sample consisted of thirty cases. It was hypothesized that differences existed between causative indicators of child abuse within the sample and those factors reported in research and survey studies. It was furthere hypothesized that differences in causative factors also existed between Mexican Americans and Mexicans. Methodology included an empirical case approach in order to thoroughly examine possible causative factors in identified cases of child abuse by persons of Mexican and Mexican American heritage. Detailed demographic and sociological data were collected. Also included were data on intergenerational influences, social isolation, personality deficits and environmental causation. Statistical analysis utilized both parametric and non-parametric techniques. The findings supported the relationship between

socioeconomic factors and child abuse in this sample. With respect to psychological factors, it was found that while the respondents had emotional problems, they did not fall under the category of psychosis. The sample did not corroborate an intergeneration learned behavioral view of child abuse. With respect to social isolation as contributing to child abuse, the sample did not support this view. Seventeen (56.6%) of the entire sample lived in a legal or common law man and wife arrangment. In looking at within-group differences between Mexicans and Mexican Americans, it was found that overall the Mexican group was better off financially than the Mexican American group. More Mexicans versus Mexican Americans experienced emotional and interpersonal problems. Both groups reported happy and memorable relationships with parents. In looking at social isolation, while the Mexican groups revealed greater family unity existed, this did not necessarily eliminate isolation. The physical presence of people in the home did not necessarily mean positive family interaction nor an existing support system. The Mexican group was at greater risk for isolation with its recency of arrival, lack of formal education, formal support systems, and fear of law officials. 81 References.

153. Author: Newell, G. R., & Boutwell, W. B. (1981).
Title: Cancer differences among Texas ethnic groups--an hypothesis.
Source: The Cancer Bulletin, 33 (3), 113-114.
Abstract: This report presents a hypothesis that differences in cancer rates in ethnic populations are related to diet and nutrition. Reducing cancer of the breast and colon by changing eating habits would provide a new approach to preventing such cancers. In south and southwest Texas, the Spanish-surname population consistantly has the lowest rates for breast and colon cancers, with Whites having the highest rates. Statistics report a sharp increase in breast and colon cancer after premenopausal age among Whites and Blacks, while Spanish-surnamed persons show no peak in rates but a constant increase and have a lower rate than Whites or Blacks in all groups. The role of fat, starch and fiber consumption is discussed. The authors suggest two studies as a new approach for the prevention of breast and colon cancer: 1) a survey of the general

population in the selected areas to determine eating habits and other risk factors by ethnic groups, and 2) a concurrent case-comparison investigation of the etiologic importance of suspected food and eating patterns in the incidence of breast and colon cancer. 7 References.

154. Author: Ortega, A. (1982, September).
Title: An education program designed to prepare the Spanish speaking pregant woman for the experience of fetal monitoring.
Source: Paper presented at the meeting of the National Association of Hispanic Nurses, Los Angeles, California.
Abstract: A protocol for an educational program to prepare Spanish-speaking women for the experience of fetal monitoring. Developed for Santa Clara Medical Center in San Jose, in which institution 46% of the births were to Spanish-surnamed women. About half were monolinqual Spanish-speaking, tended to be immigrant women from small rural towns in Mexico, experiencing their first birth. These women have risk factors which make them high-risk category patients: poor nutrition, seeking care late, inappropriate weight loss or gain, low income, and others, which make electronic fetal monitoring (EFM) indicated. Reports of Mexican immigrant women's fears about EFM are given. These fears indicate monitoring is a stressful experience. The proposed teaching situation includes: individual teaching using photographs and a pamphlet in Spanish illustrating monitoring, inclusion of EFM information into the content of Spanish-speaking group prenatal classes, demonstration of EFM equipment and procedures during a tour of the maternity unit for the Spanish-speaking woman. 47 References.

155. Author: Ortiz, J. S. (1980).
Title: The prevalence of intestinal parasites in Puerto Rican farm workers in western Massachusetts.
Source: American Journal of Public Health, 70(10), 1103-1105.
Abstract: Parasitic examination was done for stool samples of 377 Puerto Rican subjects. 281 subjects had been born in Puerto Rico, and had been on the mainland U.S.A. for an average of one year and 11 months. 96 subjects were born in the U.S. All were farm workers residing

in the area of Holyoke, Massachusetts, of which 152 were children. Of all stool samples, 35.5% were positive for parasites. The rate for native born was 30%, and for foreign born, 37%, statistically insignificant. These infestation rates are higher than have been reported in eariler studies. 16 References.

156. Author: Patterson, R. M., Hayashi, R. H., & Cavazos, D. (1983).
Title: Ultrasonographically observed early placental maturation and perinatal outcome.
Source: American Journal of Obstetrics and Gynecology, December, 773-777.
Abstract: The purpose of this study was to 1) define the relationship of ultrasonographically observed placental maturation to gestational age in a large homogenous population, 2) establish a definition of early placental maturation for this population, and 3) evaluate the significance of early maturation with respect to perinatal outcome. All nondiabetic Spanish-surnamed patients with singleton gestations that demonstrated either a Grade II or Grade III placenta were retrospectively selected for study. Perinatal outcome in 398 patients was analyzed in a cross-sectional study. Statistical analysis was done by means of an unpaired two-tailed t test and chi square test. Findings indicated a trend toward lower mean birth weights in the group identified with early placental maturation as compared to controls. Statistical significance was achieved in the Grade II population. With the Grade III population, early placental maturation identified a group of patients with 16.7% incidence of growth retardation as compared to 4.1% in control patients. Early placental maturation was found to be an insensitive predictor of poor perinatal outcome with respect to maternal hypertension, antepartum or intrapartum fetal distress, and prenatal asphyxia. 10 References.

157. Author: Penk, W. E., Brown, A. S., Roberts, W. R., Dolan, M. P., Atkins, H. G., & Robinowitz, R. (1981).
Title: Visual memory of male Hispanic American heroin addicts.
Source: Journal of Consulting and Clinical Psychology, 49(5), 771-772.
Abstract: A comparative testing of impaired visual memo-

ry, as detected by the Revised Benton Visual Retention Test, given 55 Hispanic (nationality unspecified) heroin addicts. Test results were compared with Blacks and Whites. Data show that Hispanics display interferences in visual memory and that Hispanic visual memory is more comparable to Blacks than Whites. Questions are raised about establishing norms for minorities on neuropsychological tests. 5 References.

158. Author: Pockros, P. J., Peters, R. L., & Reynolds, T. B. (1984).
Title: Idiopathic fatty liver of pregnancy: Findings in ten cases.
Source: Medicine, 63(1), 1-11.
Abstract: This study concerned the incidence of Fatty liver of pregnancy (FLP) disorder. FLP is a disease causing jaundice in the third trimester of pregancy resulting in hepatic failure, bleeding diathesis and coma. FLP had received widespread attention because of high mortality of mother and infant. Using records obtained at the Los Angeles County-University of Southern California Medical Center for the period 1972 to 1982, ten cases of FLP are reported of which nine are Hispanic women and the other Black. Compared to earlier reports, a marked decrease in both maternal and fetal mortality was noted: only one mother died and 2 of 12 infants were stillborn. Eight other cases obtained from liver biopsies referred from other hospitals were also reviewed and combined mortality data were similar. Since delivery was spontaneous in 8 of the 10 patients, the lower mortality cannot be attributed to early delivery. Instead, the authors ascribe it to improved supportive therapy with transfusions, clotting factors, antibiotics, glucose and monitoring. New data concerning presenting signs and symptoms, laboratory features including serial clotting screens documenting disseminated intravascular coagulation (DIC), obstetric and perinatal information as well as maternal follow-up are presented. Although 9 of the women in this study were Hispanic and none Caucasian, this reflects the ethnic/racial composition of patients at the medical institution. It is doubtful that ethnic factors affect incidence or outcome of FLP. 36 References.

159. Author: Poma, P. A. (1984).
Title: A dangerous folk therapy.
Source: Journal of the National Medical Association, 76(4), 387-389.
Abstract: The purpose of this paper was to examine the risk of severe lead poisoning that Hispanic and other minority children undergo when given traditional ethnic remedies. The use Azarcon for "empacho" among Hispanic families has been linked to severe lead poisoning. Based on the findings, it is recommended that all children be screened at least every one to two years. Migrant children in particular are at risk and therefore should be screened yearly and those at obvious risk every two to three months. This is particularly crucial to those who have newly arrived, are transient, and distanced from health care by language, socioeconomic status, and cultural beliefs. 9 References.

160. Author: Powell, K. E., Meador, M. P., Farer, L. S. (1984).
Title: Recent trends in tuberculosis in children.
Source: The Journal of the American Medical Association, 251, (10), 1289-1292.
Abstract: A study by the Center for Disease Control which charts the progress of the incidence of tuberculosis in children across the country from 1962 through 1981. Using national morbidity data, the study particularly examines the failure of the incidence of tuberculosis to decline from 1976 through 1981, and seeks to identify the factors responsible. The study concludes that the stability of incidence of tuberculosis among Whites was caused by an increase among Hispanics, and the stability among other races was caused by an increase among Indochinese refugees. 7 References.

161. Author: Ramirez III, M (1983).
Title: Cultural and individual differences in alcohol, drug abuse, and mental health research.
Source: In ISLAS Inc., (Ed.), Hispanics and health research in the Public Health Service: Public health research issues, (pp.16-28). Rockville, Maryland: United States Department of Health and Human Services. Public Health Service (Hispanic Employees Organization).
Abstract: The purpose of this paper was to summarize the major points made on a review of research done with Hispanic groups in the United States between 1971 and 1981. Sixty-nine Hispanic

projects were reviewed focusing on the Mexican American (53%), Puerto Ricans (43%), and Cuban American (6%) populations. These projects were funded by the National Institute of Mental Health (85%), the National Institute on Drug Abuse (14%) and the National Institute on Alcohol Abuse and Alcoholism (one project). Six major research themes were identified by the reviewer. These included: 1) the development and implementation of mental health services consonant with the cultures of the various Hispanic groups, 2) the identification and utilization of supportive resources in Hispanic families and communities, 3) the relationship of characteristics and dynamics of Hispanic communities in primary prevention and intervention in individuals and families in crisis, 4) the relationship of migration to psychological adjustment, 5) the relationship of education to psychological adjustment, and 6) the psychodynamics and sociocultural factors of females who are heads of households. Three major conclusions regarding alcohol, drug abuse, and mental health services were drawn. First, primary prevention and intervention must reflect the culture and lifestyle of the people proposed to be served. Second, new models in alcohol, drug abuse, and mental health research need to be developed. Third, recognition must be given to the fact that the United States is rapidly becoming a multiple options society. Therefore, more emphasis must be given to bicultural/multicultural processes among minority ethnic groups and less on the ideas of acculturation and assimilation. Future research suggested by the reviewer included the areas of coping with rapid change, the effects of migration on psychological adjustment, identification of support networks, among youth, drug and alcohol abuse, the development of Mestizo world view theoretical approaches, instruments for data collection, and research methodologies. 22 References.

162. Author: Rassin, D. K., Richardson, C. J., Baranowski, T., Nader, P. R. Guenther, N., Bee, D. E., & Brown, J. P. (1984).
Title: Incidence of breast-feeding in a low socioeconomic group of mothers in the United States: Ethnic patterns.
Source: Pediatrics, 73(2), 132-137.
Abstract: The purpose of this study was to identify

factors which are associated with the decision to breast-feed or not in a population of 379 mothers. Three hundred and fifty-eight (94.5%) self-completed questionnaires were obtained. The data included demographic information, reproductive history, prenatal care and education. Only 27.2% of the sample chose to breast-feed. Using a chi square test for equality of proportions, marital status, head of household, maternal and paternal ethnicity, maternal education, income, and number of pregnancy were found to be the most important variables associated with breast-feeding. The effect of ethnicity was more significant than other demographic variables when examined jointly within ethnic groups. The percentage of Mexican American mothers who intended to breast-feed was 18.4% or 62 mothers while 145 Anglo Americans (42.9%) and 131 Black Americans (38.7%) chose to breast-feed. It was concluded that the importance of ethnicity in the decision to breast-feed has been underestimated. Therefore, attempts to encourage breast-feeding ought to take this factor into account. 10 References.

163. Author: Redman, J. E., & Mora, D. B. (1982).
Title: Malignant melanomas of the skin diagnosed and treated in Albuquerque, New Mexico, in 1980.
Source: The Journal of Dermatologic Surgery and Oncology, 8(1), 40-43.
Abstract: Fifty eight cases of malignant melanomas treated in Albuguerque, New Mexico were analyzed. The information was made available from the tumor registers for 1980 of Albuquerque's eight hospitals, three laboratories of pathology, two dermatologists and by the New Mexico Tumor Registry. Findings indicate that the majority (91%) of the reported cases of malignant melanoma were in White, fair-skinned patients. Only 5% of the cases were of American Indian and 3% of Hispanic ancestry. The two Hispanic cases were both females ages 52 and 42 years. The anatomic location of their malignant melanoma was the trunk for both cases with an unspecified level of thickness. The authors indicate that the number of cases of malignant melanomas among the general population treated in Albuquerque in 1980 have increased by more than 300% since data began to be kept in 1971. 2 References.

164. Author: Reed, B. D., Lutz, L. J., Zazove, P., & Ratcliffe, S. D. (1984).
Title: Compliance with acute otitis media treatment.
Source: The Journal of Family Practice, 19(5), 627-632.
Abstract: The purpose of this study was to determine whether the type of medical office, population served, written instructions to the patient, or patient familiarity with the prescribing physician influenced the patient to continue a 10-day course of antibiotics prescribed for acute otitis media. Four offices and a total of 295 patients were examined and the relationship between the recommended treatment as followed by the patient and the outcome were determined. Four different types of family practice centers were used, and study population were all patients with a newly diagnosed case of acute otitis media. Compliance was measured by follow-up rates in less than 11 days and urine antibiotic assays, varied significantly between different patient populations and office types. Results reported that written instructions did not improve compliance. When patients were diagnosed and treated by their own physicians, compliance was improved in the low socioeconomic sector. Study factors and compliance were not related to outcome. (Author's abstract modified).

165. Author: Reid, S. (1984).
Title: Cultural difference and child abuse intervention with undocumented Spanish-speaking families in Los Angeles.
Source: Child Abuse and Neglect, 8, 109-112.
Abstract: This essay seeks to identify economic factors and cultural differences among undocumented Spanish-speaking families in Los Angeles, which may result in misinterpretation of child abuse by social workers. Social workers need to understand the strong cultural values of the undocumented and how these contrast with those of the surrounding society in order to make determinations that are truly in the best interest of children. The study reviews economic factors and family values involved in the three kinds of reports of abuse most frequently received concerning such families: 1) reports of children living in inadequate housing without proper food or clothing: 2) reports of children left alone in the care of a child under 13 years of age; and 3) reports of bruises with no abrasions or serious injur-

ies, inflicted by the parents as punishment. Many of these "abusive" conditions arise from the stress attributable to the substandard living conditions of the undocumented and from cultural conflicts they experience. It is essential for a social worker to distinquish between parental neglect and poverty and between discipline and child abuse when working with undocumented Spanish-speaking families. 0 References.

166. Author: Rios, L. E. (1982).
Title: Determinants of asthma among Puerto Ricans.
Source: The Journal of Latin Community Health, 1(1),25-40.
Abstract: Several epidemiological studies have suggested a higher prevalence of asthma among Puerto Ricans as compared to Afro-Americans or non-Hispanic Caucasians. This article reviews the literature in two areas: 1) epidemiology of asthma among Puerto Ricans; and 2) known genetic and enviromental determinants of asthma as they relate specifically to Puerto Ricans. This article proposes that if Puerto Ricans exhibit greater intrinsic asthma than the general population, this may explain three disparate sets of findings about Puerto Ricans. These findings are: asthma among adults increases in severity with age, there is a higher female to male ratio of asthma patients, and Puerto Ricans are seen by emergency wards due to asthma attacks more frequently then are members of other ethnic groups. Furthermore, genetic studies to date have not found a hereditary basis for higher prevalance and/or severity of asthma among Puerto Ricans. Similarly, increased sensitivity to a specific antigen has not been demonstrated, nor have parasitic infestation been implicated. Lastly, clinical and public health applications of relevant findings are briefly dicussed and areas for further investigation are suggested. 47 References.

167. Author: Rojas, D. (1980).
Title: Effect of maternal expectations and child-rearing practices on the development of White and Puerto Rican Children.
Source: Maternal and Child Nursing Journal, Summer, 99-107.
Abstract: This study was designed to help define development in the Puerto Rican mainland child and

describe the maternity role of the socialization process within the Puerto Rican culture. The objectives of the study were to compare 1) the development status of White and Puerto Rican children 1-3 years of age, 2) the child-rearing methods and expectations of White and Puerto Rican mothers within a lower socioeconomice status, 3) the maternal child-rearing methods and expectations toward male and female children in both White and Puerto Rican groups. Eleven White and eleven Puerto Rican well children were chosen from pediatric services at a university medical center and in a neighborhood health center with specific criteria for selection. The Denver Developmental Screening Test (Frankenburg and Dobbs, 1967), was used to measure development. The Child-Rearing Practices Report (Block 1965) measured child-rearing techniques and orientation. The Maternal Expectations Report designed by the author measured the age at which a mother expects her child to perform various developmental milestones. No significant differences were found between the White and Puerto Rican children 1-3 years. A notable difference was found in language development between the two groups. The eleven White children passed 73.5% of the age-appropriate items at 50 percentile while the eleven Puerto Rican children passed 53.3.% of the respect to child-rearing practices, Puerto Ricans mothers were more protective than White mothers and had a more positive relationship with their children. Puerto Rican mothers used average control and physical punishment more often than the White mothers. Threat of future punishment was more often used by Puerto Rican mothers along with use of guilt and strict and arbitrary rule setting. The author concluded that in order to protect their children from the world, Puerto Rican mothers set strict rules and enforce them with aversive control and physical punishment. This in turn may inhibit outside exploration with response to only commands and rules. In addition, since the Puerto Rican families are low socioeconomic status, they may have an environment which lacks appropriate verbal stimulation. This, in combination with strict mothers, may have influenced the slower rate of language development. 14 References.

168. Author: Saunders, P. H., Banowsky, L. H., & Reichert,

D. F. (1984).

Title: Survival of cadaveric renal allografts in Hispanic as compared with Caucasian recipients.

Source: Transplantation, 37(4), 359-362.

Abstract: Allograft survival rates were evaluated and showed a significantly better graft survival in Hispanic (n=66) compared to Caucasian (n=38) recipients of primary cadaveric renal transplants. In terms of patient survival pretransplant transfusion status, there were no significant differencees between Hispanic and Caucasian cadaveric recipient groups. Ethnic origin of cadaveric donor did not significantly alter graft survival rates in either recipient ethnic groups, nor were they significatnly altered by immunosuppresive protocals. rejection therapy, mean age, or frequency of diabetes mellitus. Caucasian patients with splenectomies had better cadaveric graft survival than Caucasian graft recipients without splenectomies. However, splenectomy had no significant effect on the renal allograft survival rate in Hispanics. Donor recipient HLA matching (A, B, or DR), and panel reactivities of recipient pregraft serum samples were evaluated and found not to correlate significantly with cadaveric graft survival rates. Although Hispanic cadaveric renal allograft survival were superior to Caucasian recipients, 1-haplotype-matched or 2-haplotype matched living-related renal allografts had comparable graft survival rates in both Caucasian and Hispanic recipients. Findings indicate that Hispanics without splenectomy enjoy a cadaveric renal allograft survival rate superior to nonsegregated populations as reported in other studies.(Author's abstract modified.)

169. Author: Selby, M. L., Lee, E. S., Tuttle, D. M., & Loe, H. D. (1984).

Title: Validity of Spanish surnamed infant mortality rate as a health status indicator for Mexican American population.

Source: American Journal of Public Health, 74(9), 998-1002.

Abstract: The purpose of this study was to assess the validity of the Spanish surname infant mortality rate as an index of the health status for the Mexican American population in an urban, non-border, setting considered to have an excellent birth and death registration system.

The study population was composed of all 68,584 single live births of Spanish surname White, non-Spanish surname White, or Black ethnicity. Neonatal and post neonatal mortality rates were examined according to variables available from the birth certificates: birth weight, birth order, maternal age, time of first prenatal care, ethnicity, and parental nativity. It was hypothesized that if calculated Spanish-surname infant mortality rates were valid, the rates of foreign-born Spanish-surname parental nativity subgroup would be higher than the rates for the U.S. born parental nativity subgroup. If the rates were found to be higher, the migration of the foreign-born group should be considered as a confounding factor. It was found that infants born to Mexican immigrants had low mortality rates for high birth order, high maternal age, and delayed or absent prenatal care. Only infants who weighed less than 1500 grams exhibited the expected high rates. The findings suggested a loss of infant death compatible with migration and under registration of deaths. It was concluded by the authors that the Spanish surname infant mortality may be low and does not seem to be a valid indicator of Mexican American health status even in an urban, non-border area considered to have an excellent registration of births and deaths. 16 References.

170. Author: Shanley, J. D. & Jordan, M. C. (1980).
Title: Clinical aspects of CNS cysticercosis.
Source: Archives of Internal Medicine, 140(10), 1309-1313.
Abstract: Central nervous system cysticercosis (CNS), an infection with the larva of the pork tapeworm (Taenia solium), is common throughout the world. Ingestion of fecal contaminants containing the ova of T solium causes the infection. Number, age, and location of the larval cysts disrupting the neural tissues vary the clinical manifestations. Five disease patterns are given: 1) basilar cysticercosis resulting from chronic meningitis or progressive hydrocephalus, 2) parenchmal cysts with focal symptoms, 3) diffuse parenchymal cysts with intracranial hypertension, 4) ventricular localization with episodic acute hydrocephalus, and 5) spinal cord cysticercosis which appears like mass lesions. The basic pattern may occur in a mixture and asymptomatic infec-

tions are common. Menigitis cysticercosis is often mistaken for tuberculous or fungal meningitis in the United States. For a patient with these syndromes who has lived in an area of high prevalence of T. sodium, the diagnosis of CNS cysticercosis should be considered. (Author's abstract modified)

171. Author: Smith, K. J., Coonca, L. S., South, S. F., & Troup, G. M. (1983).
Title: Anti-Cra: Family study and survival of chromium-labeled incompatible red cells in a Spanish-American patient.
Source: Transfusion, 23(2), 167-169.
Abstract: After transfusion during colectomy, a 22-year old Hispanic women with juvenile rheumatoid arthritis developed anti-Cra. Among 13 relatives no Cra negative family members were found, including siblings and parents. Chromium-labeled red cells survival studies showed a T1/2 of 14 days with Cra positive cells. After ileorectal anastomosis, two units of Cra positive blood were transfused uneventfully. (Author's abstract modified).

172. Author: Spector, M. H., Applegate, W. B., Olmstead, S. J., DiVasto, P. V., & Skipper, B. (1981).
Title: Assessment of attitudes toward mass screening for colorectal cancer and polyps.
Source: Preventive Medicine, 10, 105-109.
Abstract: A study attempting to reveal the reasons for poor volunteer response to colorectal cancer screening. A questionnaire was distributed to 202 patients at the University of New Mexico outpatient clinic. Of the 154 who completed the questionnaire, only 70 volunteered for screening. Those who completed the questionnaire were all over 40. Forty-seven were men and 107 were women. Seventy-four were Anglos, 67 Hispanic, and 13 were other. The questionnaire was geared toward determining whether differences in attitude toward health care providers, aspects of the screening process, and perceived vulnerability to cancer would discriminate between volunteers and non-volunteers. Hispanics were less likely to volunteer than Anglos. Non-volunteers were more likely to deny the possibility of having cancer and to object to particular aspects of the screening process. 4 References.
I.D.No.: 13G

173. Author: Staff. (1983).
Title: Lead poisoning from Mexican folk remedies--California.
Source: U.S. Department of Health and Human Services, Public Health Service, Center for Disease Control, Morbidity and Mortality Weekly Report, 32(42), 554-555.
Abstract: As a result of the death of a 3-year old in June 1982 who had been unsuccessfully treated for diarrhea and the illness of his 15-month-old sibling, the Los Angeles County Department of Health and Human Services surveyed residents of six predominantly Hispanic geographically representative census tracts in an attempt to estimate use and knowledge of azarcon (lead chloroxide) and greta (lead oxide). A total of 545 systematically selected households, predominately Hispanic, were selected. Familiarity with the substance was greatest among Mexican Hispanics, and prior use was exclusive to this group (7.2-12%) admitted prior use). A Colorado survey in June-September, 1982, among Texas farmworkers showed that 7% of 100 migrant children under 12 years of age had been treated at some time with greta or azarcon for gastrointestional illness. Since the summer of 1981, when the first cases of azarcon poisoning were identified in California and Colorado, there have been multiple cases and there is an indication that a significant exposure to both azarcon and greta by infants and children with abdominal distress has developed. Major media effects publishing the danger of the two chemicals have been directed to the Hispanic communities in California. The U.S. Food and Drug Administration has instituted a national recall of greta and is investigating its use in other states. Mexican health authorities have reportedly instituted recall efforts in Mexico. Health professionals are urged to report cases of lead poisoning and to promote educational programs in their Hispanic communities regarding the dangers of these folk remedies. 0 References.

174. Author: Staff. (1984).
Title: Measles Outbreak--New York City.
Source: U.S. Department of Health and Human Services, Public Health Service Morbidity and Mortality Weekly Report, 33(41), 580-586.
Abstract: This article reports on the outbreak of measles in East Harlem reported by the New

York Department of Health from February 8 to May 23, 1984. Thirty-four cases, including 18 females were identified. Thirty-one cases (91%) were of Hispanic origin. While measles were simultaneously discovered in two areas of East Harlem, a common source of infection was not identified. To control the spread of measles, especially among pre-schoolers, vaccination clinic hours were increased from 3 to 24 hours of clinic time and measles vaccination was recommended for children 6 months to 11 months in the outbreak area. Subsequent reimmunization with measles, mumps and rubella (MMR) vaccine at fifteen months was recommended for all children vaccinated before their first birthday. Harlem children 12 months or older were vaccinated with a combined MMR vaccine. 0 References.

175. Author: Staff. (1982).
Title: Tuberculosis among Hispanics in the United States-1980.
Source: U.S. Department of Health and Human Services Public Health Service, Morbidity and Mortality Weekly Report, 31(18).
Abstract: This is a report of Hispanic tuberculosis case rates in the United States during 1980. The report indicates that among Hispanics age 35 and younger, the age specific incidence of tuberculosis was from 2.7 to 4.2 times greater than for other ethnic/racial groups. In the five Southwestern states, Hispanics comprised slightly more than 25% of all reported cases. The tuberculosis case rate was higher for Hispanics living in the cities with populations of 250,000 or more, than for Hispanics living in less populated areas. The report concludes that Hispanics currently at significantly higher risk of having tuberculosis than most other persons in the United States and are likely to remain so for at least several decades. 2 References.

176. Author: Stern, M. P., Gaskill, S. P. Allen,Jr. C. R., Garza, V., Gonzales, J. L. & Waldrop, R. H. (1981).
Title: Cardiovascular risk factors in Mexican Americans in Laredo, Texas. II. Prevalence and control of hypertension.
Source: The American Journal of Epidemiology, 113(5), 556-562.
Abstract: The level of hypertension control in both

Blacks and Whites have improved greatly in recent years. This information is still not available on Mexican Americans. A random sample of Mexican Americans from two low-income census tracts in Laredo, Texas, were surveyed. The percentages of hypertensive women who had been previously diagnosed, were under treatment, and were under control compared favorably with national figures for Blacks and Whites. However, the data indicated that men still lagged behind the national figures for levels of diagnosis, treatment and control. In the Laredo Project, the prevalence of hypertension was midway between those shown in national studies for Blacks and Whites. When findings were based on blood pressure distributions or elevated diastolic pressures, the results were not as clear. The number of "controlled" hypertensives in the population, comparisons between populations and across time can no longer be based exclusively on blood pressure measurements, but must include cases of controlled hypertension. (Author's abstract modified).

177. Author: Stern, M. P. (1984, December).
Title: Factors relating to the increased prevalence of diabetes in Hispanic Americans.
Source: Paper presented to the Task Force on Black and Minority Health, Bethesda, MD.
Abstract: Recent epidemiological health studies reveal a trend whereby Mexican Americans seem to be at a higher risk for developing diabetes. It remains unclear as to whether other Hispanic subgroups experience simliarly high prevalence rates. This article reviews recent diabetes prevalence studies conducted with both Mexican American and other Hispanic subgroups with a focus on methodological considerations. For example, few studies are consistent in their definition of diabetes which often results in over- or under-estimates of the disorder. The authors summarize factors which seem to contribute to the higher prevalence of diabetes among Mexican Americans emphasizing the marked effects of socioeconomic status and acculturation. The authors conclude by providing policy implications for prevention programs which are tailored to the cultural orientation of the Mexican American population. Also recommended is future research which clarifies the relationship between cultural orientation and health habits and attitudes, which can

then assist in the design of culturally acceptable educational materials. 23 References.

178. Author: Sujansky, R., Smith, A. C. M., Peakman, D. C., McConnell, T. S., Baca, P., & Robinson, A. (1981).
Title: Familial pericentric inversion of chromosome 8.
Source: American Journal of Medical Genetics, 10, 229-235.
Abstract: The purpose of this paper is to discuss seven families of Mexican American ancestry with infants presenting similar congenital anomalies and an unbalanced recombinant chromosome 8. Parental chromosomes underwent analysis. It was found that one member of each couple was found to carry a pericentric inversion of chromosome 8. The propositi had an unbalanced recombinant chromosome. The infants who were affected were developmentally delayed, with congenital heart disease, and an unusual appearance. The findings indicated a common origin of pericentric inversion. This was suggested because of geographic location and the Mexican American ancestry of the seven families. 9 References.

179. Author: Sunseri, A. J., Alberti, J. M., Kent, N. D., Schoenberger, J. A., & Dolecek, T. A. (1984).
Title: Ingredients in nutrition education: Family involvement, reading and race.
Source: Journal of School Health, 54(5), 193-196.
Abstract: An evaluation of a health education program designed for sixth-graders and their families. A pre-test and post-test was administered to 213 students, including 78 Black, 34 Hispanic, and 89 White students. The results indicate that it was possible to conduct a family intervention with an educationally and racially diverse urban population. The patterns of family involvement and student outcomes varied for the different groups. Reading was significantly related to nutrition knowledge and attitude but not to behavior. Reinforcements appear to be necessary for students to maintain changes over time. 16 References.

180. Author: Tebben, M. P. (Ed.) (1982).
Title: HHS demonstration project for hypertension control focus on Blacks and Hispanics.
Source: Public Health Reports, January/February, 84.

Abstract: An award had been made for the establishment of demonstration projects for hypertension control to provide five sites serving predominately Black and Hispanic populations. This implements recommendations of the Black Health Providers Task Force on Hypertension Education and Control. Two sites will serve urban Blacks, two will serve rural Blacks, and one will serve a rural Hispanic population. Materials based on the experiences at the site will be developed for national use, as well as treatment techniques. 0 References.

181. Author: Teberg, A. J., Howell, V. V., & Wingert, W. A. (1983).
Title: Attachment interaction behavior between young teenager mothers and their infants.
Source: Journal of Adolescent Health Care, 4(1), 61-66.
Abstract: This paper reports on behavioral interaction between teenage mothers and their infants. Study population was 26 Hispanic, low SES teenage mothers with a mean age of 15 years and their infants with a mean age of 13.5 months. The control group of thirty mothers had a mean age of 26 years and their infants mean age was 14.0 months. Only 26% of the control infants showed a limited ability to handle stress compared to 47% of the infants of teenage mothers. More effective eye, verbal, physical contact, and smiling behavior was exhibited by the control mothers. The authors suggest that limited teenage maternal behaviors may have a negative psychologic effect for both the infants and the mothers. Abstract.

182. Author: Tejani, A., Nicastri, A. D., Chen, C-K., Eikrig, S., & Gurumurthy, K., (1983).
Title: Lupus nephritis in Black and Hispanic children.
Source: American Journal of Diseases of Children, 137(5), 481-483).
Abstract: A sample of 23 children (17 Black and 6 Hispanics of unspecified national origin) was studied at the Pediatric Renal Immunology and Hematology Division of the SUNY Hospital in Brooklyn, New York. Records were reviewed for children seen between 1972 and 1981 with a diagnosis of systemic lupus erythematosus (SLE). The mean follow-up period was 5.4 years. The mean age at onset was 10.1 years,

which is younger than is usually described. There was a higher rate of death in those whose diseases started before age 10. Twenty-five percent of the patients died of renal causes, and another 25% have been undergoing dialysis, receiving transplants, or were in chronic renal failure. The mortality in the sample was higher than in other children suggesting that age and race may be interacting to produce higher morbidity and mortality. 21 References.

183. Author: The Texas Migrant Council, National Resource Center on Child Abuse and Neglect for Mexican American Migrants & Berrios, L. (1981).
Title: Child abuse and neglect among Mexican American migrants: A study of cases.
Source: Laredo, Texas: The Texas Migrant Council Inc.
Abstract: An analysis of 193 cases of child abuse in a population of Mexican American migrant workers. Data were provided on the etiology of child abuse and neglect. Attention is paid to demographic variables, definite situations and specific behaviors. A brief assessment of services offered to the clients is provided. The major conclusions are that: social environments, coupled with parental inability to cope with stressful situations, lead to child abuse and neglect; transiency accentuates the incidence and prevalence of child abuse and neglect; Mexican American culture, by emphasizing family cohesions and support, ameliorates the disruptive impact of social environmental stress. 10 References.

184. Author: Torres, A. M. (Ed.). (1982).
Title: The prevention and treatment of child abuse and neglect: A focus on the Mexican American family.
Source: Proceedings of the Second Annual Conference, Texas Migrant Council National Resource Center on Child Abuse and Neglect for Mexican Americans. San Antonio, Texas: Texas Migrant Council, Inc.
Abstract: The second Annual Conference on the Prevention and Treatment of Child Abuse and Neglect, "a focus on the Mexican American Family" sponsored by the Texas Migrant Council's National Resource Center on Child Abuse and Neglect of Mexican Americans in cooperation with AVANCE Parent-Child Education Program was held in San Antonio, Texas. Four hundred participants

interacted with top Mexican American and non-minority specialists in the field of child abuse and neglect. Goals of the conference were to increase participation of Mexican Americans and non-minority specialists in the field of child abuse and neglect, to increase participation of Mexican American professionals in child abuse and neglect issues and to increase the awareness of workers, administrators, and others of the cultural dynamics involved when working with Mexican American families. Twenty-six papers were presented. These were divided into five issues: 1) sociocultural perspectives in the prevention and treatment of child abuse and neglect among Mexican Americans, 2) research efforts in child abuse and neglect in the Mexican American community, 3) culturally relevant intervention approaches with Mexican American families, 4) innovative prevention and treatment programs and delivery systems, and 5) special topics in child abuse and neglect. Judge Enrique H. Peña in the foreward stresses that findings of the conference will serve to dispel the myths about Mexican American families and avoid stereotyping. They will challenge the system of prevention, investigation and treatment of cases involving child abuse and neglect to look at such cases from the perspective of the Mexican American family. 187 References.

185. Author: Trevthan, W. R. (1981).
Title: Maternal touch at 1st contact with the newborn infant.
Source: Developmental Psychobiology, 14(6), 549-559.
Abstract: This study investigates a report that mothers exhibit a species-characteristic pattern of touching new-born infant extremities with their fingertips and then progressing to massaging of the infant's trunk. Data on maternal tactile interaction during 10 minutes of contact following delivery was collected from a study population of 66 mothers and new-born infants. Most of these were of Hispanic origin and delivery had been by midwives in a Texas maternity center. Tactile behavior was recorded every ten seconds, using time-sampling techniques, with most observations beginning in the first ten minutes after birth. Findings were that maternal tactile behavior in the first ten minutes of active interaction was more variable than had pre-

viously been reported. There was no evidence of a touch progession: the tactile exploration seemed to vary with the sex of the infant, as well as socioeconomic or sociocultural background of the mother. (Journal abstract modified). 189 References.

186. Author: Trowbridge, F. L. (1982).
Title: Prevalence of growth stunting and obesity: Pediatric Nutrition Surveillance System.
Source: U.S. Department of Health and Human Service. Public Health Service, Morbidity and Mortality Weekly Report, Surveillance Summary, 32(4), 2355-2655.
Abstract: This paper reports on data from the 1982 pediatric surveillance summary related to growth stunting and obesity, which has been observed in from 6 to 16% of children between the ages of birth through 4 years. Findings show stunting trends increase with age, with Native American and Hispanic children having the highest increase. In different age and ethnic groups, obesity was found to vary from 5% to 13%. Although obesity increases in infants of one year compared to those of less than one year, there is no consistent trend from 2 to 4 years of age. Highest prevalence of obesity is found in Native American Children, followed by Hispanic children, when obesity is measured by weight for height. It was suggested that thinness is not a significant public health problem in the study population. Issues of interpretation are raised and it is suggested that whereas the diet of these children may be adequate in quantity, it does not have the necessary nutritional quality. 0 References.

187. Author: Tunder, J. (1984, November).
Title: Women's cancer screening and prevention project final report.
Source: (Available from Venice Family Clinic, 604 Rose Avenue, Venice, CA. 90291).
Abstract: A final report of the second year of an American Cancer Society-sponsored cancer screening clinic aimed at low income, primarily Hispanic women. The major innovation was the development and implementation of a Spanish-language cancer discussion group, piloted as a means of reducing the cultural and other barriers that keep such women from utilizing screening and prevention programs. Information about breast self-examination, Pap test, and pelvic examin-

ation was provided, with measurable increases in knowledge recorded. 572 patient visits were achieved. All the patients were low income, 76% were Hispanics, 74% were monolingual in Spanish, and 56% were 35 years of age or older. The project also provided placement for health care professional training. The report also contains appendices of original material, including: Intake Questionnaire, Breast Self-Examination Assessment Sheet, Health Professionals' Training Evaluation Questionnaire, Women's Clinic Protocols, and Venice Family Clinic Patient Statistics. 0 References.

188. Author: Vieira-Caetano, R. J. (1983).
Title: Drinking patterns and alcohol problems among Hispanics in Northern California.
Source: Ann Arbot, MI: University Microfilms International. No. 8328811.
Abstract: The data from this dissertation came from three independent general population surveys carried out in 1977, 1978, and 1980 in three communities in Northern California. The purpose of the study was to explore the alcohol comsumption problems among Hispanics. More specifically, to analyze frequency and quality of drinking patterns, levels and type of alcohol related problems and attitudes and knowledge of alcohol effects. The total number of respondents were 634 Hispanic males and females between the ages of 18 and 59 most of whom were married, employed and Catholic. The findings indicated that among Hispanic males, alcohol is consumed in large amounts by young, single, separated, or divorced and Catholic. Among Hispanic females, drinking is associated with being young, single, separated or divorced and having a higher income and education. Drinking patterns among Hispanic males are more uniform than among Hispanic females. Hispanic males get drunk more often and have more alcohol-related problems than men in the general population. As for Hispanic females, they drink less, have fewer problems and hold less permissive attitudes toward drinking than Hispanic males. 276 References.

189. Author: Wittenberg, C. K. (1983).
Title: Summary of market research for "Healthy Mothers, Healthy Babies" campaign.
Source: Public Health Reports, 98(4), 356-359.

Abstract: Reports of focused group sessions held with seven groups of Mexican American women and eight groups of Black women. There is no numerical data, but insights are offered. Conclusions include the following: in educational campaigns, the link between the mother's behavior and the baby's health must be made clear; the questions that interest the pregnant woman should first be answered before moving on to other topics that need emphasis; individual counseling should be used to teach pregnant women; a multi-media approach is needed to reach women of lower socioeconomic status; the WIC program could serve as a model of how to reach women of lower socioeconomic status. 3 References.

190. Author: Young, J. L. (1981).
Title: Cancer and the Hispanic elderly.
Source: In P. Vivo & C. S. Votow (Eds.), The Hispanic Elderly: La Fuente de Nuestra Historia, Cultura, y Cariño (pp. 1106-1112). Rockville, MD.: Department of Health and Human Services, Public Health Service (Spanish Heritage Public Health Service Workers).
Abstract: The Surveillance, Epidemiology and Results (SEER) program initiated by the Cancer Institute collected cancer related data from 1973 to 1977 in ten areas of the United States including Puerto Rico; 5% of the elderly (over 65) Hispanic population in the areas of Puerto Rico, San Francisco/Oakland and New Mexico were covered. Criteria for identifying Hispanics was Spanish surname of patient and/or residence in Puerto Rico. The data revealed that the Hispanic elderly are at lower risk for cancer than Whites or Blacks and about the same risk as Orientals and American Indians. The 10 most common cancers found among elderly Hispanic males were cancer of the prostate, lung, stomach, colon-rectum, pancreas, lymphomas, bladder, leukemias, kidney and brain, in descending order. Among elderly Hispanic females the 10 most common cancers were cancer of the breast, cervix, lung, stomach, pancreas, ovary, corpus, gallbladder and lymphomas, also in descending order. Hispanic elderly face relatively lower lung cancer risks than Whites, but are at a higher risk than Whites for cancer of the pancreas and stomach. Different risk patterns were observed in Puerto Rico, New Mexico and San Francisco. New Mexico/San Francisco had a

higher risk of pancreatic cancer and Puerto Rico had an increased risk of esophageal cancer. The overall relative cancer risks of elderly Hispanics when compared to Whites for all cancers was 65% for males and 89% for females. 0 References.

191. Author: Zeltzer, L. K., & Lebaron, S. (1985).
Title: Does ethnicity constitute a risk factor in the psychological distress of adolescents with cancer?
Source: Journal of Adolescent Health Care, 6, 8-11.
Abstract: To determine if ethnicity constitues a risk factor in the psychological distress of adolescents with cancer, ethnic comparison (Hispanic versus Anglos) were made on four psychological measures (trait anxiety, selfOesteem, locus of control, impact of illness) administered to 54 adolescents with cancer. Data from the largely Mexican American San Antonio sample were then compared to test scores from a largely Anglo Los Angeles sample. The impact of cancer did not differ among Mexican American and Anglo adolescents. Both groups experienced normal anxiety traits and self-esteem; however, both groups perceived little control over their health. A San Antonio subsample of 25 adolescents with cancer who received behavioral intervention for relief of treatment-related distress were retested on these psychological measures at six months following intervention and test score changes were compared to those found in a similar Los Angeles study. Adolescents from both ethnic groups demonstrated similar reductions in their trait anxiety scores following behavioral intervention. Authors concluded that ethnicity per se does not appear to have a major influence on the experience of cancer in adolescents. Nevertheless, their findings suggest that membership in a minority group and a clinic's attitude toward ethnic differences may play an important role in acceptance or rejection of behavioral intervention and thus merit investigation. 17 References.

192. Author: Zepeda, M. (1982).
Title: Selected maternal-infant care practices of Spanish-speaking women.
Source: Journal of Obstetric, Gynecologic, and Neonatal Nursing, 11(6), 371-374.
Abstract: This is a report of an informal study of 30

Hispanic women to discover which postpartum maternal-infant care practices were common in a Southern California Hospital. The population was surveyed first in the hospital, and then in the patient's home, where seven open-ended questions were related to umbilical cord care and isolation practices. Findings were that Hispanic women follow cultural patterns. Other implications of nursing practices for use with Hispanic women were discussed. (Journal Abstract Modified).

Reports in the Popular Press

193. Author: Associated Press Staff. (1985, February 24).
Title: Heart disease tied to poverty.
Source: New York Times, p. 24L.
Abstract: A report of a study which concluded that heart disease is more likely to kill the poor than the affluent. Researchers analyzed death certificates of Los Angeles County residents from 1979-1981. Those who made less than $13,600 were classed as poor and those who made more than $28,501 were designated affluent. The death rate from heart disease was 40% higher for the poor than the affluent. The study also found that the poor are more likely to die out of the hospital. Dr. R. R. Frerichs, a member of the study group, speculates that the high rate among the poor may be due to not getting checkups, not having health insurance, not being able to afford health care, and delaying treatment.

194. Author: Beyette, B. (1984, December 11).
Title: Alternative childbirth center assists Latinos.
Source: Los Angeles Times, Part V, pp. 1, 6, 7.
Abstract: This article reports on the Los Angeles Childbirth Center that offers assistance to Latinos in an Alternative Childbirth Center (ABC) in Santa Monica, which has a population of 88,000, including 13,000 Latinos. The city supports the Center, founded in 1977, but will withdraw its support in 1985,at which time it is expected to be self-supporting. The non-profit organization has a Latina Maternity Care Program which is intended to attract Latinas who would otherwise give birth at home without proper prenatal and postpartum care. The program includes the ABC Center as well as classes in natural childbirth. The staff of 13 includes the medical director and two nurse-midwives. The birth can take place in the home or in the Center. The ABC with two birthing rooms is available to all women. Fees are based on income, and very poor families can use MediCal. Fees charged are compared with those of private institutions. Should a problem develop, the patient is moved immediately to a public or private institution for specialized care. Mortality rates compare to those of other hospitals. There have been no preventable deaths of infants and no deaths of mothers. According to Nina Kleinberg, one of the nurse-midwives at the Center, Hispanic women, especially from rural areas, have different attitudes about childbirth, being more relaxed and accepting

childbirth as a natural part of life. Dr. Gary Richwald, The Center's medical director, participates in all initial patient evaluations and is a consultant on an ongoing basis until delivery with a nurse-midwife. He spoke of the need to decentralize health services and to reduce the financial stress of having a baby in the Los Angeles area. With the emphasis on childbirth being a "family event," the Center is reaching out to the community in an effort to become self-sustaining.

195. Author: Carmen, A. (1983).
Title: Rape.
Source: Latina, 1(23), 35-36.
Abstract: This article discusses the rape problem as it affects Latinas. The cultural, social, and economic realities of life can make rape a particularly devastating experience for the Hispanic woman. The importance of chastity, the reluctance to discuss sex openly, and the strong separation of male and female roles lead to an aggravated sense of humiliation and guilt. Family and friends often reject the victim. Factors that inhibit reporting of rape are: family and neighborhood loyalty, reluctance to report neighbors and relatives, language barriers, working women afraid of losing their jobs who are raped by their supervisors, undocumented women who are afraid of deportation when attacked by immigration officials or others. These all make Latinas less likely to report the crime or get medical or psychological help. In addition to the above, Latinas are ten times as likely to be gang raped as Anglo women. Formation of the East Los Angeles Rape Hotline was necessary to provide services from the only bi-lingual/bi-cultural hotline including crises intervention, follow-up counseling, advocacy, community education and volunteer training services. Women who might be reluctant to turn to help to other services call the East Los Angeles Rape Hotline at a rate of 30 to 40 each month. Calls are received 24 hours per day, 365 days per year, by a staff of 35 trained volunteers. The article lists precautionary activity as well as what a woman should do if she is sexually assaulted.

196. Author: Escalante, V. (1984, May 2).
Title: Latino play on sexual abuse moves community.
Source: Los Angeles Times, View Section, pp. 1, 16.

Abstract: A report on the work of the Latino Child Sexual Abuse Prevention Project, which is aimed at reaching all segments of the Latino community with information on child abuse. The project, which began in July 1984 and is due to end in June, has undertaken the following: 1) intensive training of elementary school teachers, 2) a pilot program using stories and puppets to teach children, 3) creation of a network of schools, health and social agencies, 4) compilation of a referral list of bilingual/bicultural health counseling and police agencies for parents, and 5) presentation of a play on child abuse within a Latino family. This is the first program of its kind in the nation and is a creation of the Latino Child Sexual Abuse Prevention Project.

197. Author: Fatherree, T. (1984, November 18).
Title: Study shows Hispanics have greater diabetes risk.
Source: The Monitor, Valley Section, pp. 17A, 27A.
Abstract: A report of a study conducted by the University of Texas Health Science Center in Houston established that the Mexican American population of the Rio Grande Valley has an increased risk of diabetes. Representative sampling produced 2,498 individuals over 15 years of age. These subjects were interviewed, tested for blood pressure and underwent finger-prick blood sampling. About one-third of the household targeted for interviews refused to cooperate. Interviews continued until 10% of the county population had participated. Results showed prevalence of diabetes from 0 to 19% with females generally having higher rates than men. It is believed that more than 50% of individuals over 35 years of age are directly affected by diabetes, either by having the disease or by someone in their family having the disease. It is not clear whether the increased rate is attributable to genetic predisposition or to sociocultural factors, or both.

198. Author: Goldstein, I. (1984, January 14).
Title: Why asthma hits some minorities hardest.
Source: New York Times, pp. 16(N), 10(L).
Abstract: A commentary on a University of Connecticut study in which the researchers assert that Puerto Ricans suffer twice as much asthma (10%) as other ethnic groups or twice the U.S. rate. The author cites a Columbia University study

done in New York (Brooklyn, Manhattan, Harlem) which found similar rates among Black adolescents in Harlem. These studies seem to supply strong evidence that housing conditions rather than ethnic susceptibility are responsible for high rates of asthma in inner city populations.

199. Author: Gunby, P. (1984).
Title: Medicine at a glance.
Source: Journal of the American Medical Association,252 (24), 3349.
Abstract: Describes phase II of the National Heart, Lung, and Blood Institute of Bethesda, Maryland sponsored study that compares incidence of diabetes, heart disease, and high blood pressure in two ethnic groups in San Antonio,Texas. This study is evaluating frequency and severity of diabetic complications, relation of upper body fat deposits to diabetes, and possibility of genetic factors in diabetes. Phase I, headed by Michael P.Stern, M.D. University of Texas Health Science Center, San Antonio, found that diabetes is three to five times more prevalent in Mexican Americans. Although it is hypothesized that genetics play a role, it is also known that culture and dietary factors are involved.

200. Author: Nelson, H. (1985 May 1).
Title: County high blood pressure deaths top U.S. rate by 53%.
Source: Los Angeles Times, Metro , pp. 1, 3.
Abstract: Report of a study completed last year by the UCLA School of Public Health indicates that the death rate from hypertension diseases has increased to 53% over the national average. Hypertension disease death in Los Angeles County from 1979-1981 were 20.3 per 100,000 compared to the national average of 13.3 per 100,000 during the same time. Although Blacks are at higher risk than either Whites or Latinos, the death rate for all three groups and the Chinese population were above the national average. Los Angeles averages per 100,000 were 18.7 for Whites, 47.7 for Blacks, 19.9 for Latinos, and 17.1 for Chinese. Hypertension is the most important risk factor in deaths from heart attacks, strokes, and heart and kidney disease. Survey also revealed that only 6 out of 10 individuals with high blood pressure are aware of it.

201. Author: Nelson, H. (1982, November 17).
Title: Drop in TB rate may mean hidden cases.
Source: Los Angeles Times, Part 2, p. 5.
Abstract: This report looks into the significance of the drop in the tuberculosis rate among Hispanics in Los Angeles County. Some experts think that the 31% drop in cases in 1982 is because Hispanics are simply failing to report existing cases. Shirley Fannin, the Assistant Director of the Communicable Disease Division of the Department of Health Science, Los Angeles County, believes that Hispanics don't report because they are unaware treatment is free, or they are afraid of deportation. She states that the average number of cases among Hispanics in 1980-81 was 521 and in 1982 was 357. This difference, she feels,cannot realistically be attributed to a decline in the incidence of the disease. Emily Kahlstrom, a lung expert at the U.S.C. Medical Center, concurs. She cites the 128% increase of infection between 1970 and 1981-82 in school age children as a basis for requiring tuberculosis skin tests upon entering school or employment.

202. Author: Nelson, H. (1983, September 29).
Title: Heart, stroke, death rates found to vary.
Source: Los Angeles Times, Sec. II , p. 1.
Abstract: A UCLA study sponsored by the American Heart Association's Greater Los Angeles Affiliates reported on the death rates of different racial and ethnic groups in Los Angeles County. Researchers examined all causes of death based on the census tracts and death certificates in the County and found major differences in death rates between racial and ethnic groups. John Chapman, who headed the group, reported that although deaths from cardiovascular disease are down as a whole, the rate among Blacks is the highest. The rate among Anglos is just behind that of Blacks. Latinos have a somewhat lower rate with 390.6 per 100,000 succumbing to cardiovascular disease.

203. Author: Nelson, H. (1985, February 21).
Title: Poverty kills, new heart study finds.
Source: Los Angeles Times, Sec. I, p. 3.
Abstract: A study sponsored by the American Heart Association on heart disease was a follow up to an earlier study in September of 1983 which indicated a high mortality rate for cardiovascular

disease for Blacks. The new study was based on mortality rates in Los Angeles County in 1979-1981. These rates were analyzed according to sex, race, ethnicity, and income level. The study found that the poor, regardless of race or ethnicity, were 40% more likely to die of heart disease. The out-of-hospital death rate for the poor was also high. Researchers speculate that lack of access to emergency care, less awareness of the need to control heart disease factors, and consumption of high-risk foods contribute to the high rate for the poor. Among all income groups the heart disease death rate for Latinos was 370 out 100,000.

204. Author: Nelson, H. (1982, May 16).
Title: TB rate among Southeast Asians, Latinos in U.S. higher than average.
Source: Los Angeles Times, Part I, p. 17.
Abstract: This report on the tuberculosis rate among Latinos and Southeast Asians by the Centers for Disease Control states that the tuberculosis rate among Latinos is double that of the general population. Among Southeast Asians, the rate is forty times greater. In California, 42% of the 3,099 cases of tuberculosis are among Latinos. Lee Hanh, Director of Tuberculosis Control for Los Angeles County, reports that in 1980 there were 1,431 reported cases of tuberculosis; of these, 608 were among Hispanics. In 1981, the number increased to 1,808 of which 775 were Hispanic. He adds that little is being done for Latinos in comparison to Southeast Asians who receive federal aid and special programs. Dr. Einstein of the Barlow Hospital states that the staff of that facility is attempting to provide some preventive services that had formerly been provided by the County before recent cutbacks.

205. Author: Nicols, B. (1982, May 16).
Title: Chicanos warned on diabetes.
Source: Los Angeles Times, Part I p. 3.
Abstract: A study administered through the National Institues of Health has found that Hispanics may be three times as likely to develop adult onset diabetes as Anglos. Among 1,924 Mexican American residents of Starr County, Texas, over age 15, 130 cases of diabetes were found. Dr. Ferrell, one of the researchers, states that Indian ancestry is suspected as a cause.
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206. Author: Olvera-Stotzer, B. (1984, January).
Title: Women's health: A Latina perspective.
Source: Testimony presented to U.S.Department of Health and Human Services Task Force on Women's Health.
Abstract: This paper presents problems within the current system of health care delivery for Latinas, as seen by Comision Femenil Mexicana Nacional, Inc. These problems are frequently caused by isolated decisions made without consideration of the cultural background of Latina women, and the effect not only on them but on the entire community. Information is given on abortion, utilization and Medicaid funding restrictions. Characteristics of Latinas are given as ethnicity, young age, low socioeconomic status, and high fertility. Medicaid funding is analyzed, including legal issues surrounding the abortion decision, and an assessment is made of the social and psychological impact of these issues. Discussion centers on funding of abortions under Medicaid, and problems created by not having such funding. Outlined are the results of unwanted childbearing, teenage child bearing, and childbearing by middle age women. Three recommendations are made for assuring equitable distribution of health services: 1) development of incentive programs to encourage physicians to practice in medically underserved communities, 2) encourage and support health planning programs, and 3) stricter monitoring and enforcement of federal as well as state statutes and regulations prohibiting discrimination on the basis of national origins.

207. Author: Orijel, J. (1984, January).
Title: Women's health: A Hispanic perspective.
Source: Paper presented to the Department of Health and Human Services Task Force on Women's Health.
Abstract: This paper was presented to give some understanding of the variety of problems facing Hispanic women and issues relevant to their health. Dr. Fernando Guerra (1980) stated that Hispanics exist in more stress-producing situations, have higher morbidity and mortality rates, attend substandard schools, have higher dropout rates, higher unemployment rates, poor housing, poor nutrition, higher incidence of poverty and a shortage of relevant and accessible health care services. Priority issues for Hispanic women are prenatal health care, preventive health, nutrition, and bilingual and bicultural health services. The major Hispanic subgroup in the

Southwest is Mexican American. Eighty percent are in the dependent age ranges (under 16 and over 64), with only 3.3% over 65. Acculturation has changed the traditional pattern of high fertility. Income and education levels in this subgroup are lower than that of the greater population. The most common cause of death among Mexican American women is heart disease, but tuberculosis, infectious and parasitic diseases take a higher toll than in the Anglo population. Cancer of the cervix has been observed to be frequent in this population; diabetes and hypertension are a major concern. The status of nutrition is similar to that of other predominantly low income groups. Cultural influences account for dependency on home remedies and folk healers for primary health care. Recommendations are: 1) Priority given to a comprehensive national health insurance for everyone with emphasis on preventive health services, 2) funds for maternal and child health should be encouraged and reimbursement for new approaches for prenatal care, deliveries and post-partum care should be provided, 3) funds be allocated for the identification of Hispanic data in health research, and 4) funds for direct services programs be prioritized to community non-profit groups in order to reflect culturally sensitive health care.

208. Author: Sahagun, L. (1983, April 20).
Title: Diabetes: a special risk for Latinos.
Source: Los Angeles Times, Part I, p. 11.
Abstract: This study, done by Robert Ferrell and Michael Stern, University of Texas researchers, provides the first statistical evidence of a higher risk of diabetes among Hispanics. In the Lower Rio Grande Valley, 27,000 residents were surveyed and subjected to a socioeconomic cross study. The results indicate that Mexican Americans of South Texas are five times as likely to develop adult onset diabetes as Anglos. The cross study established that socioeconomic differences did not explain the gap. The researchers believe a genetic link to Indian ancestry could be responsible. Dr. Brown asserts that there is an urgent need to reach Hispanics with this information and to make sure this group receives the proper care. Dr. Bennet, whose 1970's studies are confirmed by this report, agrees and also says there is a need for more studies on Hispanic health issues. Many doctors who practice in the barrio think this study re-

flects the reality they encounter. The American Diabetes Association of East Los Angeles is attempting to bring the Texas studies to the attention of Hispanics through Spanish-language television, but feels its efforts are being seriously hampered by recent severe cutbacks. Another study to be administered by the National Center for Health Statistics is planned to confirm or deny these results.

209. Author: Staff. (1983, Summer).
Title: Child abuse.
Source: Research Bulletin, (Spanish Speaking Mental Health Research Center) p. 4.
Abstract: Report of a study conducted in Los Angeles County of child abuse cases by K. J. Lindholm, UCLA, and Richard Wiley, Los Angeles County Sheriff's Office, to determine whether there were differences related to the ethnicity of the victim or suspect. The study indicated that although there were differences in the rate and type of abuse, type of injuries suffered, or who reported the incident based on ethnicity, there is a need for more systematic research of the relationship between ethnicity and child abuse.

210. Author: Staff. (1984, November 19).
Title: Congenital syphilis study.
Source: Hispanic Link Weekly Report, p. 2.
Abstract: A study reported in the October 5, 1984, Journal of the American Medical Association indicates that congenital syphilis, passed from mother to child, could be reduced among Hispanics and Blacks with increased prenatal care. The study group consisted of 50 cases in Texas in 1982, of which 27 were Hispanic and 23 were Black. The Texas Hispanics made up 17% of the 159 cases reported nationally.

211. Author: Staff. (1983, Summer).
Title: Hispanic mothers less likely to smoke.
Source: Research Bulletin (Spanish Speaking Mental Health Research Center), pp. 2-3.
Abstract: More than 7,000 mothers and their physicians were surveyed by the National Institute on Alcohol and Alcoholism and the National Center for Health Statistics. The survey consisted of questions regarding pregnancy, history, and outcome, and a review of medical records. Two groups were surveyed: those who had success-

fully delivered in the past and those with stillborn deliveries. The survey found little difference in cigarette or alcohol use between the two groups. One-fifth of the mothers smoked and drank before pregnancy and one-third abstained from cigarettes and alcohol. Race, education, and income levels had some bearing on smoking/drinking habits of pregnant women. Hispanic mothers are less likely to be drinkers or smokers before and during pregnancy.

212. Author: Staff. (1983, Summer).
Title: Mexican Americans and diabetes.
Source: Research Bulletin, (Spanish Speaking Mental Health Research Center), p. 2.
Abstract: Reports of two separate studies conducted by Drs. Robert Ferrell and Michael Stern with Mexican Americans in Texas, revealed that 16.7% of Mexican Americans in South Texas had adult diabetes and 6.8% of the residents of Starr County, Texas, had the disease. Dr. Ferrell's hypothesis is that the higher incidence may be related to the fact that many Texas Mexican Americans are of mixed Indian and European descent. Dr. Stern suspects a genetic basis for the increased prevalence in Mexican Americans over Anglo Americans.

213. Author: Staff. (1983, December 28).
Title: Puerto Ricans have high asthma rate study concludes.
Source: New York Times. Sec. A, p. 21 (L).
Abstract: A study done by the University of Connecticut reports the first scientific confirmation that Puerto Ricans suffer a higher rate of asthma than other ethnic groups. Researchers did a door-to-door survey among 1,079 (55% Puerto Rican) families in Hartford's Oak Terrace Heights Housing Project in 1981. Data revealed that 10% of the Puerto Ricans surveyed had asthma, twice the national average, with 38% of the Puerto Rican families having at least one family member with asthma. The study concludes that Puerto Ricans suffer from asthma twice as much as other northeastern ethnic groups.

214. Author: Staff. (1985, March).
Title: Reye syndrome.
Source: The COSSMHO Reporter, p. 3.
Abstract: The U.S. Department of Health and Human Services' Center for Disease Control reports a

significant increase in Reye Syndrome among Hispanics. As of December 1, 1984, 7% of the voluntarily reported cases (196) were Hispanics. Five cases were in Texas, four in California, two in Colorado, and one in the District of Columbia. Studies suggest a link between the use of aspirin products and Reye Syndrome. The Department of Health and Human Services urges everyone to check with their doctors, learn the symptoms, and act promptly.

215. Author: Staff. (1984, Spring/Summer).
Title: Sexual Abuse.
Source: Research Bulletin (Spanish Speaking Mental Health Research Center), pp. 3-4.
Abstract: Study of child abuse within Hispanic, Black and Anglo families based on 611 cases investigated by the Los Angeles County Sheriff Department's Child Abuse Detail from January 1981 through November 1982. The study reports ethnic differences in relation to suspect, victim and informant.

216. Author: Staff. (1984, Spring/Summer).
Title: Smoking.
Source: Research Bulletin, (Spanish Speaking Mental Health Research Center), p. 5.
Abstract: A report on the methods and goals of a 1984 research project on cigarette smoking among Hispanic and White Americans in Los Angeles County, conducted by the Seventh Day Adventist Church and the Spanish Speaking Mental Health Research Center.

217. Author: Staff. (1984, July 2).
Title: T.V. proves successful in reaching Spanish Speaking.
Source: Cancer Com-Line, 5(2), p. 1.
Abstract: The University of Southern California Cancer Center participated in a nationwide pilot program designed to reach the Spanish Speaking. Spanish language services were presented on the Cancer Information Service hot-line. Materials in Spanish were distributed through health fairs, Roman Catholic churches, professional agencies and the staff made public and television appearances on a Spanish-language station in Los Angeles, urging the Hispanic community to utilize a cancer information hot-line. From November, 1983, through March, 1984, 559 Spanish speakers called. Of these, 80% said they

were calling as a result of the television appearances. Findings indicate that when Spanish-speaking Hispanics are reached through utilization of the proper media, use of their own language and people of their own heritage, they will ask for cancer information and help.

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APPENDIX FOR QUESTIONNING RESEARCHERS

AUTHOR: Andrade, S. J. (1981, April).
TITLE: Contraceptive use by adolescents: What do we know about Chicanas?
SOURCE: Paper presented in the Symposium "Passages a la Mexicana", at the annual meeting of the American Educational Research Association, Los Angeles, CA.

AUTHOR: Ansari, R. & Scheiderman, L. J. (1982).
TITLE: Ethnic group response to preventive health education.
SOURCE: Urban Health. 11(6), 335-348.

AUTHOR: Chin, D.M. (1985).
TITLE: Telephone contacts for data users. (No. 4).
SOURCE: Washington, DC: U.S. Department of Commerce, Bureau of the Census, Data User Services Division.

AUTHOR: Coe, M. F. (1983).
TITLE: Factors affecting choice process of medical care utilization in a Latino minority's dual use: La Clinica de la Raza and Kaiser
SOURCE: Ann Arbor, MI: University Microfilms International No. 8413288.

AUTHOR: Comas-Diaz, L. (1981).
TITLE: Ethnicity and treatment -- Puerto Rican espiritismo and psychotherapy.
SOURCE: American Journal of Orthopsychiatry, 51(4), 636-645.

AUTHOR: Cuellar, J. B. & Sanford, E. P. (1983).
TITLE: A guide to minority aging references (DHHS Publication No. OHDS 83-209141).
SOURCE: Washington, DC: U.S. Government Printing Office.

AUTHOR: Cumming, G. R. (1980).
TITLE: What will be the picture of hospital services for 1990? Recommendations for California health facilities commission goals and program 1980-1990.
SOURCE: California Health Facilities Commission, 555 Capitol Mall, Sacramento, CA 95814.

AUTHOR: Curren, D. J. (Ed.). (1985, March).
TITLE: The COSSMHO Reporter, 10(1).
SOURCE: Available from the COSSMHO National Office, 1030 15th Street NW, Suite 1053, Washington, DC 20005.

AUTHOR: Curren, D. J. & Soler, R. (Eds.). (1982, April/May).
TITLE: The COSSMHO Reporter, 8(1).
SOURCE: Available from the COSSMHO National Office, 1030

15th Street NW, Suite 1053, Washington, DC 20005.

AUTHOR: CURREN, D. J. (Ed.). (1978).
TITLE: Hispanic Report on families and youth.
SOURCE: Available from the COSSMHO National Office, 1030 15th Street NW, Suite 1053, Washington, DC 20005.

AUTHOR: Delgado, M. (1983).
TITLE: Hispanic natural support systems: Implications for mental health services.
SOURCE: Journal of Psychosocial Nursing and Mental Health Services, 21(4), 19-24.

AUTHOR: Delgado, M. & Delgado, D. (1982).
TITLE: Natural support systems: source of strength in Hispanic communities.
SOURCE: Social Work, 27, 83-90

AUTHOR: Elizondo, E. T. (1980).
TITLE: 38th annual meeting (abstracts).
SOURCE: Available from the United States/Mexico Border Health Association.606 N.Mesa, Suite 700, El Paso, Texas 79912.

AUTHOR: Ezzati, T. M. & Massey, J. T. (1980, October).
TITLE: Sample design issues for the Hispanic health and nutrition examination survey.
SOURCE: Paper presented at the meeting of the American Public Health Association, Detroit, MI .

AUTHOR: Foster, G. M. (1981).
TITLE: Relationship between Spanish and Spanish American folk medicine.
SOURCE: Transcultural Health Care. Addison-Wesley Press.

AUTHOR: Griffith, S. (1982).
TITLE: Childbearing and concept of culture.
SOURCE: Journal of Obstretics, Gynecologic and Neonatal Nursing, 11(3), 181-184.

AUTHOR: Guerra, F. A. (1980).
TITLE: Hispanic child health issues.
SOURCE: Children Today, 9(5) 18-22.

AUTHOR: Hall, W. T., St.Denis, G. C., & Young, C. L. (Eds.).
TITLE: The family: A critical factor in prevention". (Grant No. MCJ-00014-25).
SOURCE: University of Pittsburg. Graduate School of Public Health.

AUTHOR: Hardwood, A. (Ed.).
TITLE: Mainland Puerto Ricans.
SOURCE In Ethnicity and Medical Care, MA: Harvard

University Press.

AUTHOR: Health Resources and Services Administration.(1984).
TITLE: Minorities and women in the health fields (DHHS Publication No.HRSA HRS-DV 84-5).
SOURCE: Washington, DC: U. S. Government Printing Office.

AUTHOR: Islas, Inc., (Ed.). (1983).
TITLE: Hispanic and health research in the Public Health Service: Public health research issues.
SOURCE: Rockville, MD: U.S. Department of Health and Human Services. Public Health Service (Hispanic Employees Organization).

AUTHOR: Islas, Inc., (Ed.). (1984).
TITLE: Hispanic women's health issues.
SOURCE: Rockville, MD: U.S. Department of Health and Human Services. Public Health Service (Hispanic Employees Organization).

AUTHOR: Keefe, S. M, (1982).
TITLE: Native-born Mexican Americans.
SOURCE: Social Science and Medicine,16, 1467.

AUTHOR: Kennedy, C. G. (1982).
TITLE: Descriptive study of factors influencing the level of self-health assessment and health-illness behaviors of the Mexican American elderly.
SOURCE: Unpublished master's thesis. California State University, Los Angeles.

AUTHOR: Kenton, C. (1982).
TITLE: Health needs and services for Hispanic Americans: January 1980-July 1982.
SOURCE Literature Search Program, Reference Section, National Library of Medicine, 8600 Rockville Pike, Bethesda, MD 20209.

AUTHOR: Lefkowitz, B., & Andrulis, D. (1981).
TITLE: Better health for our children: A national strategy. (DHHS Publication No. 79-55071).
SOURCE: Washington, DC: U.S. Government Printing Office.

AUTHOR: Lopez-Aqueres, W., Kemp, B., Staples.F., & Brummel-Smith, K. (1984).
Title: Use of health care services by older Hispanics.
SOURCE: Journal of the American Geriatrics Society, 32(6), 435-440.

AUTHOR: Marin, B. V., Marin, G., Padilla, A. M., de la Rocha, C. & Fay, J., (1981).
TITLE: Health care utilization by low-income clients of a community clinic: An archival study. (occasional

paper No.12).
SOURCE: University of California, Los Angeles. Spanish Speaking Mental Health Research Center.

AUTHOR: Markides, K. S. (1983).
TITLE: Mortality among minority populations: A review of recent patterns and trends.
SOURCE: Public Health Reports, 98(3), 252-260.

AUTHOR: Martinez, R. A. (Ed.). (1979).
TITLE: Hispanic culture and health care: Fact, fiction, folklore.
SOURCE: St.Louis: C. V. Mosby Co.

AUTHOR: Mirowsky, J., & Ross, C. E. (1984).
TITLE: Mexican culture and its emotional contradictions.
SOURCE: Journal of Health and Social Behavior,25, 2-13.

AUTHOR: Montiel, M. (Ed.). (1978).
TITLE: Hispanic families: Critical issues for policy and programs in human services.
SOURCE: Available from the COSSMHO National Office. 1030 15th Street NW, Suite 1053, Washington, DC 20005.

AUTHOR: Mull, J. D., & Mull, D. S. (1981).
TITLE: Residents' awareness of folk medicine beliefs o f their Mexican patients.
SOURCE: Journal of Medicine,56(6), 5 20-522.

AUTHOR: Murillo-Rhode, I. (1981).
TITLE: Hispanic American patient care.
SOURCE: Transcultural Health Care. Addison Wesley.

AUTHOR: Nathanson, D. (1980).
TITLE: Ambient lead concentrations in New York City and their health implications.
SOURCE: Bulletin of the New York Academy of Medicine,56(9).

AUTHOR: National Center of Health Statistics. (1981).
TITLE: The Hispanic health and nutrition examination: survey: Fact sheet (DHHS Publication No. PHS 82 -1287).
SOURCE: Washington, DC: U. S. Government Printing Office.

AUTHOR: Poma, P. A. (1983).
TITLE: Hispanic cultural influences on medical practice.
SOURCE: The Journal of the American Medical Association, 75 (10), 941-946.

AUTHOR: Roberts, R. E. & Lee, E. S. (1980).
TITLE: The health of Mexican Americans: Evidence from the human population of laboratory studies.
SOURCE: American Journal of Public Health, 70(4), 375-384.

AUTHOR: Rodriquez, J. (1983).
TITLE: Mexican Americans: Factors influencing health practices.
SOURCE: The Journal of School Health, February, 136-139.

AUTHOR: Rodriquez, S. S., & R. M. Rodriquez (Eds). (1982)
TITLE: The new federalism: Impact on Hispanic health care. Public health policy issues.
SOURCE: Rockville, MD: U. S. Department of Health and Human Services. Public Health Service. (Hispanic Employees Organization).

AUTHOR: Sahadi, J. A. (1980).
TITLE: Pseudoexfoliation syndrome encountered in South Texas.
SOURCE: Ophthalmic Surgery, 11(2), 112-114.

AUTHOR: Sanchez, A. L. (1983).
TITLE: Salud popular: An ethnographic study of the lay health beliefs and health seeking behaviors of Hispanic elderly.
SOURCE: Ann Arbor, MI: University Microfilms International No.8319453.

AUTHOR: Schmidt, A. (1982).
TITLE: Grandparent - grandchild interaction in a Mexican American group (Occasional Paper No. 16).
SOURCE: University of California, Los Angeles. Spanish Speaking Mental Health Research Center.

AUTHOR: Signell, K. A.(1983).
TITLE: Starting prevention work.
SOURCE: Community Mental Health Journal, 19(2), Summer, 144-162.

AUTHOR: Staff. (1984).
TITLE: Border epidemiological bulletin.
SOURCE: Available from the U.S.-Mexico Border Health Association, 6006 N. Mesa, Suite 700, El Paso, TX 79912.

AUTHOR: Staff (1983/Summer).
TITLE: HHANES comes to Los Angeles.
SOURCE: University of California, Los Angeles, Spanish Speaking Mental Health Research Center. Research Bulletin.

AUTHOR: Staff (1984).
TITLE: Hispanic mental health bibliography. Folk medicine/ curanderismo/espiritismo.
SOURCE: Unniversity of Calilfornia, Los Angeles. Spanish Speaking Mental Health Research Center.

AUTHOR: Staff (1984, November).

TITLE: Latino health study.
SOURCE: Nuestro. p.12.

AUTHOR: Sullivan, T. A., Gillespie, F. P., Hout, M. & Rogers, R. G. (1984).
TITLE: Alternative estimates of Mexican American mortality in Texas, 1980.
SOURCE: Social Science Quarterly, pp.609-617.

AUTHOR: Torres-Gil, F. (1979).
TITLE: Health issues in the Chicano community: Some preliminary findings on older Chicanos and decisionmakers' perceptions of health problems.
SOURCE: University of Southern California, Los Angeles. Andrus Gerontology Center.

AUTHOR: Trevino, F. M. & Moss, A. J. (1984).
TITLE: Health indicators for Hispanic, Black, and White Americans (DHHS Publication No. PHS 84-1576).
SOURCE: Washington, DC: U.S. Government Printing Office.

AUTHOR: Trevino, F. M. (1982).
TITLE: Vital and health statistics for the U.S. Hispanic population.
SOURCE: American Journal of Public Health, 72(Sept), 979-981.

AUTHOR: Trotter II, R. T. (1981).
TITLE: Folk remedies as indicators of common illnesses: Examples from the United States Mexico border.
SOURCE: Journal of Ethnopharmacology, 4, 207-221.

AUTHOR: Unterman, R. D. W. (1983).
TITLE: Folk health beliefs, health/illness needs and concerns, and personal health behavior of the Hispanic adolescent.
SOURCE: Ann Arbor, MI: University Microfilms International No. 132112.

AUTHOR: Vivo, P (Ed.). (1980).
TITLE: La familia Hispana: The United States health perspective.
SOURCE: Rockville, MD: U. S. Department of Health and Human Services, Public Health Service, (Spanish Heritage Public Health Service Workers).

AUTHOR: Vivo, P. & C. D.Votaw (Eds.). (1981).
TITLE: The Hispanic elderly: La fuente de nuestra historia, cultura y carino.
SOURCE: Rockville MD: U. S. Department of Health and Human Services, Public Health Service, (Spanish Heritage Public Health Service Workers).

AUTHOR: Vivo, P. (Ed.). (1978).

TITLE: Hispanic Mosaic: A Public Health Service perspective.
SOURCE: Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, (Spanish Heritage Public Health Service Workers).

AUTHOR: Vivo, P. (Ed.). (1979).
TITLE: International year of the child: The United States Hispanic health perspective.
SOURCE: Rockville, MD: U.S. Department of Health Education and Welfare, Public Health Service, (Spanish Heritage Public Health Service Workers).

AUTHOR: Wallace, H. M., & Polhemus, D. (Eds.). (1981).
TITLE: Proceedings in the BiRegional conference on health status and health care of mothers and children.
SOURCE: San Diego State University. Graduate School of Public Health.

AUTHOR: Watts, M. S. M. (Ed.). (1983).
TITLE: Cross-cultural medicine.
SOURCE: The Western Journal of Medicine, 139(6).

AUTHOR: Zaldivar, C. A., Nichols, A. W., Gonzales, H. P., & Kelly, J. B. (1985).
TITLE: Border health.
SOURCE: Available from United States- Mexico Border Health Association, 6006 N. Mesa, Suite 700, El Paso, Texas 79912.

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Henrietta Villaescusa
Project Director

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Inventory of DHHS Program Efforts in Minority Health

INVENTORY OF DHHS PROGRAM EFFORTS IN MINORITY HEALTH

The inventory of program efforts in minority health was compiled in response to the Secretary's charge to review existing department research and services programs and activities which focus or have impact on minority health. It provides a comprehensive description of all programs, current or planned, within the Department of Health and Human Services that relate specifically to minority populations. The information was used by the Task Force in their recommendation development process to ensure that the suggested activities would provide new directions to already existing Departmental initiatives. The inventory also will be informative to organizations and individuals actively involved with minority health issues.

Program information was obtained from 11 agencies or departmental components:

- Alcohol, Drug Abuse, and Mental Health Administration
- Centers for Disease Control
- Food and Drug Administration
- Health Care Financing Administration
- Health Resources and Services Administration
- National Institutes of Health
- Office of the Assistant Secretary for Health
- Office for Civil Rights
- Office of the Secretary
- Office of Human Development Services
- Social Security Administration

The program descriptions were based on data maintained in each agency's data management system; they varied greatly in the amount of detail provided. Although the inventory originally was intended to identify programs that focused specifically on minority populations, it was found that many programs benefited all popualtions including minorities. In some instances, it was possible to identify the extent of activities targeted to minorities, for others, it was difficult to separate minority-specific components from the overall program. It is important to note that this compilation of DHHS programs and projects represents the first attempt by DHHS to group departmental activities in the area of minority health and should be viewed as a starting point for future data gathering and analysis.

Questionnaire Development

A four-page questionnaire was developed requesting program-level officers to indicate whether their programs addressed the following areas: cancer; cardiovascular and cerebrovascular disease; diabetes; arthritis and other musculoskeletal disorders; nutrition; diseases and disorders of the eye; infectious diseases; digestive disorders; genetic

disorders; infant mortality and maternal health; homicide, suicide, and unintentional injuries; chemical dependency and related diseases; mental health and illness; occupational health; respiratory diseases; dental health; kidney disorders; or some other disorder.

Another series of questions requested descriptions of programs and how each program addressed minority health issues. The major classes of activity were: health service delivery, research and data collection, health professions development, and health education/ information dissemination. Overall, the questionnaire attempted to gauge the extent of existing DHHS programs that addressed minority health concerns.

Data Collection

Inventory questionnaires were distributed to the 4 major components of DHHS: the Assistant Secretary for Health, the Assistant Secretary for Human Development Services, the Administrator of the Health Care Financing Administration, and the Commissioner of the Social Security Administration, who in turn distributed them to their respective operating divisions. Instructions were provided that explained the purpose of the survey and the required information. Meetings were held with liaison persons from each agency to explain the nature of the Task Force and answer questions. More than 195 responses were returned by the agencies.

Data Reporting

The program descriptions reflect the broad diversity of the programs administered by DHHS. Although some submissions focus on broad research issues which, by their very nature, included minority health issues, others focus on model demonstration programs that target specific minority groups. To preserve the richness of the descriptions, no attempt was made to combine the material into broader classifications.

Index of DHHS Programs

The index lists the agencies or institutional components that have ongoing or planned minority-related initiatives. More complete program descriptions follow and are organized according to sponsoring agency or other departmental component. The office/program title and phone number are included so future users may readily obtain additional information.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: DIVISION OF BIOMETRY AND EPIDEMIOLOGY (DBE)/NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA)

TELEPHONE: 301-443-4897

DESCRIPTION:

Major studies include:

- A cross-sectional survey of approximately 1,000 Black and non-Black youth 16 to 26 years of age in Baton Rouge, Louisiana. The purpose of the study is to investigate the nature, antecedents, and short-term consequences of drinking in this population. Information to be obtained includes drinking history and patterns of access to alcohol and other illicit drugs, the extent of polydrug use, demographic characteristics, social networks and social activity level.

- A longitudinal study of approximately 13,000 young adults, initiated in 1979. The design called for a cross-sectional sample of youth 14 to 21 years of age in 1979, with supplemental samples of Blacks, Hispanics, and economically disadvantaged non-Black, non-Hispanic youth. The purpose of the longitudinal study is to assess changes in the prevalence of drinking and alcohol abuse over time and to relate alcohol use to employment status including aspects of work which precipitate heavy drinking, unemployment, and whether women experiencing dual role stress (employee/homemaker) are at higher risk for alcohol abuse. Preliminary findings of the 1982 data reveal higher levels of alcohol abstinence among both minority groups (Black and Hispanic) and a later onset of drinking among Blacks compared to Hispanics and other non-Black youth.

- A cross-sectional survey of approximately 1,000 Americans of Japanese ancestry living in Hawaii and in California. The survey will be coordinated with studies of the Japanese population residing in four communities in Japan. The primary purpose of this collaborative epidemiological research effort by the U.S. and Japan is to conduct descriptive baseline studies of cross-cultural differences in alcohol consumption and drinking patterns, alcohol-related problems (including intoxication), and the perceived need for improved societal responses to reduce or ameliorate these problems.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: BLACK AND HISPANIC ALCOHOL PROBLEMS: A NATIONAL STUDY/NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA)

TELEPHONE: 301-443-1273

DESCRIPTION:

NIAAA is conducting a nationwide survey of Black and Hispanic drinking attitudes and patterns, alcohol-related problems, and community experiences with problem drinking. Interviews are completed with 1,500 black and 1,500 Hispanic respondents in a probability design representative of the adult Black and Hispanic populations of the 48 coterminous States. The study is coordinated with a nationwide survey of the general U.S. population that is being conducted under an Alcohol Research Center Grant. The study provides a comprehensive description of the distributions and interrelations of rates of heavy drinking and alcohol-related problems. Special attention is paid to subgroups of the two populations under study: Blacks, Puerto Ricans, Cuban Americans, Mexican-Americans living on the West Coast, and Mexican-Americans living in the Southwest. Also, a comparative analysis of patterns among Blacks, Hispanics, and Whites (especially those living in circumstances similar to the minority subject) is conducted. Finally, explanatory analysis of patterns of variation within each of the two ethnic populations is done. A variety of explanatory factors derived from the literature are measured and analyzed to test for their potential power in explaining cultural specificities in Black and Hispanic drinking practices and problems.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: NATIONAL DRUG ABUSE MEDIA CAMPAIGN/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-1124

DESCRIPTION:

A significant number of ethnic minority constituencies were not reached through the 1983-85 campaign. In order to be more responsive to these audiences, NIDA will develop strategies to expand its multicultural initiatives and encourage support from these groups.

- The campaign will be expanded from the original target audiences, young people ages 12-14 and their parents, to include minority inner-city youngsters ages 10-14 years and their parents. To accomplish this transit ads with anti-drug messages will be developed and placed in subway stations; radio public service announcements with Black and Hispanic narrators, and a television public service announcement designed to reach minority parents is being developed and will be distributed to broadcasters throughout the country.

- Production of the music video as part of the campaign, with an urban setting aimed at young people to increase audience contact.

- Placement of a music video as part of the campaign, with an urban setting aimed at young people to increase audience contact.

- Placement of announcements and articles in ethnic minority newspapers and magazines.

- Drug abuse flyers developed for the initial phase of the campaign are being translated into Spanish for Hispanic groups and other consumers.

- The NIDA exhibit will be presented at ethnic minority meetings and national conferences to reinforce the messages and increase ethnic minority public awareness of the health consequences of drug abuse.

- Conduct a pretesting service to evaluate print materials, audio visuals, and mass media messages before final production for minority audiences.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: ETHNIC COMMUNITY INITIATIVE/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)/DIVISION OF PREVENTION AND COMMUNICATIONS

TELEPHONE: 301-443-6720

DESCRIPTION:

NIDA's Division of Prevention and Communications (DPC) Technology Transfer Branch (TTB), sponsors a series of community initiative workshops to identify and assemble a wide range of representatives from the American Indian, Black, Hispanic, and Asian American population and provide a forum in which they may begin to address substance abuse problems in their respective communities.

As part of NIDA's initiative to encourage minority groups to incorporate alcohol and drug abuse problems onto their national agendas and to begin to address prevention strategies the Institute initiated two meetings in Washington, D.C., for Blacks and Hispanics respectively.

These groups established themselves as the Black Advisory Committee on Drug and Alcohol Abuse and Policy and the National Hispanic Coalition on Drug and Alcohol Abuse Prevention.

The American Indian communities have also received extensive assistance from the Institute. Staff attended the annual American Indian Substance Abuse School in Spokane, Washington, presented workshops and held discussions with leaders of the American Indian communities regarding the development of prevention programs in their communities. Also, a special series of workshops ("Community Initiatives") will be scheduled for the 1985 American Indian Substance Abuse School. The workshops will have as their theme the establishment of community initiatives for prevention of drug abuse and drug use among American Indian youth.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: NIDA STARTER AWARD/OFFICE OF POLICY DEVELOPMENT AND IMPLEMENTATION (OPDI)/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-6460

DESCRIPTION:

The purpose of this program is to recruit minority investigators and facilitate their entry into the drug abuse field.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: MINORITY ACCESS TO RESEARCH CAREERS (MARC)/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-6720

DESCRIPTION:

This program has three goals (1) to increase minority IPA staff, (2) to provide greater exposure and promotion of the MBRS program and (3) to develop postgraduate training of MARC graduates in an effort to bring more competitive minority investigators into drug abuse research.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: PREVENTION OF DRUG ABUSE AMONG MINORITY POPULATIONS/DIVISION OF CLINICAL RESEARCH (DCR)/PREVENTION RESEARCH BRANCH (PRB)/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-1514

DESCRIPTION:

These efforts have focused on a minority workshop and a series of monographs on minorities and prevention.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: TREATMENT OF DRUG ABUSE AMONG MINORITY POPULATIONS/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-4060

DESCRIPTION:

The Treatment Research Branch develops and directs a nationwide program of drug abuse treatment research activities to evaluate and test current and innovative techniques for delivering drug abuse treatment services and to establish national treatment guidelines in areas in which guidelines are absent and/or treatment techniques unsuccessful. The following activities are of particular interest:

- An inner-city research/clinical group is part of a grant to provide outreach, early treatment intervention and to evaluate the effectiveness of their early intervention program with Black adolescent heroin users.

- Together with the prevention branch, TRB is involved in a program that will train a cadre of Native American drug abuse counselors who will initiate a program of early intervention and the development of coping skills for Native American youth. This program is one that has the potential of being self-perpetuating after government funding ends.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: ETHNIC MINORITY FAMILY MOBILIZATION PROJECT/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-2450

DESCRIPTION:

The Ethnic Minority Family Mobilization Project was implemented in October 1984 in response to drug abuse problems confronting ethnic minority communities. Drug abuse prevention programs in ethnic minority communities have historically focused on the individual affected or potentially affected by drug use. There is a growing recognition within the prevention field that parents and families should be involved in the development and implementation of programs and approaches to prevent drug use among youth. The involvement of parents in developing strategies for combatting drug use in middle-class white communities has proven to be effective. However, ethnic minority parents have not been organized to the same degree. This initiative has been designed to stimulate the involvement of minority families in the prevention of drug use among youth.

The Institute, through its Ethnic Minority Family Mobilization Project, will, over the next 2-1/2 years, promote the replication of successful ethnic minority grassroot parent group pilot projects in 10 cities across the country. Technical assistance may be provided to other communities in an effort to expand the number of ethnic minority groups involved in the prevention of drug abuse among minority youth.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: ESTIMATING MENTAL HEALTH NEED/NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

TELEPHONE: 301-443-2974

DESCRIPTION:

The substance abuse supplement to this mental health grant will permit the comparison of survey-based estimates of drug use in a community with estimates based on less costly social indicators such as vital statistics and local data from schools, communities, and public agencies. The drug supplement also provides for the addition to the study of 2 Hispanic and 2 Black population areas. In the total sample, the social indicator estimates will be compared with the direct surveys in 44 areas in Colorado.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: PREVENTION/OFFICE OF PREVENTION/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-6130

DESCRIPTION:

This program:

- Designs national goals and establishes national priorities for the prevention of mental illness and the promotion of mental health; encourages local entities and State agencies to achieve these goals and priorities; and develops and coordinates Federal prevention policies and programs and assuring increased focus on the prevention of mental illness and the promotion of mental health.

- Stimulates, develops, supports, coordinates, and monitors a variety of activities, including developing and convening planning workshops, commissioning key technical and advisory reports, preparing and disseminating relevant prevention information, initiating and facilitating policy studies, and arranging for expert consultations.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CENTER FOR STUDIES OF THE MENTAL HEALTH OF THE AGING/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: Karen Urbany, 11C-03 Parklawn, 443-1185

DESCRIPTION:

This program includes:

- Research support programs to increase knowledge and improve research methods on mental and behavioral disorders; to generate information regarding basic biological and behavioral processes underlying these disorders and the maintenance of mental health; and to improve mental health services.

- Research training provides support for the training of research scientists in the area of mental health and aging.

- Clinical/services training which is designed to improve mental health and related services to the aging within both the established mental health service delivery system and the mental health-related support systems.

- Career development.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CENTER FOR STUDIES OF MINORITY GROUP MENTAL HEALTH/DIVISION OF PREVENTION AND SPECIAL MENTAL HEALTH PROGRAMS (DPSMHP)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-2988

DESCRIPTION:

The Center for Studies of Minority Group Mental Health serves as the focal point, stimulator, and coordinator for the National Insitute of Mental Health (NIMH) research, clinical manpower development and training, and technical assistance activities which directly impact and improve the mental health of minority groups (i.e., American Indians, Alaskan Native, Asian American, Pacific Islanders, Blacks and Hispanics), individually and organizationally. Some specific projects are:

- Factors in Adolescent Suicide - The purpose of this research is to investigate the social and cultural factors contributing to a sharp increase in the rate of suicide among adolescent males over the last 20 years in Micronesia. The suicide rate among adolescent males (15-24 years) has reached proportions surpassing the reported rates for the same cohort among other national population or cultural groups.

- Folktales as Therapy with Hispanic Children - "Tell-me-a-story" (TEMAS I) is a culturally sensitive therapy modality which incorporates: 1) the Puerto Rican heritage as manifested in the folktales; 2) the mother as a sacred figure in the Puerto Rican family; and 3) adaptive ego functions as reflected in the dominant U.S. culture. The present study explores whether TEMAS I is an effective treatment modality and whether Puerto Rican mothers are effective therapeutic agents as compared with professional therapists.

- Black Family Mental Health and Teenage Pregnancy - This project examines: 1) issues of sexuality and childbirth in the Black teenager; 2) the coping strategies and response styles associated with teenage pregnancy in Black families; 3) isolate the variables associated with family mental health support systems; and 4) given the cultural meaning of teenage pregnancy, specify what measurable effects adolescent pregnancy has on the teenager, the offspring, and the teenager's family.

- Health and Behavior: Research Agenda for Amerinds - The purpose of this conference is to generate a research agenda specific to American Indians and Alaskan Natives, a population in which these issues and directions assume special importance for intervention as well as prevention.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CENTER FOR STUDIES OF ANTISOCIAL AND VIOLENT BEHAVIOR//NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-3728

DESCRIPTION:

The NIMH Center for Studies of Antisocial and Violent Behavior, in cooperation with the NIMH Center for Studies of Minority Group Mental Health, has provided funds to the Centers for Disease Control for the establishment of new data bases on homicide deaths among young Black males and Hispanics.

- A national data file for the period 1970-1982 has been established on homicide deaths among Black males aged 15 to 24.

- A data file on homicide deaths among Hispanics in five southwestern States has been established for the years 1975-1982.

The NIMH Center for Studies of Antisocial and Violent Behavior implemented an interagency agreement with Brookhaven National Laboratory for development of the first reliable population-based estimates on risks for homicide cases among Black males and females who come to hospital emergency departments as victims of nonfatal assaults.

The NIMH Center for Studies of Antisocial and Violent Behavior awarded a contract to Dr. Fred Loya of the University of California at Los Angeles for analysis of factors associated with a major rise in Hispanic male homicide deaths in Los Angeles during the period 1970-1979.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CENTER FOR PREVENTION RESEARCH/DIVISION OF PREVENTION AND SPECIAL MENTAL HEALTH PROGRAMS (DPSMHP)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-4283

DESCRIPTION:

The Center for Prevention Research (CPR) is the focal point for activities related to research and training on the early preventive intervention of mental disorders and behavioral dysfunctions. CPR is interested in all aspects of preventive intervention research and therefore provides support for research efforts involving preventive intervention strategies which avoid and/or interrupt the development of mental disorders of behavioral dysfunctions and improve individual adaptive capabilities. CPR's goal is to contribute to the development of a solid empirical base for conceptualizing, implementing, and evaluating preventive interventions. CPR will make funds available for the support of prevention research in the following areas:

- Development, testing, and evaluation of preventive interventions (to include research characteristics, priority areas, etc.).
- Risk-assessment studies.
- Methodological advances.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CENTER FOR MENTAL HEALTH STUDIES OF EMERGENCIES/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-1910

DESCRIPTION:

The Center for Mental Health Studies of Emergencies (CMHSE), has four different programs: research on rape; research on emergencies; crisis counseling; and emergency preparedness.

The Hispanic Social Network Prevention Intervention Study is designed to address a number of issues provoked by the July 18, 1984, violence which occurred in one prospective research site, San Ysidro, California. The principal investigator will:

- Conduct an extensive screening in San Ysidro of virtually all women in the age rank 35 to 49 using the instrumentation from the parent project and, in addition, a Post Traumatic Stress measure.

- Cooperate with and provide technical assistance to the local human services providers in order to develop a community wide intervention-planning process.

- Carry out the procedures identified in the parent proposal for second level screening and grouping in order to derive a cohort suitable for preventive intervention using merience educativa modality.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CENTER FOR EPIDEMIOLOGIC STUDIES/DIVISION OF BIOMETRY/CENTER FOR EPIDEMIOLOGIC STUDIES/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-3774

DESCRIPTION:

This division serves as the focal point and coordinates Institute activities in mental health epidemiology and related demographic research. The division conducts and supports research in the following areas:

- Mental health epidemiology and related demographic research;
- Risk factors distribution, the national history of mental disorders in populations, and the related need for mental health services;
- Longitudinal and cross-sectional surveys to assess the distribution, determinants, and strategies for lessening risk factors for specific mental disorders;
- The development of instruments and methodologies to find and to identify individuals with mental disorders or at risk of developing such disorders; and,
- The demographic and ecological aspects of mental disorders and the need and demand for mental health services.

Additionally, it provides support for programs of research training in epidemiology and biostatistics.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: MENTAL HEALTH CLINICAL RESEARCH CENTERS/DIVISION OF CLINICAL RESEARCH/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-3563

DESCRIPTION:

The Mental Health Clinical Research Centers program was developed to provide a stimulating and productive research environment, in a clinical or community treatment setting, in which biological, behavioral, and/or sociocultural scientists and clinicians can interact and study problems of classification, etiology, mechanisms, psychosocial and/or psychopharmacologic treatment, and prevention of severe mental disorders. MHCRC's are funded at either developmental or full-scale levels, and provide core support to bring together basic and clinical researchers focusing on selected problem areas.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: RESEARCH SCIENTIST DEVELOPMENT/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-4347

DESCRIPTION:

Major projects include:

Mexican-American Health and Social Factors and Disease. This project will (1) investigate the role of psychosocial risk factors in nonclinical depression; (2) begin analyses of data on the mental health (depression, alcoholism, drug abuse) of Mexican Americans collected as part of the Hispanic Health and Nutrition Examination Survey by the National Center for Health Statistics; and, (3) begin collection of data on the reliability and validity of psychiatric diagnoses made with the Diagnostic Interview Schedule when used with Anglos and with Hispanics with varying degrees of acculturation into mainstream American life and with varying degrees of ability to speak English and Spanish who are psychiatric inpatients at San Antonio State Hospital.

Factors Affecting the Mental Health of Afro-American Women. In this study a quote sample of 100 Afro-American women from 18 to 35 years of age who are characteristic of Afro-American women residing in Los Angeles County by age, level of education, marital status and the presence of children will be interviewed at their choice of locations. A comparison group of white American women, matched on the above criteria will also be interviewed. Survey research techniques are utilized in a socioculturally sensitive model of sex research. This model was developed with Afro-American women and identifies aspects of their socialization to sexuality and mental health that are culturally specific. It may also have utility in research with women ranging in age and ethnic group affiliations.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: NIMH MINORITY BIOMEDICAL RESEARCH SUPPORT/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-4337

DESCRIPTION:

The NIMH Minority Biomedical Research Support Program of the Division of Extramural Research programs and the ADAMHA Minority Access to Research Careers (MARC) Program of the Division of Human Resources plan to jointly convene a Historically Black Colleges and Universities workshop in an effort to increase the number and quality of research and research training applications submitted to the Institute and to increase the number of fundable applications submitted to NIMH.

Some projects include:

- Biofeedback control as a function of subject and task variables.
- The emergence of semantic categories in the language of black children.
- Detection versus control of stress-related physiological variables.
- Internal and external aspects of obesity.
- Physiological and subjective reactions to stressful imagery.
- Aging and motivation: Biobehavioral and psychopharmacology studies.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CLINICAL RESEARCH BRANCH/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-4524

DESCRIPTION:

The purpose of this program is to increase knowledge regarding the bases and clinical aspects of mental and emotional disorders as well as the interactive relationships of these disorders with general health status. NIMH provides support in the following areas:

- Basic and clinical research on the nature and description, diagnosis and classification, etiology, course, prognosis, and followup of mental disorders, and the development and improvement of theories, methods, and technologies for such investigations.

- Studies of clinical and subclinical populations, populations at high risk for clinical disorders, ethnic or cultural groups, and other normal populations where the aim is to collect either control or baseline data on clinical variables directly relevant to a better understanding of clinical processes or etiological mechanisms; human or animal studies using experimentally induced states (e.g., stress-induced states, models or experimentally induced psychopathologic states); cross-cultural or cross-ethnic research in psychopathology; and studies of family and cultural factors in the etiology, expression, diagnosis, and outcome of mental disorders.

- Studies at the interface of biomedical and behavioral research as they pertain to physical disorders where the major focus of the research is on the prevention of mental disorders or on techniques to measure coping behaviors and cognitive, emotional, motivational, or other psychosocial correlates in relation to health status.

An example of a specific project is The Course of Schizophrenia Among Mexican Americans. This project examines the influence of family and social factors on the outcome of schizophrenic illness among British patients, using a Southern California population of Mexican American patients; the relationship between the level of a key relative's expressed emotion (EE) and a patient's relapse in regard to other social/familial factors; and explores the role of communication deviance and relationship with (EE) in the household and relapse.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: SMALL GRANT PROGRAM/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-4337

DESCRIPTION:

This program provides relatively rapid financial support which is principally intended for newer, less experienced investigators, those at small colleges, and others who do not have regular research grant support or resources available from their institutions. Small grants may be used to carry out exploratory or pilot studies, to develop and test a new technique or method, or to analyze data previously collected. The direct cost limit for the Small Grant Program applications is $15,000 and the support is limited to a 1-year period and is not renewable.

This program invites applications for research grants which cover the entire range of scientific areas relevant to mental health, or to drug or alcohol abuse. While proposals may involve a wide variety of biomedical, behavioral and related disciplines, relevance to the missions of the ADAMHA Institutes must be present.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: PSYCHOSOCIAL TREATMENTS RESEARCH/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-4527

DESCRIPTION:

The Psychosocial Treatments Branch is authorized to plan, initiate, and support, by means of grants, cooperative agreements, and contracts, such research as may advance knowledge permitting the more effective treatment of the full range of mental disorders suffered by children, adolescents, and adults. For example, there is an ongoing study to investigate the relative impact of Individual Psychodynamic Child Therapy (IPCT), Structural Family Therapy (SFT), and a Naturalistic Control Condition (NCC) on elementary school age Cuban children and their families. The differential impact of these therapeutic strategies will be assessed for 67 Cuban children who present problems in the categories of conduct disorders and anxiety-dependency problems.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM (CASSP)/OFFICE OF STATE AND COMMUNITY LIAISON (OSCL)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: Judith Katz-Leavy, 11C-17 Parklawn, 301-443-3604

DESCRIPTION:

To insure the availability of a comprehensive, coordinated system of care for mentally disturbed children and youth in communities by assisting States in assuming a leadership role and by improving State level planning and technical assistance capacities to meet the service needs of severely disturbed children and adolescents on a statewide basis. This statewide service system improvement approach has the potential for a broad, nationwide impact on systems of care for mentally disturbed children and youth.

The CASSP has implemented a major technical assistance, training, and knowledge exchange program through two interagency agreements. These agreements will be used to provide onsite technical assistance to both funded CASSP and unfunded States; to support training and dissemination activities focusing on the needs of seriously emotionally disturbed children; to conduct research in areas important to the development of the CASSP concept; and to conduct short-term studies related to service system improvement for this population.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: COMMUNITY SUPPORT PROGRAM/COMMUNITY SUPPORT AND REHABILITATION BRANCH (CSRB)/OFFICE OF STATE AND COMMUNITY LIAISON (OSCL)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-3653

DESCRIPTION:

Initiated in 1977, the NIMH Community Support Program (CSP) works with States and localities to improve opportunities and services for adults with chronic mental illness. CSP focuses specifically on those adults who are inappropriately institutionalized in hospitals or nursing homes, and the larger number of such individuals who are living outside of hospitals without adequate housing or life support services--estimated at 1.7 to 2.4 million persons.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: NATIONAL RESEARCH SERVICE AWARD/DIVISION OF HUMAN RESOURCES (DHR)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-3855

DESCRIPTION:

This program is intended to assist institutions with substantial minority enrollment in the training of greater numbers of scientists and teachers in fields relating to alcoholism, drug abuse, and mental health. The primary objectives are:

- Increase the number of well-prepared students from institutions with substantial minority enrollment who can compete successfully for entry into Ph.D. degree programs in disciplines related to alcoholism, drug abuse, and mental health, and

- Help develop and strengthen biobehavioral, psychological, social, and/or public health sciences curricula and research training opportunities in institutions with substantial minority enrollment in order to prepare students for research careers related to alcoholism, drug abuse, and mental health.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: MENTAL HEALTH CLINICAL TRAINING/DIVISION OF HUMAN RESOURCES (DHR)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-5850

DESCRIPTION:

Workshop on Minority Mental Health Educational processes - This workshop, comprised of minority mental health education experts from the four core mental health disciplines, was designed for the purpose of focusing attention on minority mental health training activities in the mental health professions and eliciting recommendations for the continued refinement and enhancement of mental health education for minorities. Nine minority mental health educators presented papers reflecting their perceptions of what has been accomplished to date, the continued need for minority mental health education, and ideas for future programming directions. The workshop has resulted in a substantial internal Division of Human Resources "publication," which will be distributed appropriately for the purpose of advancing minority mental health education in the several disciplines.

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PROGRAM: NATIONAL REPORTING PROGRAM/SURVEY AND REPORTS BRANCH (SRB)/NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

TELEPHONE: 301-443-3343

DESCRIPTION:

The Survey and Reports Branch is organized into three interrelated research programs: the Inventory Research Program, the Sample Survey Research Program, and the Developmental and Special Populations Research Program. The Inventory and Sample Survey Research Programs conduct the organizational inventories and patient/client surveys that comprise the National Reporting Program for Mental Health Statistics. The Developmental and Special Populations Research Program engages in research to develop methodologies and extend the scope of coverage for the inventories and surveys. In addition, this program serves as a focal point within NIMH for research on the chronically mentally ill and the homeless mentally ill through a range of intramural and extramural activities. Items of interest are:

- The 1985 Combined Inventory of Mental Health Organizations - This inventory of General Hospital Mental Health Services will collect enumeration data on minorities served in all mental health organizations in the United States.

- The 1985 Patient Sample Survey of Inpatient, Outpatient, and Partial Care Organizations will collect detailed patient data on minorities admitted, under care, or terminated from mental health organizations.

- The 1985 Inventory of State Prison Mental Health Services will enumerate minorities receiving mental health services in these settings.

CENTERS FOR DISEASE CONTROL

PROGRAM: INVESTIGATIONS AND TECHNICAL ASSISTANCE

TELEPHONE: 404-329-3243

DESCRIPTION:

The objectives of this program are:

- To assist State and local health authorities and other health related organizations in controlling communicable diseases, chronic diseases and other preventable health conditions. Investigations and evaluation of all methods of controlling or preventing disease are carried out by providing epidemic aid, surveillance, technical assistance, consultation, and by providing leadership and coordination of joint national, State, and local efforts.

- To strengthen State and local disease prevention and control programs, such as tuberculosis, childhood immunization, and venereal disease.

Services are provided in the following areas: epidemic aid; technical assistance (field studies and investigations of ongoing disease problems; occupational safety and health); consultation; dissemination of technical information; provisions of specialized services and assistance, including responses to public health emergencies such as Love Canal and Mount St. Helens. Additionally, there is training of State and local health professionals in broad areas of epidemiology, at State's request, in such specific areas as hospital infections, rabies, hepatitis, and venereal disease.

CENTERS FOR DISEASE CONTROL

PROGRAM: INJURY PREVENTION (IP)

TELEPHONE: 404-329-3243

DESCRIPTION:

This project will assist in the development of a national injury surveillance system and a comprehensive injury prevention demonstration program for selected Indian reservations.

CENTERS FOR DISEASE CONTROL

PROGRAM: CHILDHOOD IMMUNIZATION GRANTS (CIG)

TELEPHONE: 404-329-3243

DESCRIPTION:

These grants assist States and communities in establishing and maintaining immunization programs for the control of vaccine preventable disease of childhood (including measles, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and mumps).

Projects grants are awarded to any State, and in consultation with State health authorities, political subdivisions of States and other public entities. Private individuals and private nonprofit agencies are not eligible for immunization grants.

CENTERS FOR DISEASE CONTROL

PROGRAM: OCCUPATIONAL SAFETY AND HEALTH - RESEARCH GRANTS (OSH)

TELEPHONE: 404-329-3243

DESCRIPTION:

These grants are intended to further the understanding of the underlying characteristics of occupational safety and health problems in the general industry and in the mining industry and for effective solutions in dealing with them; to eliminate or control factors in the work environment which are harmful to the health and/or safety of workers; and, to demonstrate technical feasibility or application of a new or improved occupational safety and health procedure, method, technique, or system.

Project grants are awarded to individual State or local governments, public and state colleges or universities, private, junior and community colleges and public or private agencies or institutions capable of conducting research in the field of occupational safety or health.

CENTERS FOR DISEASE CONTROL

PROGRAM: OCCUPATIONAL SAFETY AND HEALTH - TRAINING GRANTS (OSH)

TELEPHONE: 404-329-3243

DESCRIPTION:

These funds are intended to develop specialized professional personnel in occupational safety and health problems with training in occupational medicine, occupational health nursing, industrial hygiene, and occupational safety.

CENTERS FOR DISEASE CONTROL

PROGRAM: HEALTH PROGRAMS FOR REFUGEES (HPR)

TELEPHONE: 404-329-3243

DESCRIPTION:

This program assists States and localities in providing health assessments to newly arrived refugees and in addressing refugee health problems of public health concern.

Projects grants are awarded to official State health agencies and, in consultation with the State Health agency, health agencies of political subdivisions of a State.

CENTERS FOR DISEASE CONTROL

PROGRAM: VENEREAL DISEASE CONTROL GRANTS (VDC)

TELEPHONE: 404-329-3243

DESCRIPTION:

The purpose of these grants is to reduce morbidity and mortality by preventing cases and complications of these diseases. Project grants under Section 318c are awarded to State and local health departments. These grants emphasize the develoment and implementation of nationally uniform control programs which focus on disease intervention activities designed to reduce the incidence of these diseases, with education activities supporting these basic program activities authorized under 318b.

Projects grants are awarded to any State and, in consultation with the appropriate State Health authority, any political subdivision of a State.

CENTERS FOR DISEASE CONTROL

PROGRAM: VENEREAL DISEASE RESEARCH, DEMONSTRATION, AND PUBLIC INFORMATION AND EDUCATION GRANTS

TELEPHONE: 404-329-3243

DESCRIPTION:

These grants are used to develop, improve, apply, and evaluate mthods for the prevention and control of syphilis, gonorrhea, and other sexually transmitted diseases (STD) through demonstration and applied research; to develop, improve, apply, and evaluate methods and strategies for public information and education about syphilis, gonorrhea, and other STD; and to support particularly deserving public information and education programs which cannot be supported through other grant programs.

Projects grants are awarded to any State, political subdivisions of States, and any other public or private nonprofit institutions.

CENTERS FOR DISEASE CONTROL

PROGRAM: PROJECT GRANTS AND COOPERATIVE AGREEMENTS FOR TUBERCULOSIS CONTROL PROGRAMS

TELEPHONE: 404-329-3243

DESCRIPTION:

This program assists State and local health agencies in carrying out tuberculosis control activities designed to prevent transmission of infection and disease. The goal is to ensure an average annual reduction of reported tuberculosis cases of at least 5 percent.

Projects grants, under Section 317 of the Public Health Service Act, are awarded to official public health agencies of State and local governments, including the District of Columbia, and Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Trust Territory of the Pacific Islands, the Northern Mariana Islands, and American Samoa. Private individuals or profit and private nonprofit agencies are not eligible for these grants.

CENTERS FOR DISEASE CONTROL

PROGRAM: COOPERATIVE AGREEMENTS FOR STATE-BASED DIABETES CONTROL PROGRAMS, DIABETES CONTROL (DC)

TELEPHONE: 404-329-3243

DESCRIPTION:

The purpose of this program is to improve the quality of life and effectiveness of health services for diabetics.

Projects grants are awarded to eligible applicants of official State health agencies of the U.S., the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Trust Territory of the Pacific Islands, the Northern Mariana Islands, and American Samoa.

CENTERS FOR DISEASE CONTROL

PROGRAM: VIOLENCE EPIDEMIOLOGY BRANCH/CENTER FOR HEALTH PROMOTION AND EDUCATION (CHPE)

TELEPHONE: 404-329-3521

DESCRIPTION:

Major projects include:

Information and Education - Suicide. CDC has prepared a Suicide Surveillance Report which presents and analyzes information on national trends in suicide for the years 1970-80. This report is based on published and unpublished data derived from NCHS death certificate information. Objectives of the report include a) dissemination of suicide statistics to focus attention on suicide as a public-health problem; b) delineation of populations at high risk for suicide to direct suicide prevention efforts toward these groups; and c) stimulation of the collection of specific information on suicide and suicide "clusters" at the State or local level. This information is broken down by race-specific categories.

Research (Epidemiology)/Homicide/Suicide. There has never been a comprehensive study of the incidence of mortality due to suicide and homicide among Hispanics in the United States. Although sixteen million Hispanics live in this country, national mortality statistics cannot identify deaths to Hispanics as a specific ethnic subgroup. Thus, Hispanic ethnicity has not been epidemiologically examined as risk factor related to suicide and homicide as a cause of death, because of a lack of sufficient data. CDC is attempting to rectify that problem by studying the incidence of suicide and homicide specifically among the largest segment of Hispanics in the United States--Hispanics (primarily Mexican Americans) living in five States near the U.S.-Mexico border.

Research (Epidemiology) - Domestic Violence. CDC has undertaken a project to examine the feasibility of establishing a surveillance system for monitoring the incidence of domestic violence between adults at the national and local levels. Consequently, basic descriptive and analytic epidemiology in this area remains largely uncharted. Collecting data on the morbidity and mortality associated with domestic violence would be a logical first step, but it is not yet clear how to go about establishing such a data collection system. This study will help to specify appropriate procedures for the collection of data on domestic violence, the ability of State and local health departments to acquire such data, and their capacity to disseminate and utilize limited resources effectively in planning and implementing model domestic violence surveillance systems.

Research (Epidemiology) - Domestic Violence. CDC, in cooperation with the Atlanta Department of Public Safety and the Georgia Department of Human Resources, plans to review cases of domestic violence (homicides and non-fatal assaults between family and intimates). The results of this study will provide information on 1) the role of health, social service, law

enforcement, and judicial agencies with respect to their contact with affected families prior to death or assault; 2) the contacts these agencies may have had with each other regarding the affected families; 3) situational variables which precede death or assault; and 4) programmatic suggestions regarding health and social service agency capability to respond effectively and prevent violence in such cases. This study will have particular relevance for the understanding of violence among Blacks since they are at high risk for injuries resulting from domestic violence and constitute a large proportion of the study population.

Information and Education - Homicide. As a part of a reimbursable agreement with the National Institute of Mental Health, CDC will be producing a homicide surveillance report focusing on Black and Hispanic minority groups in the United States. The purpose of this report is to a) document the patterns and rates of homicide of high risk minority groups; and b) provide up-to-date information on the magnitude and nature of the homicide problem within these groups.

Research (Epidemiology) - Homicide. In collaboration with researchers at the Neuro-psychiatric Institute of the University of California at Los Angeles, CDC has undertaken a large study examining patterns of homicide victimization in Los Angeles between 1970 and 1979. This study will examine: a) patterns of homicide victimization in high risk Anglo, Black, and Hispanic race ethnic groups; b) the association of alcohol and drug use with homicide victimization (this part of the study is part of a reimbursable agreement with the National Institute of Justice); and c) intervention/prevention strategies for reducing the incidence of the predominant forms of homicide affecting high risk population categories in Los Angeles.

FOOD AND DRUG ADMINISTRATION

PROGRAM: CENTER FOR FOOD SAFETY AND APPLIED NUTRITION (CFSAN)

TELEPHONE: 202-245-1198

DESCRIPTION:

The goals of this program are health promotion and disease prevention. The long term strategy for meeting these goals is to improve the nutrition scientific knowledge base that is needed for policy decisions, regulatory actions and education efforts, and to monitor and influence dietary and technological trends that may impact on the nutritional health status of the American public and on the nutrient quality of their food supply. The strategy is pursued by maintaining a high quality research capability in several areas. Two of these areas involve applied laboratory research that addresses CFSAN strategic goals in an Integrated Nutrition-Toxicology Program and in Food Science/Food Technology. A third area is research in nutrient analysis. Another important facet of the strategy is research on and monitoring of the nutrient content of selected foods and the nutrition status of the public, fostering of sound nutrition practices by normal persons and persons with abnormal or disease conditions, and providing to consumers opportunities to improve their understanding and awareness of foods and nutrition. Finally, as part of the strategy, the Nutrition Program will serve as a focal point for the Department's nutrition objectives by shouldering most of the responsibility assigned to FDA for overseeing the refinement and monitoring of implementation plans for those objectives. The Department objectives include: dietary control of obesity, blood cholesterol levels, sodium intake, and iron deficiency anemia; increased public and professional awareness of dietary factors influencing health and disease; improved nutrition labeling of food and improved nutrition education programs; and improved surveillance and evaluation of the public's nutrition and health status.

PROGRAM: TASK FORCE TO INCREASE INTERACTION WITH MINORITY HEALTH PROFESSIONAL SCHOOLS/OFFICE OF HEALTH AFFAIRS (OHA)

TELEPHONE: 301-443-5470

DESCRIPTION:

This task force's goal is to increase interactions with the minority health professional schools. Membership consists of representatives for the Centers and the Commissioner's office and management staff as well as the schools represented in the Association of Minority Health Professional Schools. The task force plans to coordinate on four areas:

- Contracts and grants.
- Recruitment.
- Professional exchange.
- Advisory committee membership.

The task force will discuss initiatives or programs that the Agency has and which the minority schools might join in such efforts.

FOOD AND DRUG ADMINISTRATION

PROGRAM: OFFICE OF CONSUMER AFFAIRS

TELEPHONE: 301-443-5006

DESCRIPTION:

Major projects include:

- Black College Consumer Education Training Conference
  In September 1984, a contract was awarded to Morehouse College, Atlanta, GA, to plan, coordinate, implement, and evaluate a three-phase consumer education training conference with primary focus on and involvement with Black college students, faculty, and community liaison and leadership.

  The primary focus will be on "how to deliver" the consumer education message to the Black consumer through the formation and utilization of a coalition of consumers, health professionals, students, and the private sector. The conference will involve a cross representation of the consumer and health professional communities, as well as the private sector, but primarily the Historically Black Colleges and Universities' populations; and it will serve as a model for subsequent national, regional, and State consumer education conferences via Black colleges. The coalition formation will also serve as a model for other parts of the country as a viable resource for other FDA activities.

- Hispanic Consumer Education - "Consumer Help Line"
  The Los Angeles District Office is conducting a consumer education program in conjunction with the Hispanic Consumer Advocates and Radio KALI in Los Angeles, CA. The program, implemented with funding assistance from FDA's Office of Consumer Affairs, is aimed at improving the protection of the Hispanic consumer through education and information.

  The project consists of a "Consumer Help Line," staffed by volunteers, one day per week/four hours per day, using the facilities of Radio Station KALI, Los Angeles, CA.

- Project Health PACT - Puerto Rico
  On June 29, 1984, FDA's Office of Consumer Affairs awarded a contract to the University of Colorado's Health Sciences Center to develop, implement, and evaluate an adapted version of Project Health PACT for Hispanic audiences in Puerto Rico.

  Health PACT is a consumer health education program developed at the University of Colorado Health Sciences Center which teaches children from preschool through high school how to participate with health care providers during health care visits. The children learn to resolve problems and develop appropriate plans of care by collaborating with the health care provider. Health PACT teaches children to communicate

effectively with health care providers through the use of five health consumer behaviors.

- Sodium Reduction Consumer Education Program

  The program was conducted in the cities of New York; Richmond, Virginia; Dallas, Texas; and Fort Wayne, Indiana. It is part of the Agency's priority sodium initiatives to encourage consumers to reduce their salt intake.

  Educational materials developed for use with the program were:

  --Four low literacy and culturally specific program pamphlets titled "Why and How to Reduce Sodium," "How to Shop For and Prepare Foods Low in Sodium," "Bringing and Eating Out."

  --Three culturally specific posters to illustrate "Youth and Sodium," "Salt Substitute," and "Elderly and Sodium."

  --A bibliography of low sodium cookbooks.

- Hispanic Patient Education Project

  Last year, FDA's Office of Consumer Affairs and Orlando District Office collaborated to meet the special needs of Florida's Hispanic community. The Orlando District established a local Planning Board in Miami to develop recommendations for a Hispanic Patient Education Project. This advisory board includes representatives from Hispanic health professionals, community, and consumer organizations in Miami.

  The "kick-off" of this phase will be a 30-minute television program on patient education, to be aired around April 1985, developed by Up-Front, Inc., a local non-profit organization specializing in drug education/information services, with the assistance of other Hispanic health professionals. At the end of the television program, a 24-hour Medication Information System where local Hispanic consumers will be able to call in for information will begin its operations. University students from health-related careers will be answering a telephone line four to six hours a day, working for credit on a rotational basis, while at the same time gaining experience in the drug information field. During the rest of the 24-hour period, the system will be answered by taped medication information messages. Program will be supplemented by handouts and newspaper columns. The program will continue through September 31, 1985.

FOOD AND DRUG ADMINISTRATION

PROGRAM: COMMUNICATIONS

TELEPHONE: 301-443-3220

DESCRIPTION:

The functions of this program include preparation and distribution mainly through field offices of publications, newspaper columns, slide shows, video tapes, and radio scripts containing medical and nutritional information relating to the needs of Hispanics and Blacks.

FOOD AND DRUG ADMINISTRATION

PROGRAM: CONSUMER AFFAIRS EDUCATION PROGRAM (FIELD OFFICES)

TELEPHONE: 301-443-4166

DESCRIPTION:

This program conducts education programs for consumers in the area of food safety and nutrition labeling; drugs and biologics; radiological health products and medical devices; and health fraud. These programs were designed to educate and inform consumers about all products regulated by FDA--safety and efficacy and benefit/risk factors. The objective was to help consumers make positive behavior changes and intelligent decisions in the marketplace about FDA-related products.

PROGRAM: MEDICARE

TELEPHONE: 301-597-5985

DESCRIPTION:

The Medicare program covers hospital, physician, and other medical services for persons aged 65 and over, disabled persons entitled to Social Security cash benefits for twenty-four consecutive months, and most persons with end-stage renal disease. Medicare has two complementary, but distinct, parts: Hospital Insurance (HI), known as Part A, and Supplemental Medical Insurance (SMI), known as Part B. The Hospital Insurance program covers 90 days of inpatient hospital care in a benefit period ("spell of illness")--which begins with hospitalization and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility (SNF) for 60 continuous days. Nearly everyone covered by hospital insurance voluntarily enrolls in the SMI program. Unlike the HI program, SMI coverage is contingent upon the payment of a monthly premium. The SMI program provides payments for physicians as well as related services and supplies ordered by the physician. SMI also covers outpatient hospital services, rural health clinic visits, and home health visits.

PROGRAM: END-STAGE RENAL DISEASE

TELEPHONE:

DESCRIPTION:

End-stage renal disease (ESRD) is the condition in which the kidneys permanently cease to function at a level that will support life. The two basic therapies for treating this condition are dialysis and transplantation. Coverage began on July 1, 1973. ESRD beneficiaries comprise about one-fourth of 1 percent of all Medicare beneficiaries. In 1983, they accounted for an estimated 3.7 percent of total Medicare expenditures (Parts A and B) and 8.5 percent of Part B expenditures.

PROGRAM: MEDICAID

TELEPHONE:

DESCRIPTION:

Medicaid is a Federally supported and State administered assistance program that provides medical care for certain low income individuals and families. Medicaid accounted for over $23 billion in Federal and State expenditures for medical services in FY 1980. The program is designed to provide medical assistance to those groups or categories of people who are eligible to receive cash payments under one of the existing welfare programs established under the Social Security Act; that is Title IV-A, the program of Aid to Families with Dependent Children (AFDC); or Title XVI, the Supplemental Security Income (SSI) program for the aged, blind, and disabled. In most cases, receipt of a welfare payment under one of these programs means automatic eligibility for Medicaid. In addition, States may provide Medicaid to the "medically needy," that is, to people who (1) fit into one of the categories of people covered by the cash assistance programs (aged, blind, or disabled individuals or members of families with dependent children when one parent is dead, absent, incapacitated, or at State discretion - unemployed), and who (2) are not recipients of cash assistance but whose income falls below certain levels.

Based on 1983 data and projects for the fifty States and the District of Columbia, Medicaid recipients were 60.7% white, 31.9% Black, 5.4% Hispanic, 1.9% Native Americans, and .9% Asian/Pacific Islander (may not equal 100% due to rounding of figures).

HEALTH CARE FINANCING ADMINISTRATION

PROGRAM: RESEARCH AND DEMONSTRATION

TELEPHONE: 301-594-7476

DESCRIPTION:

Specific activities of interest focused on the FY 1985 strategies for eliminating barriers. Minorities were assisted in understanding and responding to the competitive process and nature of grants, cooperative agreements, and contracts. This had been a major factor in preventing minorities from participating in the research demonstrations and contracting activities. Consistent with these activities, HCFA will use Cooperative agreements, when appropriate.

Staff members of HCFA have given a great deal of time, support, and encouragement to the Black Colleges and Universities and other minority programs, in particular the Hispanic. Contacts were made, information and data were shared, and conferences were conducted. Additionally, there were numerous telephone calls and correspondence.

PROGRAM: INDIAN HEALTH SERVICE (IHS)

TELEPHONE: (As provided below)

DESCRIPTION:

- Hospitals and Clinics
  The hospital and health clinic activity represents the core of IHS programs and includes: hospital inpatient care, ambulatory patient care, eye care, model diabetes program, emergency medical services, laboratory services, and radiology services. These programs are operated by both the IHS and the tribes. The programs operated by the tribes provide bascially the same health services as are provided by IHS operated programs. The IHS health delivery system includes 47 hospitals, 84 health centers, and over 300 smaller health stations and satellite clinics. The tribal health delivery system, through contractual arrangements with the IHS, encompasses four hospitals and over 250 health clincs. (TELEPHONE 301-443-3024)

- Clinical Research
  In 1978, the IHS was authorized to expend directly or by contract specified minimal amounts of funds for research in each of five identified activities--patient care, field health, dental care, mental health, and alcoholism. Each year since then the IHS has funded research in these five categories. (TELEPHONE: 602-261-2186)

- Dental Program
  Dental services to American Indians and Alaskan Natives are provided through a variety of means including IHS clinics, tribal programs and contract care. Clinics are located in close proximity to beneficiary groups. Where population groups are small, mobile dental untis or portable equipment may be utilized. Purchase of dental care under contract can also be an effective mechanism for serving small populations in locations where private dentists are available and their services are acceptable to the Indian community.

  The dental program strives to achieve a balance between immediate clinical treatment and long-term results through prevention and education. In order to decrease the incidence of active disease conditions, dental staff are increasing their efforts to make patients and communities aware of the benefit of available disease prevention techniques. The delivery of these public health priority services continues to be the basis for the delivery of oral health services in order to maximize oral health gains for all ages.
  (TELEPHONE: 301-443-1106)

  Nursing Education Center for Indians
  This is a work study program which allows Indians to achieve a degree or license in Nursing. (TELEPHONE: 301-443-1830)

- Alcoholism Treatment

  The Alcoholism Program Branch was created to manage the alcoholism treatment programs transferred from NIAAA for the purpose of treatment and control of alcoholism as mandated by Congress in P.L. 94-437. The following activities have been achieved in the past three years:

  -- A data management system was developed to assure quality services and accountable and sound management of programs.
  -- A National Fetal Alcohol Syndrome research and prevention project has been implemented.
  -- An alcoholism training package has been developed for the primary care providers.
  -- Drafts for an employee counseling service program have been developed by two IHS Area Offices that will eventually lead to an IHS-wide program effort.
  -- An annual indepth evaluation of all IHS alcoholism programs has been implemented. This evaluation will identify the strengths of programs in outcome, cost, and overall effectiveness. (TELEPHONE: 301-443-4297)

- Central Diabetes Program

  This program is developing health care delivery models which are documented to improve the health status of diabetics. The model projects are prototypes so that developed methods and materials will be applicable IHS-wide. The staff provides direct patient services at clinics and supports the service of five model sites. In addition, the program provides three basic activities: 1) direction, training, and technical assistance in diabetes control (direct care--preventive); 2) Headquarters staff is responsible for overall program control and evaluation; 3) The staff also coordinates the program interface with interested groups within and outside IHS. Multiple groups within IHS such as nursing, clinical directors, nutritionists, pharmacists, etc., must be kept abreast of program development. Technical and consultative services are provided to Tribal groups nationwide. Interested outside organizations include the American Diabetes Association, National Diabetes Advisory Board, National Indian Health Board, Centers for Disease Control, and the National Institutes of Health. (TELEPHONE: 505-766-3980)

- Sanitation Facilities

  The Sanitation Facilities program is authorized under the Indian Sanitation Facilities Act of 1959, which provides for the construction of water supply and waste disposal facilities for Indian homes and communities. Its purpose was and is to improve the health status of American Indians and Alaska Native people by providing them with safe domestic water supplies and an adequate means of waste disposal. American Indians and Alaska Natives have experienced a higher infant mortality rate and excessive rates of infectious diseases in comparison to the rest of the country due, in part, to the unsafe water and sanitary systems.

The Sanitation Facilities Construction (SFC) activity is an integral component of a comprehensive health services program which has as its goal the elevation of the health of Federally recognized American Indians and Alaska Natives to the highest possible level. As with the other activities of the IHS, sanitation facilities projects are carried out as a cooperative effort with the people to be served. The program emphasizes the "total community" concept when providing sanitation facilities to existing homes and communities and to newly constructed or renovated homes sponsored by various Federal and State agencies, tribes, and nonprofit organizations.

The SFC activitiy, in conjunction with other preventive health activities, continues to have a major impact in the reduction of environmentally related diseases. It has also had a significant impact upon the economy of the areas where the facilities are built. In addition to the American Indians and Alaska Natives directly employed by the IHS for the construction of sanitation facilities, many other local Indians are employed by Indian tribes and firms that annually administer and/or construct 50 to 60 percent of the sanitation facilities funded and administered through the IHS. (TELEPHONE: 301-443-1046)

- Public Health Nursing

This program comprises the integration of nursing practice and public health practice applied to the promotion and preservation of the health of the population. The public health nurse has responsibilities in general and comprehensive areas of health practice for: (a) identifying health needs of the individual, the family, and the community; (b) assessing health status and health practices; (c) implementing health planning based on individual and/or family care plans and community profile; (d) providing primary health care; and (e) evaluating the impact of health activities on the community. The nature of this practice is continuous and comprehensive, including all ages and diagnostic groups. The primary focus of public health nursing is on the prevention of illness and the promotion and maintenance of health. Therefore, public health nursing practice includes the provision of needed therapeutic services, counseling, education, coordination, and advocacy activities. The public health nurse who is in constant contact with people in groups who seek and need health care has unique opportunities to identify actual and potential health problems. The public health nurse is involved in the planning and coordination of community health programs and services.

Program efforts will be concentrated on coordination of team efforts both within the public health nursing group and with other health personnel. These efforts include:

-- Collaboration with other IHS staff and American Indians and Alaska Natives to plan for coordinated and expanded services.
-- Prevention of complications of pregnancy and improvements of the general health status of expectant mothers and their infants through family planning education and early care of pregnant women.

-- Further reduction of infant morbidity and mortality through early visits to newborns, and by giving highest priority care to high risk infants.
-- Followup of communicable disease cases including contact investigation.
-- Strengthening of health teaching in homes, hospitals, clinics, schools, and the community, with the goal of preventing disease or reducing the ill effects of disease; teaching a member of the family to give nursing care to the non-hospitalized sick and handicapped; development of habits conducive of health; and increasing the capability of families, groups, and communities to cope with health problems associated with problems of daily living.
-- Provision of counseling and guidance in health and family living to teenagers and young adults.
-- Prevention of infectious disease in infants and children by achieving and maintaining a high level of immunization. (TELEPHONE: 301-443-1840)

- Health Education

The goal of this program is to assist the Indian people to adopt health-promoting lifestyles; wisely select and use health care resources, products and service; and influence policy and planning on health care issues and larger environmental matters that affect health. IHS is concerned with the organized approach to all educational deficiencies related to specific disease as well as health and safety hazards among the American Indian and Alaska Natives which can be prevented. The ultimate goal of this program is to utilize educational and behavior change skills to cause the individual person to assume the major responsibility for taking action to bring about the best health possible for himself, his family, and his community.

The traditional health education program components within the IHS include school health education services, community health education services, patient education services, staff health education support services, and tribal program development. Other health related activities are being provided by Indian tribes and Alaska Natives through contracts with IHS, enabling tribes to provide health education services.

The goal of education in FY 1985 is to reach 50% of the 931,000 Indians and Alaska Natives and to impact on the lifestyle of the family and community. Of the ten leading causes of death, health, education will concentrate on alcohol and druge abuse, accident prevention, heart disease, and nutrition. (TELEPHONE: 301-443-1870)

- Nutrition and Dietetics

This program is responsible for education in nutrition and nutritional care services for American Indians and Alaska Natives. This is accomplished through preventive and direct care nutrition services; management and operation of 48 IHS dietary departments; education and development of Indians in nutrition and dietetics to encourage careers in this health discipline; recruitment of qualified professionals for

both IHS facilities and tribally-administered health departments; consultation and direct services to Tribal feeding programs with food service and nutrition education components; assumption of the advocacy role in improving the quantity and nutritional quality of the food supply and inservice education for other members of the IHS. (TELEPHONE: 301-443-1114)

- Scholarship Program
  This program's goal is to seek out Indian students with a desire to pursue a health care career and to provide the appropriate training, health careers orientation, counseling, financial support, and other supportive functions, as required, on an individual basis. The purpose is to increase the proportion of Indian students in health professions in relation to the Indian population, which has been excessively low.

  The program has achieved its goal by dramatically increasing the number of these Indian students, who in return payment for their scholarships, provide health care services to the Indian tribes. (TELEPHONE: 301-443-5440)

- Tribal Management
  This program supports non-recurring direct and indirect costs for general tribal developmental activities such as health department development, development or improvement of management systems, general health planning, evaluation, training, etc. and other activities designed to improve the capacity of a tribal organization to enter into the P.L. 93-638 contracts. Funds shall not be used to support operational programs or to pay for direct or indirect costs of such programs. (TELEPHONE: 301-443-6840)

- Community Health Representative Program
  This program is a unique, community-based health program made up of indigenous (native) staff who provide a variety of health services to American Indian and Alaskan Native communities.

  The goal of the program is to improve the access of these communities to health care through the provision of community health services, including traditional native concepts, in multiple settings utilizing community-based, well-trained, medically guided paraprofessional health care providers. The IHS contracts with 234 American Indian and Alaskan Tribes and groups to manage and operate the program. The FY 1984 budget of $26 million supported approximately 1,550 positions and provided an estimated 2.2 million community-based health care services in maternal and child health, gerontological health care, environmental, dental, and general health (e.g., disease control/prevention, emergency medical services, etc.) in the home, community, and clinic settings. (TELEPHONE: 301-443-4644)

- Alaska Hepatitis B Screening and Immunization Program
  The program's ultimate goal is eradication of Hepatitis B (HBV) in Alaskan Natives through immunization and early detection. Short term goals could include regional eradication in hyperendemic areas such as

the Yukon-Kuskokwim Delta, Bristol Bay, and Iliamna by vaccinating all seronegative individuals, even those living in low risk villages, and routinely immunizing newborns in those areas. The Director, IHS, had decided that funding should be requested for the eradication of HBV in all Alaska Natives.

Currently, over 30,000 Alaskan Natives have been tested for HBV seromarkers and approximately 10,000 have received at least one dose of HBV vaccine. All seronegative Natives residing in hyperendemic areas are being immunized, as well as any Natives living in villages where the prevalence of HBsAg is less that 2%. In addition, approximately 2,000 prenatal women per year are being screened for HBsAg at the Arctic Investigations Laboratories and almost 100 babies born of HBsAg positive mothers have received both Hepatitis B immunoglobulin and HBV vaccine. HBV vaccine is now routine childhood immunization in Yukon-Kuskokwim Delta, Bristol Bay, and Iliamna areas.

The program has maintained a registry of HBsAg positive persons. Currently, 1,500 individuals are on this register.

This program is the first in the world to address control of HBV through immunization, as well as early detection of PHC in HBsAg carriers. Experience gained operating this program will be potentially valuable to the majority of countries in the world where HBV infection and PHC are major health problems, as well as the U.S. where the incidence of HBV infection is increasing. (TELEPHONE: 907-279-6661)

- Urban Health

The purpose of this program is to encourage the establishment of programs in urban areas to make health services more accessible to the medically underserved urban Indian population.

The 37 programs are engaged in a variety of activities, ranging from the provision of outreach and referral services to the delivery of direct comprehensive ambulatory health care. Services currently being provided include medical and dental services, outreach and referral services, and a variety of other health related services, such as family planning, mental health, nutrition and health education, social services, alcoholism counseling, home health care, etc. (TELEPHONE: 301-443-6840)

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: COMMUNITY HEALTH CENTERS (CHC)

TELEPHONE: 301-443-5295

DESCRIPTION:

The purpose of these centers is to provide health services to medically underserved populations in both urban and rural areas. During FY 1984, 575 centers received operational funds and ambulatory health care services were provided to 4.8 million persons. All centers must provide a range of primary health care services which include basic physician services, preventive dental services, diagnostic laboratory and radiologic services, and preventive health services (including well child services and family planning services). Supplemental services which may be provided or arranged for include mental health, dental, vision, allied health, and health education services.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: BLACK LUNG CLINICS

TELEPHONE: 301-443-2270

DESCRIPTION:

Black Lung Clinics evaluate and treat coal miners with respiratory and pulmonary impairments. Services include case-finding and outreach, medical care (both diagnostic and treatment), education for both the patient and his family, and followup.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: MIGRANT HEALTH PROGRAM

TELEPHONE: 301-443-1153

DESCRIPTION:

The purpose of this program is to provide support (through grants and contracts) for planning, developing, and delivering high quality health care to migrants, seasonal farm workers, and their families. Centers and Projects are located in "high impact areas" where groups (4,000 or more) reside for 2 months or longer in a calendar year.

A variety of health services are offered at each site which includes primary, supplemental, educational, environmental, preventive, referral, etc. Centers coordinate arrangements with existing facilities and programs within State and local communities to provide these services.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: HOME HEALTH SERVICES

TELEPHONE: 301-443-2270

DESCRIPTION:

The goal of this program is to increase the availability of home health services through the provision of loans and grants to entities to develop and expand home health agencies and to train homemaker home health aides.

Home health services have been proven to reduce the dependency on institutional care (hospitals and nursing homes) which is typically more expensive.

The program was reauthorized in 1984 as part of the "Preventive Health Amendments of 1984," P.L. 98-555. The 1985 Enacted Appropriation provided $3 million for the continuation of the program to provide access to home health agencies by expanding the number of Medicare-certified home health agencies and expanding the capacity of the existing agencies to serve the aged, ill, and disabled.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: NATIONAL HEALTH SERVICE CORPS (NHSC)

TELEPHONE: 301-443-1470

DESCRIPTION:

The purpose of the Corps is to improve the capacity to provide health manpower to areas with the greatest need and demand for health care and which have been unable to attract providers of primary care services. To accomplish this, the NHSC recruits and places physicians and other professionals in HMSAs. The NHSC was to be, and is, a joint community and Federal Government project. Through the NHSC, the Government provides and pays medical, dental, and other health personnel while the community provides a medical facility and support personnel and assumes responsibility for managing the practice.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

TELEPHONE: 301-443-3744

DESCRIPTION:

These scholarships are awarded to U.S. citizens enrolled or accepted for enrollment as full-time students in accredited U.S. schools of allopathic or osteopathic medicine, dentistry, and other health disciplines needed for the mission of the NHSC. These scholarships include a monthly living stipend and payment of school tuition and fees. Each year of scholarship support incurs a year of Federal service obligation. The minimum service obligation is 2 years.

The NHSC places full-time primary health care practitioners in selected Federally-designated Health Manpower Shortage Areas of the U.S. Virtually all of these practitioners owe service obligations of 2 to 4 years due to their participation in the NHSC Scholarship program. Service may be performed as a Federal employee or, under specified conditions, as a private practitioner. Besides placement under NHSC auspices, service may also include placement at the health care facilities of the Indian Health Service or the Federal Bureau of Prisons.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: HANSEN'S DISEASE PROGRAM

TELEPHONE: 301-443-6910

DESCRIPTION:

The purpose of this program is to identify/detect and provide total care, diagnosis, and treatment for people in the U.S. with this disease.

The National Hansen's Disease Center in Carville, LA, provides these services to 130-150 inpatients at any one time plus numerous patients on an outpatient basis. The Center provides advanced and rehabilitative treatment and presently has approximately 50 lifetime residents.

Additionally, the program provides 12 contract sites (which are located where the old PHS hospitals were) which provide outpatient and inpatient services to populations of persons with this disease.

The program maintains a registry of persons with this disease.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: HEALTH CAREERS OPPORTUNITY PROGRAM/DIVISION OF DISADVANTAGED ASSISTANCE/BUREAU OF HEALTH PROFESSIONS

TELEPHONE: 301-443-2100

DESCRIPTION:

Section 787 of the PHS Act, as amended by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, authorizes the Secretary to make grants to schools of medicine, osteopathy, public health, dentistry, veterinary medicine, optometry, pharmacy, podiatry, and allied health, and other public or private nonprofit health or educational entities to carry out programs which assist individuals from disadvantaged backgrounds to enter and graduate from health professions schools.

The 1981 amendments require that at least 80 percent of the funds appropriated in any fiscal year must be obligated for grants or contracts to institutions of higher education. Also, the 1981 amendments permit the obligation of no more than five percent of the funds appropriated in any fiscal year for awards for projects having information dissemination as their primary purpose.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: ADVANCED FINANCIAL DISTRESS/OFFICE OF PROGRAM SUPPORT/BUREAU OF HEALTH PROFESSIONS

TELEPHONE: 301-443-6880

DESCRIPTION:

This program provides Federal assistance to health professions schools to meet operating costs of those schools that are in serious financial straits, to meet pressing accreditation requirements, or to carry out operational, managerial, or financial reforms.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: NURSING SPECIAL PROJECT GRANTS/DIVISION OF NURSING/BUREAU OF HEALTH PROFESSIONS

TELEPHONE: 301-443-6193

DESCRIPTION:

This program is designed to improve the quality and availability of nurse training opportunities through providing grant and contract support to public and nonprofit private schools of nursing and other entities. Not less than 20 percent of the funds appropriated will be used to increase the supply or improve the distribution by geographic area or specialty group of adequately trained nursing personnel. Nursing education opportunities for individuals from disadvantaged backgrounds will be increased by obligating not less than 20 percent of the available funds for this purpose. Ten percent of the funds will be used to support projects to upgrade the skills of LPNs and other paraprofessional nursing personnel. Additional projects will provide continuing education for practicing nurses or retraining programs for inactive nurses.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: PROFESSIONAL NURSE TRAINEESHIP GRANT PROGRAM/DIVISION OF NURSING/BUREAU OF HEALTH PROFESSIONS

TELEPHONE: 301-443-6333

DESCRIPTION:

This program provides support to eligible public or nonprofit institutions who in turn award traineeship grants to professional nurses receiving advanced educational preparation for leadership positions. These traineeships prepare the professional nurse to teach in various fields of nursing, to serve in administrative or supervisory capacities, to serve as nurse practitioners or to serve in other professional nurse specialties, with special consideration given to nurse practitioner training programs.

PROGRAM: AREA HEALTH EDUCATION CENTERS (AHEC)/DIVISION OF MEDICINE/BUREAU OF HEALTH PROFESSIONS

TELEPHONE: 301-443-6190

DESCRIPTION:

This program addresses problems of geographic maldistribution and overspecialization of health professionals through changes in the traditional pattern of health professions education. The program provides funds to medical and osteopathic schools for the purposes of decentralizing education by having portions of training provided in primary medical personnel shortage areas and by improving the coordination and use of existing resources. Thus, the AHEC concept is a regionalized systems approach to the development of needed health personnel. AHEC is one of several Federal programs aimed at making health care accessible at a reasonable cost.

Current program efforts emphasize relieving health personnel shortages. Awards are for planning, development, operation, and special initiatives. Projects include emphasis on health promotion, programs for the disadvantaged, and coordinating Federal efforts with agencies such as the National Health Service Corps and health planning entities. Continuing education for health professionals is made available and provides complementary necessary backup educational support systems for the National Health Service Corps. Cost containment is encouraged by better organization of resources.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: HEALTH PROFESSIONS ANALYTICAL STUDIES AND REPORTS/OFFICE OF DATA ANALYSIS AND MANAGEMENT/BUREAU OF HEALTH PROFESSIONS

TELEPHONE: 301-443-6936

DESCRIPTION:

This program provides up-to-date, carefully analyzed information on health professions supply, geographic and specialty distribution and utilization to the President, the Congress, the Department, the public, and other organizations. This information is essential to the development and evaluation of national health policy decisions to assure that an adequate supply of practicing health professionals (accessible and equitably distributed) is available. The health fields encompass over 6 million workers and 1,700 health professions schools enrolling almost 400,000 students.

This authority directs the Secretary of HHS to carry out a wide variety of analytical activities through this program, including:

- development of reliable, impartial health professions data and analyses to assist national health policy, development and evaluation;
- monitoring and analyzing developments and changes in the health professions and the type, amount, and cost of the care they provide;
- projection of supply and requirements for physicians and other health personnel by professional specialty and by geographic location;
- preparation of required reports to the President and the Congress.

In addition, this program is charged with the responsibility for properly identifying, designating, and reviewing health professions shortage areas throughout the U.S., in coordination with the States, local communities, and professional groups.

The desired result of this program is to identify achievements, to anticipate potential health professions problems, to provide useful analysis of current complex health professions issues, and to provide practical assessments of the impacts of alternative health professions policies on the content, cost, and configuration and quality of care delivery resources.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: NURSE MIDWIFERY OFFICE

TELEPHONE: 602-871-5888

DESCRIPTION:

This program is one component of an interdisciplinary MHC team providing comprehensive health care to Native American and Alaskan Native women and infants. Certified Nurse Midwives (CNM) are stationed at 14 service units located in 6 IHS areas. Eleven of the service units are located in remote geographical areas where there are no other, or very limited, health resources available.

Services provided by CNMs include a full range of maternal services including antepartum, intrapartum, postpartum, family planning, minor gynecological and preventive health surveillance activities. The initial physical assessment of the newborn, following delivery, and daily assessment/teaching during the postpartum period are part of the CNM responsibility.

Major emphasis is given to teaching and counseling activities. Educational efforts are directed towards clients either individually or in groups and in the community. CNMs also participate in education of health professionals by supervising clinical preceptorships of student nurse midwives, medical students, general medical officers (who have limited OB experience), and others.

During FY 1984 a total of 53,857 ambulatory services were provided to this patient population by 25.8 FTE CNMs. In addition, CNMs managed the intrapartum care of 35 percent (2,558) of the total deliveries occurring at these service sites. CNM co-management of high risk physician delivered patients were provided to a significant number of patients.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

PROGRAM: CONTRACT HEALTH SERVICE (CHS)

TELEPHONE: 301-443-2694

DESCRIPTION:

The purpose of this program is to purchase medical care services, coincidental equipment, and supplies for direct patient care, to supplement and complement other health care resources available to eligible Indian people. CHS is utilized in situations where: (1) no IHS direct care facility exists; (2) the direct care element is incapable of providing required emergency and/or specialty care; (3) the direct care element has an overflow of medical care workload; and (4) supplementation of alternate resources such as Medicare, is required to provide comprehensive care to eligible Indian people.

The CHS funds may be expended to purchase services delivered to an individual physically present in an IHS facility. Cost must not be incurred for patients admitted by a non-IHS physician (or other health care provider) practicing outside the rule and by-laws of an IHS facility, unless the patient is eligible under 42 CFR 36.23.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: ANIMAL RESOURCES PROGRAM/DIVISION OF RESEARCH RESOURCES (DRR)

TELEPHONE: 301-496-5507

DESCRIPTION:

The goal of this program is to support resource projects that enable scientists to obtain and use animals effectively in health-related research. Special attention is given to those animal resource activities that support the missions of the various NIH components. The objectives are accomplished through the Regional Primate Research Centers Program and the Laboratory Animal Sciences Program. Specifically:

- Regional Primate Research Centers Program
  The original objective was to meet a recognized need for suitable facilities and appropriate research environments where biomedical research employing the nonhuman primate could be best conducted.

- Laboratory Animal Sciences Program
  This program assists institutions in developing and improving animal resources for biomedical research and training through the award of research and resource grants.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: BIOMEDICAL RESEARCH SUPPORT PROGRAM/DIVISION OF RESEARCH RESOURCES (DRR)

TELEPHONE: 301-496-5507

DESCRIPTION:

The Biomedical Research Support (BRS) Program consists of three distinct activities: the Biomedical Research Support Grant (BRSG) Program, the BRS Shared Instrumentation Grant (SIG) Program, and the Minority High School Student Research Apprentice Program (RAP). The authorizing legislation allows NIH to fund research grants for general support to strengthen institutional research in sciences related to health.

- Biomedical Research Support Grants (BRSG)
  The objective of this activity is to strengthen and enhance the research environment of institutions heavily engaged in health-related research through the use of flexible funds and local decision-making, which enable them to conduct their biomedical research programs more efficiently and effectively.

- BRS Shared Instrumentation Grant (SIG) Program
  The overall SIG Program objective is to make available to institutions major research instrumentation on a shared-use basis for groups of NIH-funded investigators.

- Minority High School Student Research Apprentice Program (RAP)
  The purpose of the apprentice program is to stimulate minority high school students to seek careers in science.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: GENERAL CLINICAL RESEARCH CENTERS PROGRAM/DIVISION OF RESEARCH RESOURCES (DRR)

TELEPHONE: 301-496-5507

DESCRIPTION:

The program provides resources for 76 General Clinical Research Centers where highly qualified investigators have the opportunity to advance the knowledge of medicine in a clinical setting.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: BIOMEDICAL RESEARCH TECHNOLOGY PROGRAM/DIVISON OF RESEARCH RESOURCES (DRR)

TELEPHONE: 301-496-5507

DESCRIPTION:

This program now places greater emphasis on regional and national sharing of resources. Today, it focuses on applications of knowledge engineering, information technology, biomedical engineering and digital technology for biomedical and clinical research programs, and technologies for the study of biomolecular and cellular structure and function.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: MINORITY ACCESS TO RESEARCH CAREERS (MARC) PROGRAM

TELEPHONE: 301-496-7941

DESCRIPTION:

This program is a research training program for faculty members and students at minority institutions having health-related research activities. It is composed of a predoctoral and postdoctoral faculty fellowship program, a visiting scientist program, an honors undergraduate research training program, and an individual predoctoral fellowship program.

The central goal of this program remains that of increasing the number of highly qualified minority group biomedical scientists. To accomplish this objective, a marked increase in the enrollment of minority group students as Ph.D. candidates in major universities nationwide must first be achieved. Sound preparation of even the most outstanding students during their undergraduate years must precede their successful entrance into graduate school. The MARC Program, through its MARC Honors Undergraduate Research Training Program, focuses on strengthening the traditional minority institutions toward developing a pool of highly qualified predoctoral candidates.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: MINORITY BIOMEDICAL RESEARCH SUPPORT PROGRAM/DIVISION OF RESEARCH RESOURCES (DRR)

TELEPHONE: 301-496-5507

DESCRIPTION:

The objective of this program is to increase the number and quality of minority biomedical research scientists. This program accomplishes its objectives by: strengthening the capability of eligible institutions to support the conduct of quality research in the health sciences; supporting faculty at eligible institutions as they pursue biomedical research interests and capabilities; and supporting minority students engaged in research projects at the undergraduate and graduate levels to motivate and prepare them for careers in biomedical research.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: EPIDEMIOLOGY RESEARCH PROGRAM/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Activities of interest include:

- The contract which supports epidemiologic studies of cancer among Alaskan natives (supported jointly with CDC's Bureau of Alaskan Activities) terminated at the end of FY 1984. A new initiative in FY 1985 and FY 1986 will include a national epidemiologic investigation of four cancers dominant in Blacks—esophageal, prostate, pancreas, and multiple myeloma to determine why these cancers occur more frequently among Blacks.

- A major new effort is being launched to identify the risk factors for cervical cancer in Latin American women, which should be relevant to this same disease problem in American-Hispanic women.

- Added new sites to SEER registry; i.e., the New Jersey Department of Health.

- A major new population-based, case-control study for tumors, which are excessive in Blacks, with the specific goal for identifying risk factors for the disease in Whites and Blacks and assessing the amount of difference will be launched. New focus will concentrate on an evaluation of the risk factors for cancers of the uterine cervix, another malignancy which is particularly excessive among Black and Hispanic women.

- Recently a case-control study of esophageal cancer among Blacks in Washington, D.C. was conducted. The study confirmed that a substantial amount of the disease could be attributed to cigarette smoking and excessive alcohol use. The findings in this study are currently being pursued in a study of esophageal cancers in Blacks in South Carolina and Florida.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: CHEMICAL AND PHYSICAL CARCINOGENESIS RESEARCH PROGRAM (CPCRP)/ NATIONAL CANCER INSTITUTE

TELEPHONE: 301-496-3505

DESCRIPTION:

This program conducts research concerned with the occurrence and the inhibition of cancer caused or promoted by chemical or physical agents acting separately or together, or in combination with biological agents. Research supported here places emphasis on environmental carcinogenesis, mechanisms of action of chemical and physical carcinogens, the role of DNA repair and damage, the role of tumor promoters, hormones, etc.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: BIOLOGICAL CARCINOGENESIS RESEARCH PROGRAM (BCRP)/NATIONAL CANCER INSTITUTE

TELEPHONE: 301-496-3505

DESCRIPTION:

The aim of this research program is to provide valuable insights into the mechanisms of vital carcinogenesis and the means by which the transformation of cells from the normal to the malignant state occurs. An example of research conducted in this area is studies dealing with Acquired Immunodeficiency Syndrome (AIDS) and Kaposi Sarcoma.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: NUTRITION RESEARCH PROGRAM (NRP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Nutrition research efforts seek to identify foodstuffs containing naturally occurring mutagens and carcinogens and their characterization and seeks to identify a wide variety of chemically diverse substances in food that can inhibit the initiation, promotion, and progression of cancer.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: TUMOR BIOLOGY RESEARCH PROGRAM/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

This program supports a broad spectrum of basic biological research to determine what cellular and molecular factors distinguish cancer cells from normal, healthy cells and tissues. The supposition is that knowledge of these properties and processes will help us learn how to manipulate or change the biological signals responsible for the aberrant behavior of cancer cells. Ultimately, this should result in more effective methods for the diagnosis, treatment, and management of cancer victims. Emphasis is on understanding the basic biochemical mechanisms involved in growth control, cancer cell invasion, and cancer cell differentiation.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: IMMUNOLOGY RESEARCH PROGRAM/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

The immune system provides a defense mechanism for the elimination of foreign, non-self substances from the body. The cancer cell, having new or non-self characteristics, should be the target of this surveillance mechanism and should thus be prevented from establishing a tumor. This program supports research associated with this phenomena.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: DIAGNOSTIC RESEARCH PROGRAM (DRP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Supports research leading to the development of instrumentation and methodology to improve the diagnosis and management of cancer.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: PRECLINICAL TREATMENT RESEARCH PROGRAM (PTRP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Supports research in areas of biochemistry, pharmacology, molecular biology, chemistry, and radiobiology to enhance fundamental understanding of treatment at the cellular and molecular level in order to better transfer effective clinical treatment applications.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: CLINICAL TREATMENT RESEARCH PROGRAM (CTRP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Investigates the use of chemotherapy, surgery, radiotherapy, and immunotherapy (either alone or in combination) to obtain optimal treatment. Primary supporter of clinical trials research within the NCI.

Increased emphasis will be given to expansion of clinical trials with emphasis directed towards underserved populations to improve ability to access latest and most effective cancer treatments.

In conjunction with Comprehensive (Cooperative) Minority Biomedical Program efforts, has provided supplemental support to cooperative group grants so that minority patient accrual can be increased.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: REHABILITATION RESEARCH PROGRAM (RRP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

This program seeks to counsel cancer patients, studies prosthetic and physical restorative measures, pain control, continuing care, and rehabilitative nutrition.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: COMPREHENSIVE MINORITY BIOMEDICAL PROGRAM (CMBP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Major activities of interest include:

The Minority Investigator Supplement (MIS) is an initiative designed to encourage participation in cancer-related research by members of underrepresented ethnic American minorities by providing supplemental funds to NCI grantees to include minority researchers.

The Satellite Program is an inter-divisional special initiative between several NCI divisions that seeks to increase the number of minority patients involved in NCI-supported clinical trials treatment protocols. Thus, improve survival and cure rates in minority cancer patients. This is being accomplished through supplemental grants to cooperative group grants.

"Cancer in Minorities" is the theme for a conference to be held in Washington, D.C., in conjunction with Cancer Prevention and Control.

Staff visits are made regularly to institutions that may have affiliate hospitals to promote the cancer research grant mechanism and to access minority physicians, patients, and others as resources in response to concerns about cancer care, information, and education.

This program provides support to mission-related cancer research projects through MBRS, DRR, and the MARC, NIGMS to broaden participation by minorities in cancer-related research and training activities and to enhance the effectiveness of programs in cancer medicine and cancer control in reaching the minority community and other historically underserved segments of the population. This is accomplished through co-funding agreements and special initiatives.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: CANCER CONTROL PROGRAM (CCP)/NATIONAL CANCER INSTITUTE (NCI)

TELEPHONE: 301-496-3505

DESCRIPTION:

Major activities include:

In 1985 two RFAs will solicit applications for smoking cessation programs for Blacks and Hispanics to reduce the number of smokers in these populations. This will be continued in 1986.

Minority-oriented grants will be funded in 1985 for the prevention of preventable mortality. These grants will study reasons why deaths occur from those cancers for which early detection and/or effective treatment technology already exist, and stimulate the development of intervention programs to eliminate those causes. The sites to be targeted include: for Blacks - cancers of the lung, breast, prostate, colon-rectal, and cancer of the cervix; for Hispanics - cancers of the cervix and lung; for Orientals - cancers of the stomach and esophagus.

A new program of cooperative agreements with state and local health departments is being launched to improve the technical capability of such agencies to conduct prevention and control initiatives. Emphasis will be placed on areas with a high concentration of minorities.

A Cancer Control Science Association Program is being developed to provide interested scientists with an intensive education exposure to the current opportunities in cancer control science. Efforts will be made to recruit minority scientists here.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: RETINAL AND CHOROIDAL DISEASES BRANCH/NATIONAL EYE INSTITUTE (NEI)

TELEPHONE: 301-496-4308

DESCRIPTION:

Plans and conducts the Institute's research grants, training grants, fellowships, and career award programs in the vision sciences of retinal and choroidal disorders and related areas as the mission of the Institute indicates.

This program is currently funding a study to investigate synchysis senilis and posterior vitreous detachment in eyes of Blacks and compare these changes with those in Whites in an attempt to explain the significantly lower incidence of rhegmatogenous retinal detachment in Blacks.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: STRABISMUS, AMBLYOPIA, AND VISUAL PROCESSING/NATIONAL EYE INSTITUTE (NEI)

TELEPHONE: 301-496-4308

DESCRIPTION:

Plans and conducts the Institute's research grants, training grants, fellowships, and career award programs in the vision sciences of sensory-motor disorders, rehabilitation, and related areas as the mission of the Institute indicates.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: INTRAMURAL RESEARCH PROGRAM/NATIONAL EYE INSTITUTE (NEI)

TELEPHONE: 301-496-4308

DESCRIPTION:

Plans and conducts the Institute's laboratory and clinical research program, which encompasses five major disease areas: retinal and choroidal diseases, corneal diseases, cataract, glaucoma, and strabismus, amblyopia, and visual processing, to ensure maximum utilization of available resources in the attainment of Institute objectives.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: ANTERIOR SEGMENT DISEASES BRANCH/NATIONAL EYE INSTITUTE (NEI)

TELEPHONE: 301-496-4308

DESCRIPTION:

Plans and conducts the Institute's research grants, training grants, fellowships, and career award programs in the basic and clinical sciences relating to corneal diseases, cataract, and glaucoma, and in other related areas as the mission of the Institute indicates.

The NEI has awarded a grant which has the general objectives of verifying and determining the source of this reported greatly increased prevalence of glaucomatous blinding in Blacks. This study will measure the prevalence of glaucoma in Whites and Blacks in east Baltimore and based on the cases ascertained in the prevalence survey, identify and measure potential risk factors in cases and controls stratified by race.

A study is being funded which was designed as a prospective evaluation of a multivariate estimate of risk in a selected population of subjects with ocular hypertension. Approximately 20 percent of the study population is Black, and therefore important information regarding the utility of this estimate of risk in Blacks should be gathered.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: HEART AND VASCULAR DISEASES PROGRAM/DIVISION OF EPIDEMIOLOGY AND CLINICAL APPLICATIONS (DECA)/NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

TELEPHONE: 301-496-3620

DESCRIPTION:

Activities of relevance include:

The NHLBI-HRSA Community Health Center Project for High Blood Pressure Control. This project conducts, documents, and evaluates high blood pressure control efforts in four underserved communities (two are predominantly Black, rural populations; one is a predominantly Black, urban population; and the fourth is a predominantly Hispanic, rural population). The project was started in 1981 and is modeled on the stepped-care approach of the Hypertension Detection and Follow-Up Program and is responsive to the recommendation made by the National Black Health Providers' Task Force on High Blood Pressure Education and Control that a community organization approach may be essential to successful blood pressure control.

Biobehavioral Factors affecting Hypertension in Blacks. This portfolio of seven grants to geographically diverse research institutions was initiated for a three year period in 1983 to investigate the interaction of behavior with physiology in the etiology of hypertension, a notable health hazard for Blacks.

The Development of Obesity in Young Black and White Females. This long-term prospective study of preadolescent girls, to start in 1985, will investigate those factors such as psychosocial, family, physical activity, dietary, and socioeconomic that may determine black/white differences in development of obesity, which is more prevalent in black women than in white women.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: EPIDEMIOLOGY AND BIOMETRY PROGRAM/DIVISION OF EPIDEMIOLOGY AND CLINICAL APPLICATIONS (DECA)/NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

TELEPHONE: 301-496-2327

DESCRIPTION:

Activities of relevance include:

- The Longitudinal Studies of Coronary Heart Disease Risk Factors in Young Adults: CARDIA. This prospective, epidemiological investigation of the precursors and determinants of CHD risk factors and their evolution will study 5,100 participants, 50% of whom will be Black. This biracial cohort, geographically diverse, will comprise young men and women, ages 18-30 years, who will be examined at intervals to quantify changes in lifestyle and risk factor profiles that occur over time.

- The Community and Cohort Surveillance Program: CCSP. This is a large, long-term program that will measure associations of established and suspected coronary heart disease (CHD) risk factors with both atherosclerosis and new CHD events in four diverse communities, and compare the communities with respect to risk factors, medical care, atherosclerosis and CHD incidence. The project will include surveillance of about 80,000 men and women in each community and repeated examinations of representative cohorts of about 4,000 persons in each community. One cohort will be predominantly Black and the other three will reflect the ethnic composition of the communities in which they live. Surveillance will be achieved through monitoring hospital records and death certificates.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: LUNG DISEASES PROGRAM/DIVISION OF LUNG DISEASES (DLD)/NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

TELEPHONE: 301-496-7208

DESCRIPTION:

The lung diseases program is concerned with six major areas related to respiratory disorders: structure and function of the respiratory system, pediatric pulmonary diseases, and chronic obstructive pulmonary diseases, occupational and immunologic lung diseases, pulmonary vascular diseases, and respiratory failure.

Activities of relevance include:

Respiratory Diseases in Hispanics: This study is being directed primarily towards describing the prevalence of respiratory symptoms and diseases in Hispanics, determining risk factors for respiratory diseases in this population, and developing predictive equations for respiratory parameters in Hispanics.

Minority Summer Research Program in Pulmonary Research. The objective of this program is to encourage minority school faculty members and graduate students to develop interest and skills in research in pulmonary disease at established Pulmonary Training Centers.

PROGRAM: BLOOD DISEASES AND RESOURCES PROGRAM (DBDR)/NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

TELEPHONE: 301-496-6931

DESCRIPTION:

The Blood Disease and Blood Resources Program plans and directs the Institute's research grant, contract, and training programs in blood disease and resources. The four major areas of responsibility are: bleeding and clotting disorders, disorders of the red blood cell, sickle cell disease and blood resources.

Major activities include:

Comprehensive Sickle Cell Disease Centers. The purpose of the Sickle Cell Disease Centers is to focus resources, facilities and work force in a coordinated approach to sickle cell disease. This approach includes a combination of research and demonstration service activities designed to bridge the gap between these two disciplines. Programs of the Sickle Cell Disease Centers include basic or fundamental research, clinical research, clinical application, clinical trials, professional and paraprofessional education programs, public education, screening, counseling and related activities. Currently there are ten centers located throughout the country.

Cooperate Study of Sickle Cell Disease. A large-scale national cooperative study involving 23 institutions and 3,535 patients to investigate the clinical course or natural history of sickle cell disease is in its 7th year. This cooperative study should expand our understanding of the clinical aspects and management of sickle cell disease and provide baseline information for future research, including evaluation of antisickling agents.

A prospective multi-center cooperative study has been initiated to study the relation of immune function changes to the use of blood and blood products. Among the study cohorts, heavily transfused sickle cell disease patients will be entered and prospectively evaluated during the duration of the study.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: COMPANION ISSUES/RESEARCH TRAINING AND DEVELOPMENT/NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

TELEPHONE: 301-496-1763

DESCRIPTION:

NHLBI initiated a task force with the Association of Minority Health Professions Schools to explore how the Institute could contribute to the development and strengthening of the biomedical research base at minority health professions school. As a result the NHLBI Minority Investigators and Minority Institutional Research Plan was developed consisting of four initiatives: Minority School Faculty Development Award; Minority Institutional Research Training Program; Research Fellow Program for Investigators at Minority Institutions; and the NHLBI Visiting Professor Program.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: OFFICE OF PREVENTION, EDUCATION AND CONTROL (OPEC)/NATIONAL HEART, LUNG, AND BLOOD INSTITUTE (NHLBI)

TELEPHONE: 301-496-1763

DESCRIPTION:

Activities of relevance include:

Ad Hoc Committee on High Blood Pressure Control in Minority Populations. The mission of this committee has been expanded to include cholesterol and smoking.

Media Campaigns. There have been PSAs targeted to minority populations.

Reports Completed. Two reports of relevance are: "Guide to Church Programs for High Blood Pressure Control" and "Review of Media Approaches for Reaching Black Audiences."

Open Airway--Respiro Abierto. This is the first educational module for asthma self-management targeted to Black and Hispanic patients at Columbia University.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: BEHAVIORAL SCIENCES RESEARCH/NATIONAL INSTITUTE ON AGING (NIA)

TELEPHONE: 301-496-3136

DESCRIPTION:

Research in variability among racial and ethnic groups is important. It is known that individuals grow up and grow old under varying conditions and that there is social, cultural, and individual variability in aging to be found and understood. In general, life expectancy, health status, and environmental influences have been less favorable for minorities than for the majority population. BSR/NIA has issued a standing program announcement directed to social and behavioral research in minority aging.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: SYSTOLIC HYPERTENSION IN THE ELDERLY/NATIONAL INSTITUTE ON AGING (NIA)

TELEPHONE: 301-496-4996

DESCRIPTION:

The Systolic Hypertension in the Elderly Program (SHEP), is a multicenter study of the efficacy of antihypertensive treatment in elderly patients with isolated systolic hypertension (ISH). The primary objective of this study is to determine whether the long term administration of antihypertensive therapy for the treatment of isolated systolic hypertension in elderly persons reduces the incidence of combined fatal and nonfatal stroke.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: PUBLIC INFORMATION OFFICE/NATIONAL INSTITUTE ON AGING (NIA)

TELEPHONE: 301-496-1752

DESCRIPTION:

Major activities in this area are provided below:

- Smithsonian Folklife Festival--This is a joint effort between the NIA and the Smithsonian folklore specialists to highlight the experiences of very old Americans, particularly Black Americans.

- Market research study of aging and health promotion--The goal of this project was to determine how interested older people (specifically minority elderly) are in acquiring health information and whether they want to, and are able to, make lifestyle changes.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: EPIDEMIOLOGY, DEMOGRAPHY, AND BIOMETRY PROGRAM/NATIONAL INSTITUTE ON AGING (NIA)

TELEPHONE: 301-496-1178

DESCRIPTION:

Major projects in this area are:

The Center for Aging and Human Development at Duke University is conducting a study of an elderly population of 4,500 persons 65 years of age or older of which at least 50 percent will be Black. The purpose of this study is to investigate the influence of social, environmental, behavioral, and economic forces on the mortality, morbidity, and utilization of health services in the study population. Funding for this study of a Black population began in late FY 1984.

A five year contract was awarded to Yale University in June of 1980 to conduct a prospective study of the elderly living in New Haven, Connecticut. This midsize city is predominantly a low to middle income community of mixed racial background (21 percent Black). The purpose of this study is to investigate the influence of social, environmental, behavioral, and economic forces on the mortality, morbidity, and utilization of health services in the study population.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: GERONTOLOGY RESEARCH PROGRAM/NATIONAL INSTITUTE ON AGING (NIA)

TELEPHONE: 301-955-1705

DESCRIPTION:

Investigators in the Stress and Coping Section have published a study utilizing data on non-whites from the earlier NHANES data collected during the period 1971-1974. These analyses on minority individuals investigated the relations among depression, general well-being, and chest pain complaints in the NHANES sample and replicated findings from a similar random sample of White subjects. It is planned to repeat these analyses using the NHANES followup data.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: MICROBIOLOGY AND INFECTIOUS DISEASES PROGRAM/OFFICE OF PROGRAM PLANNING AND EVALUATION (OPPE)/NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES (NIAID)

TELEPHONE: 301-496-6752

DESCRIPTION:

This program funds research in the following areas:

- Respiratory Infections
- Hepatitis
- Sexually Transmitted Diseases
- Hospital-Associated Infections
- Parasitic Diseases
- Enteric Diseases
- Bacterial Vaccines
- Antibiotic Trials
- Antiviral Substances
- Molecular Biology

Additionally, the Institute's International Biomedical Research Program involves both grants and contracts to promote scientific research on diseases of great importance to the health of the people in developing countries of the world and to improve their quality of life.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: IMMUNOLOGY, ALLERGIC AND IMMUNOLOGIC DISEASES PROGRAM/OFFICE OF PROGRAM PLANNING AND EVALUATION (OPPE)/NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES (NIAID)

TELEPHONE: 301-496-6752

DESCRIPTION:

This program focuses on the immune system as it functions in the maintenance of health and as it malfunctions in the production of disease. It encompasses both basic and clinical research.

Basic research is conducted under two segments: Immunology and Immunochemistry, and Genetics and Transplantation Biology. Clinical research is supported in two areas: asthma and allergic diseases, and clinical immunology and immunopathology. NIAID's approach integrates anatomy, physiology, cell biology, and immunochemistry.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: ARTHRITIS, MUSCULOSKELETAL AND SKIN DISEASES/NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASES (NIADDK)

TELEPHONE: 301-496-6623

DESCRIPTION:

- Lupus Erythematosus
  The NIADDK is supporting numerous diverse research projects on the cause and treatment of lupus.

- Vitiligo
  The NIADDK has recently launched a major research initiative to find improved interventions to be used in the treatment of Blacks suffering from vitiligo.

- Rheumatoid Arthritis
  The NIADDK is supporting several educational and community health services projects for minorities through its Multipurpose Arthritis Centers. One study will examine the relationship between chronically ill people of various ethnic diverse backgrounds, particularly Hispanics and Blacks, and the scientific health care system. Another study will examine the differences among three ethnic groups (Blacks, Hispanics, and Whites of European origin) in their beliefs about arthritis, use of medical treatment for chronic joint symptoms, and patterns of self care and home remedies. A third project will develop a method of arthritis patient education targeted to Black and Hispanic adults with low literacy. It is intended that the entire project, consisting of a patient education program and associated manuals and evaluation methods, will be combined into a transportable project for use nationally.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: DIABETES/NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASES (NIADDK)

TELEPHONE: 301-496-6623

DESCRIPTION:

Predisposing factors for diabetes and diabetic complications are thought to include heritage, genetic background, increased levels of obesity and sedentary activity, diet and nutritional preferences, life style and socioeconomic status. These and other factors can vary widely in minority populations. The degree to which any or all of these factors contributes to the risk of diabetes is as yet unknown.

The diabetes programs in the DEMD Division support a number of large, epidemiologic studies on specific populations at increased risk for diabetes, especially NIDDM. Additionally, the National Diabetes Data Group collaborated with the National Center for Health Statistics in development of the Hispanic HANES survey and analysis of the HANES II survey.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: DIGESTIVE DISEASES AND NUTRITION (DDN)/NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASE (NIADDK)

TELEPHONE: 301-496-6623

DESCRIPTION:

The Division of Digestive Diseases and Nutrition is responsible for the extramural support of grant awards and contracts pertaining to diseases and disorders of the gastrointestinal tract and associated organs and to nutrition.

- Gallstones
  The prevalence of gallstones in the U.S. is unknown, but the prevalence for this disease among Hispanics is suspected to be high. The NIADDK and the NCHS have agreed to include an epidemiological study of gallstones in two Health and Nutrition Examination Surveys (HANES).

- Fat-Free Body Composition in Children
  Evidence indicates there is a difference in the fat-free body composition of children between sexes and racial groups. NIADDK is funding a research investigation on the variation in the fat-free body composition of children and youth as a function of maturation, sex, and racial background. A combined sample of 475 children using cross-sectional and longitudinal studies will include Black, Hispanic, and Native American children.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: KIDNEY, UROLOGIC, AND HEMATOLOGIC DISEASES (DKUHD)/NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASES (NIADDK)

TELEPHONE: 301-496-6623

DESCRIPTION:

Research efforts supported by DKUHD are concentrated on the development of new methods of preventive therapy, early diagnosis, and more effective treatment through understanding of the basic mechanisms and causes of these disorders.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: PIMA INDIAN STUDIES/NATIONAL INSTITUTE OF ARTHRITIS, DIABETES, AND DIGESTIVE AND KIDNEY DISEASES (NIADDK)

TELEPHONE: 301-496-6623

DESCRIPTION:

The Division of Intramural Research covers investigations within the Institute's laboratory and clinical facilities in Bethesda and Phoenix. Intramural research activities are conducted by eight branches engaged primarily in clinical research on arthritis and rheumatic diseases, metabolism, endocrinology, hematology, digestive diseases, diabetes, and genetics; a ninth branch addresses theoretical mathematical modeling of biological problems.

The Southwestern field studies section continues to investigate the determinants of diabetes and its complications during a longitudinal study of the natural history of diabetes in the Pima Indian population.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: CENTER FOR RESEARCH FOR MOTHERS AND CHILDREN/NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

TELEPHONE: 301-496-1971

DESCRIPTION:

This program is responsible for the following projects:

- Premature Births
  Premature birth is defined in terms of low birthweight (2,500 grams or less) and/or short gestation, that is, being born too small, too early, or both. About 7 percent of all babies in the U.S. are born with low birthweight. They account for nearly two-thirds of the 13 per 1,000 live births infant mortality rate. They also account for a significant number of developmental abnormalities seen among survivors. Higher premature birth rates among Black, Hispanic, and Native American women remain a major health issue.

  Studies supported by the NICHD are examining normal and abnormal factors that influence the onset of labor and that influence the intrauterine conditions present in the intrapartum and puerperal periods. Research in NICHD Perinatal Emphasis Research Centers addressing this important issue includes studies on the endocrine factors, mechanical factors, and other indicators of impending labor.

- Breastfeeding
  There is considerable evidence that breastfeeding is medically, nutritionally, and psychologically the best method for feeding human infants. Of particular importance from the perspective of infant health is the relatively low incidence of breastfeeding among Black, Hispanic, and Native American women.

  Intervention strategies to increase breastfeeding will be developed and their effects will be tested among multi-ethnic, low-income populations.

- Transmission of Cardiovascular Risk Factors
  In a cross-cultural genetic and epidemiologic study, 540 pairs of U.S. Whites, U.S. Blacks, and Norwegian monozygotic twins are being investigated. The unique genetic relationships contained within these kinships are to resolve the genetic, environmental and maternal determinants of selected anthropometric, biochemical and genetic traits.

  A comparison of the distribution of variation of heart disease risk factors in the offspring of the high risk and control families will permit a more detailed analysis of existing evidence that maternal influence affects several risk factors. An important goal of the research will be the testing and modification of existing methodologies for the analysis of monozygotic twin kinship data and a cross-cultural comparison of the causes for phenotypic variation in three ethnic groups located in two quite different geographic areas of the world.

- Cognitive and Socio-emotional Development of Young Blacks

  Cognitive and socio-emotional development of young black children in the first two years of school is frequently observed to be below that of young white children.

  NICHD is examining how social structural variables, such as racial and socio-economic mix of the school/classroom and household composition (single parents vs. other arrangements), and social-psychological factors, such as the performance expectations of teachers, peers, and parents, affect children's cognitive and social development in the transition to formal schooling.

- Neonatal Asphyxia

  Low birthweight and premature infants are particularly susceptible to neonatal asphyxia which in turn affects cerebral circulation. The frequency of such births is elevated in Black infants.

  The NICHD supported minority biomedical research concerned with this issue is at Howard University, Washington, D.C.

- Mild Mental Retardation Intervention

  Black children may be at higher risk of mental retardation consequent to depriving psychosocial environments.

  The NICHD supports The Carolina Abecedarian Project, University of North Carolina at Chapel Hill, to study the effects of comprehensive early day care intervention in the development of Black children at risk for mild mental retardation.

- Psychosocial Maturity in Black Adolescents

  Development of psychosocial maturity in Black adolescents appears to follow markedly different patterns than in White adolescents.

  An NICHD grantee is exploring the way in which Black adolescents use social networks to solve life problems and achieve more mature functioning in such areas as independence, self-concept, work orientation, and interpersonal communication.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: HEALTHY MOTHERS, HEALTHY BABIES PROGRAM/NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

TELEPHONE: 301-496-5133

DESCRIPTION:

The NICHD has become very active in the Department's Healthy Mothers, Healthy Babies program. This past year, the NICHD sponsored one of six posters distributed by the HM, HB program to clinics serving low-income, pregnant women. Many of these clinic users were minority group members. The NICHD sponsored the printing and distribution of 25,000 posters and more than 1,000,000 take-home cards emphasizing the importance of prenatal care and the importance of keeping clinic appointments. Both the poster and the take-home card were printed in English and Spanish.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: CENTER FOR POPULATION RESEARCH/NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

TELEPHONE: 301-496-1971

DESCRIPTION:

This Center is responsible for the following programs:

- Reproductive Disorders
  In co-sponsorship with the Department of Obstetrics and Gynecology of the College of Medicine at Howard University, the NICHD participated in the organization, conduct, and support of annual or biennial conferences on "Highlights and Trends in Reproductive Medicine." These conferences are designed to focus on reproductive diseases and disorders, in general, and on their occurrence in minority groups, in particular.

- Contraceptive Risk Profiles Altered Among Hispanics
  The NICHD provided $600,000 to the National Center for Health Statistics to augment its Health and Nutrition Examination Survey of American Hispanics. This surveillance morbidity survey will be used to characterize the risk factors for chronic disease in women who use the pill. How the pill alters metabolic measures and health status indicators in Hispanics, compared to U.S. White females, will be the focus of analysis. To date, over 6,000 Hispanic Americans have been interviewed, examined, and given routine screening tests, such as those used at admission to the hospital. Complete birth control pill-use history questionnaires have also been administered with these surveys.

- Indochinese Health and Adaptation Research Project
  The NICHD supports several studies on the diversity of health-related characteristics of Indochinese refugees and their needs for health services as they adapt to the U.S. The most important of these is the IHARP (Indochinese Health and Adaptation Research Project) data set which contains logitudinal data collected, 1983-84, and reasonably representative of the national Indochinese population.

  The IHARP drew heavily upon refugees for staffing through academic internships, independent research, and "faculty mentor" programs for students who contribute their work in return for research experience and academic credit.

- Black Sexuality
  The program supports a number of researchers who are comparing health problems/conditions of minority with White populations. These data contain information on sexual activity, fertility, health care during pregnancy, including cigarette and alcohol use, pregnancy problems, and the health care of infants and children.

- Hispanic Demography Studies

  The program has been very successful in supporting research on Hispanic demography. In particular, we have learned that Hispanic groups differ among themselves, as well as in comparison to White and Black populations. In addition, two companion surveys of the fertility patterns of Puerto Ricans in Puerto Rico and New York City were under way in FY 1984. There are several studies of the impact and assimilation of immigrants which were active in FY 1984. One study addresses the specific health problems of Hispanic immigrants in California.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: INTRAMURAL/NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD)

TELEPHONE: 301-496-1971

DESCRIPTION:

This program is responsible for the following projects:

- Premature Sexual Development
  The Intramural Research Program made a commitment to undertake clinical research among a subset of Puerto Rican children thought to be affected by this disorder. Plans were made to bring a number of these children to the Clinical Center, NIH, for intensive study and possible therapy.

- Minority Research Students
  The Intramural Research Program made special efforts during FY 1984 to increase the number of minority students exposed to biomedical research opportunities. In particular, the FY 1984 summer program was enriched in the ratio of minority to non-minority students at both undergraduate and graduate levels. Moreover, other NIH programs that focus on minority students were used more extensively than had been the case previously, including the Federal Junior Fellowship Program and the Cooperative Education Program.

- Low Birthweight
  - The NICHD Epidemiology and Biometry Research Program conducted a study, using data from a Northern California health plan, collected in the mid-1970s, which included White, Asian, Black, and Hispanic American women. They examined the extent to which major known risk factors, such as smoking, alcohol consumption, maternal weight, maternal weight for height, and other demographic and reproductive characteristics accounted for differences in birth weights.

  - A case control study of factors associated with low birthweight is under way in the District of Columbia which includes approximately 90% of all births to D.C. residents. The project explores the risk due to socioeconomic and demographic factors, work history, unemployment, stress, exposure, lifestyles and prior and current reproductive health.

  - To explore the role of infection of the genital urinary tract in increasing the risk of preterm and low birthweight delivery among Blacks, Whites, and Hispanics, a clinical trial is under development. Different organisms, including chlamydia, mycoplasma, and streptococci will be examined for their relation to low birthweight deliveries. Women will be randomized to treatment or placebo after screening at around 24 weeks of gestation.

- A study is in progress to identify risk factors associated with the birth of intrauterine growth-retarded babies and to determine the growth and development of the babies during the first year of life. The study compares a Black population in Alabama with a White population in Norway and Sweden.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: OFFICE OF THE DIRECTOR (OD) NATIONAL INSTITUTE OF DENTAL RESEARCH (NIDR)

TELEPHONE: 301-496-7220

DESCRIPTION:

The educational program on dental caries prevention for migrant workers and their families is an activity of the Health Promotion and Science Transfer Section. "Una buena denadura para usted y su bebe" (Good teeth for you and your baby) is a product of the Public Inquiries and Reports Section. Over 100,000 copies of this Spanish version of a very popular title have been distributed and an equal number remain for distribution to individuals and health providers.

PROGRAM: EXTRAMURAL PROGRAMS/OFFICE OF PREVENTION, EDUCATION AND CONTROL (OPEC)/OFFICE OF THE DIRECTOR (OD)/NATIONAL INSTITUTE OF DENTAL RESEARCH (NIDR)

TELEPHONE: 301-496-7220

DESCRIPTION:

This program is responsible for the following projects:

- Growth and Development of the Human Head. The research team will aim to elucidate more information on the role of genetics in the development of the physiognomy of the face. Equally as important will be the effects of the environmental factors on maxillo-facial development. Normative data will be developed to give much needed facial growth standards on American Blacks to serve as a guide to orthodontists, plastic surgeons, maxillo-facial surgeons, pedodontists and other physicians, dentists, and health care professionals treating American Blacks.

- A Genetic Study of Cleft Lip and Cleft Palate in Hawaii. The proposal intends to study critically the etiological mechanisms of human cleft lip with or without cleft palate and isolated cleft palate not associated with known syndromes. Clear understanding of genetic and nongenetic basis of the etiology of these conditions is essential for estimates of recurrence risks for genetic counseling and their eventual prevention.

- Periodontal Diseases and Diabetes in the Gila River Indian Community. In the proposed 3-year supplemental project, a team of investigators from the State University of New York at Buffalo, Periodontal Disease Clinical Research Center will collaborate with established diabetics epidemiologists at the NIH, Southwestern Field Study Section in Phoenix, Arizona, to study relationships between the two diseases in a controlled population of Pima Indians with a high prevalence of non-insulin dependent diabetes mellitus.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: TRAVEL FELLOWSHIPS FOR MINORITY NEUROSCIENTISTS/NATIONAL INSTITUTE ON NEUROLOGICAL AND COMMUNICATIVE DISORDERS (NINCDS)

TELEPHONE: 301-496-9271

DESCRIPTION:

The NINCDS in FY 1982 awarded a three-year grant to the Society for Neuroscience for the establishment of a program that will provide funds for minority students and scientists to attend annual meetings of the Society. A major goal of the program is to attract minority students to careers in the field of neuroscience.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: SURVEY OF MAJOR NEUROLOGICAL DISORDERS IN COPIAH COUNTY, MISSISSIPPI/NATIONAL INSTITUTE ON NEUROLOGICAL AND COMMUNICATIVE DISEASES (NINCDS)

TELEPHONE: 301-496-9271

DESCRIPTION:

The primary objective of the project is to establish the prevalence of major neurological and developmental disorders (cerebrovascular disease, convulsive disorders, cerebral palsy, psychomotor delay, Parkinson's disease, essential tremor, and dementia) in a well-defined population of southern Blacks and Whites.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: CHRONIC CNS DISEASE STUDIES: SLOW, LATENT, AND TEMPERATE VIRUS INFECTION/NATIONAL INSTITUTE ON NEUROLOGICAL AND COMMUNICATIVE DISEASES (NINCDS)

TELEPHONE: 301-496-9271

DESCRIPTION:

The focus of research efforts is in two large projects. The first involves medical surveillance of disease patterns in many primitive and isolated populations. Particular attention is directed to child growth and development, behavior, and learning.

In order to determine the usual mode of infection with the virus, a worldwide epidemiological study of transmissible visus dementia (CJD) cases is under way with special attention to familial clusters of cases with a quest for possible relationship of scrapie of sheep to the human disease.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: SUMMER RESEARCH FELLOWSHIP PROGRAM/NATIONAL INSTITUTE ON NEUROLOGICAL AND COMMUNICATIVE DISEASES (NINCDS)

TELEPHONE: 301-496-9271

DESCRIPTION:

This is a highly selective (competitive) program designed to provide research training for medical students contemplating a career in research or academic medicine.

Since the inception of the program in 1982, a total of 22 medical students have received short-term research training in the Institute's Intramural Research Program. Eighteen (55%) were ethnic minorities, and six (18%) were women.

NATIONAL INSTITUTES OF HEALTH

PROGRAM: PHARMACOLOGICAL SCIENCES PROGRAM/NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES (NIGMS)

TELEPHONE: 301-496-7707

DESCRIPTION:

This program supports research and research training concerned with providing improved understanding of the biological phenomena and related chemical and molecular processes involved in the actions of therapeutic drugs and their metabolites. The scope of the research program ranges from synthetic chemistry and basic biological and biochemical studies in molecular pharmacology, to comparative studies in laboratory animals and tissue culture, to controlled clinical studies in normal volunteers and patients.

The NIGMS funds National Research Service Individual Fellowship awards. These awards provide basic multidisciplinary research training. The program staff seeks to identify minority candidates, and utilizes affirmative action principles to select minority candidates for training, provided their qualifications and future potential are similar to non-minority candidates. The staff also is strongly encouraging program directors of Institutional National Research Service awards to make similar efforts.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL HOSPITAL DISCHARGE SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS).

TELEPHONE: 301-436-7050

DESCRIPTION:

The National Hospital Discharge Survey was initiated in 1965 to provide national statistics on the experience of the civilian population of the U.S. in short-stay non-Federal hospitals. Data are abstracted from the face sheet of the sampled patient's medical record on demographic characteristics of the patient, diagnoses and surgical procedures along with administrative information about the hospital stay.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NHANES I EPIDEMIOLOGIC FOLLOWUP SURVEY: CONTINUED FOLLOWUP 1985-86/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

The first NHANES Survey was conducted from 1971-75. This was the first and largest in-depth national survey of health and nutrition ever conducted on a representative sample of the U.S. population. In 1982-84 the 14,407 adults (ages 25-75 in 1971-75) were traced and information was collected by inperson interviews in their homes. The surviving cohort will be reinterviewed in 1985-86 by telephone.

OFFICE OF THE SECRETARY FOR HEALTH

PROGRAM: NATIONAL MEDICAL CARE UTILIZATION AND EXPENDITURE SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

The National Medical Care Utilization and Expenditure Survey (NMCUES), Cycle I (1980) was composed of three separate but interrelated surveys designed to: (1) provide a statistical base for the Department's health care cost containment effort; (2) provide updated, comparable measures of utilization and expenditures for monitoring national health insurance programs; and (3) provide data on trends and costs over time of health care services for different population subgroups (e.g., the poor, the elderly, and the uninsured). The survey was cosponsored by the NCHS and HCFA.

A feasibility study is planned to determine an appropriate methodology to collect comparable information for the institutionalized population. This study would begin in 1985 and the methodology developed would be used to add the insitutionalized population to the next cycle of NMCUES planned for 1987. The 1987 survey will be called the National Medical Expenditure Survey.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL AMBULATORY MEDICAL CARE SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

This survey was begun in 1973 as a continuing survey to gather statistical data on ambulatory medical care provided by office-based physicians to the population of the U.S. Information about the demographic characteristics of patients involved in sampled visits and about the reason for the visit, diagnoses, treatments or services and disposition is recorded on a brief form by the physician or a staff member.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL NURSING HOME SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

This is a national sample survey of nursing homes, their residents, and staff. Resident data are obtained by review of the medical record and by interviewing the nurse who usually cares for the resident to determine demographic characteristics, health status, participation in social activities, monthly charge, and source of payment. Staff members complete a self-administered form about their training, previous experience, salary, duties performed, and fringe benefits.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL MASTER FACILITY INVENTORY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

This is a national inventory of all inpatient health facilities in the U.S. which provide medical, nursing, personal, or custodial care to groups of unrelated persons. The inventory was initiated in 1962 and is updated biennially.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

This survey measures the prevalence of certain health and nutritional conditions, to monitor nutritional indicators and changes in them over time and to provide normative data with respect to health characteristics for the civilian, noninstitutionalized population of the U.S., ages one month to 74 years.

The next survey will be in 1988 (NHANES III) and will oversample for Blacks and Hispanics.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: HISPANIC HEALTH AND NUTRITION EXAMINATION SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

HHANES was a probability sample survey of persons 6 months through 74 years who are of Mexican-American heritage in five Southwestern States, Puerto Rican heritage from the New York City area, or Cuban-American heritage from the Miami area. The HHANES is similar to the National Health and Nutrition Examination Survey with respect to content and operation.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: VITAL STATISTICS FOLLOWBACK SURVEY PROGRAM/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

Major activities are described below:

- A 1986 National Mortality Followback Survey will be pretested in 1985 and fielded in 1986. Data on death rates, hospital and health care utilization and disability will be obtained by race and ethnicity.

- A 1988 National Natality/National Fetal Mortality/National Infant Mortality Followback Survey will be planned. The 1988 surveys will study low birthweight and infant mortality rates, which are twice as high for Black infants as compared with White infants.

- These surveys are often referred to as "followback" surveys because they follow back to one or more informants (e.g., mothers, hospitals, physicians, other medical sources) identified on live birth or fetal death vital records. Many 1980 data items are comparable to those collected in earlier surveys (such as radiation during pregnancy, maternal smoking during pregnancy, Caesarean section delivery, future birth expectations), thus permitting trend studies in demographic and health characteristics of births. The data are used by public health specialists, demographers, epidemiologists, health planners, policymakers, and other health professionals.

  There are limits on the data that can be collected routinely on all death certificates. The purpose of mortality followback surveys is to augment the information on mortality characteristics by inquiring more fully into various aspects of concern to policymakers, health care providers, and administrators. The surveys are conducted primarily by mail questionnaire, with followup for nonrespondents by telephone or personal interview.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL VITAL STATISTICS PROGRAM/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

This program was initiated in 1915 and utilizes the official birth certificate filed in each State for each live birth to produce uniform national, State, and local data on live births.

- National Marriage and Divorce Statistics--National statistics on marriages and divorces or dissolution of marriages provide data on family formation and dissolution and on the sociodemographic characteristics of the principals. NCHS makes available only statistical summaries of characteristics of marriages and divorces and the persons involved.

- National Mortality Statistics--This program, initiated in 1900, utilizes the official death certificate filed in each State for each death to produce uniform national, State, and local data on the numbers of deaths, the causes of death, and the sociodemographic characteristics of decedents.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL SURVEY OF FAMILY GROWTH/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-436-7050

DESCRIPTION:

This program is a nationally representative survey of women in the childbearing ages, which has been conducted periodically by the NCHS since 1971. The NSFG is an important--in some cases, the only--source of nationwide data for monitoring trends and evaluating programs in such public health areas as: unwanted childbearing and the effectiveness of family planning services--adolescent pregnancy, sexually transmitted diseases, sex education, prenatal care, Caesarean-section deliveries, and unmarried cohabitation.

Survey data permit analysis for ever-married, as well as never married, women by age group within the Black population that can be compared with comparable statistics for White women. Data for Black women are shown in published reports and are available on public use data tapes from the survey.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL HEALTH INTERVIEW SURVEY/NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)

TELEPHONE: 301-496-7050

DESCRIPTION:

This survey is a cross-sectional household survey of the civilian non-institutionalized population of the U.S. Its purpose is to provide national data on the incidence of acute illness and accidental injuries, the prevalence of chronic conditions and impairments, the extent of disability, the utilization of health care services, and other health related topics, in addition to information on basic demographic and socioeconomic characteristics of household members.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: HEALTHY MOTHERS, HEALTHY BABIES COALITION/OFFICE OF PUBLIC AFFAIRS

TELEPHONE: 202-245-3102

DESCRIPTION:

The Healthy Mothers-Healthy Babies Coalition subcommittee on low income women is undertaking a national survey of successful strategies and techniques for motivating low income pregnant women to seek prenatal care. The study will be published as a compendium of program ideas for working with low income women and a summary of behavioral research in this area.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: INFORMATION AND EDUCATION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME/ OFFICE OF PUBLIC AFFAIRS

TELEPHONE: 202-245-6867

DESCRIPTION:

In addition to knowledge of the syndrome, related tests and symptoms, this group needs to understand what the "at risk" designation means, precautions for avoiding contracting the syndrome, and sufficient understanding of the means of AIDS transmission so that they can counter misconceptions about the syndrome which are directed against them.

The Office of Public Affairs has reordered "Lo que todos deben saber sobre AIDS," a 16-page cartoon booklet in Spanish, for the general public.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL HEALTH PROMOTION PROGRAM/OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (ODPHP)

TELEPHONE: 202-472-5660

DESCRIPTION:

The purpose of the National Health Promotion Program is to educate the public about environmental, occupational, societal, and behavioral factors which affect health in order that individuals may make informed decisions about health-related behavior. It also serves as a Federal focal point for the development, implementation, and coordination of programs that promote good health habits designed to prevent disease and disability.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: NATIONAL HEALTH INFORMATION CLEARINGHOUSE (NHIC)/OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (ODPHP)

TELEPHONE: 202-522-2590

DESCRIPTION:

The National Health Information Clearinghouse (NHIC) has four specific objectives:

- To identify health information resources;
- To channel requests for information to these resources;
- To provide one-stop service to the inquirer; and
- To develop publications providing information on health-related topics of widespread interest.

The NHIC accomplishes these objectives through the following activities:

- Database Development
- Information Services
- National Information Center for Orphan Drugs and Rare Diseases (NICODARD)
- Materials Collection
- Publications, and
- Materials Dissemination

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: 1990 OBJECTIVES FOR THE NATION INITIATIVE/OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (ODPHD)/PUBLIC HEALTH SERVICE (PHS)

TELEPHONE: 202-245-7611

DESCRIPTION:

A series of measurable objectives to be achieved by 1990 has been established and published in Promoting Health/Preventing Disease: Objectives for the Nation. These objectives are national guideposts for Federal and non-Federal prevention efforts, and the ODPHP oversees implementation efforts involving all PHS agencies, as well as state and local governments and private and voluntary organizations. A number of objectives pertain specifically to minority populations in the areas of disease prevention, health protection, and health promotion.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: U.S. TASK FORCE ON PREVENTIVE SERVICES/OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION (ODPHP)/PUBLIC HEALTH SERVICE (PHS)

TELEPHONE: 202-245-7611

DESCRIPTION:

In 1984 the Department of Health and Human Services convened the U.S. Preventive Services Task Force composed of prominent researchers, clinicians and scholars to review the scientific basis of over 100 clinical preventive interventions and to develop a set of recommendations for the use of preventive services in clinical settings. Recommendations will be made as to appropriate packages of preventive interventions for particular age and sex specific groups, risks and conditions. Depending upon the strength of the scientific evidence, recommendations for inclusion of a given preventive service will be further defined by three criteria: effectiveness, burden of suffering, and detection. Smoking, immunization, inappropriate use of alcohol, breast cancer screening, dietary fat, motor vehicle injury, and functional dependence in the elderly are among the topics which the Task Force has considered. The Task Force's final report will contain all of its recommendations accompanied by an implementation guide discussing the behavioral and structural issues that influence the integration of preventive services into clinical settings.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: REFUGEE PREVENTIVE HEALTH (RPH)/OFFICE OF REFUGEE HEALTH (ORH)/PUBLIC HEALTH SERVICE (PHS)

TELEPHONE: 301-443-4130

DESCRIPTION:

This program provides funds for (1) monitoring overseas medical screening and health services provided to U.S. bound refugees, (2) inspecting refugees at U.S. ports of entry and notifying local health departments of the arrival of refugees, and (3) technical assistance to other Federal, non-Federal governmental and private agencies regarding refugee health matters both overseas and in the U.S.

Current program activities include:

- Monitoring the medical screening of refugees overseas;
- Referring refugees to U.S. health departments, after arrival in the U.S., for followup of conditions such as tuberculosis and serious mental health problems and for health assessments;
- Improving health services for U.S. bound refugees in overseas camps and refugee processing centers (particularly in Southeast Asia); and,
- Development in conjunction with the Office of Refugee Resettlement, a national strategy for improving culturally sensitive mental health services to overseas refugees awaiting resettlement in the U.S. and to refugees already resettled here.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: CUBAN/HAITIAN ENTRANT PROGRAM/OFFICE OF REFUGEE HEALTH (ORH)/PUBLIC HEALTH SERVICE (PHS)

TELEPHONE: 301-443-4130

DESCRIPTION:

PHS provides, or arranges for, all health screening, physical and mental health services for Cuban and Haitian entrants who are detained by INS (in other than Bureau of Prisons facilities) or who require special mental health services prior to their resettlement or parole into the U.S.

Special mental health programs are being provided to Cuban entrants both in Federal facilities or in Federally-funded, community-based treatment facilities.

Other detained aliens are receiving comprehensive services from PHS staff in INS facilities or in community hospitals (at PHS expense) depending on the level of required care.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: HEALTH PROGRAM FOR REFUGEES/OFFICE OF REFUGEE HEALTH (ORH)/PUBLIC HEALTH SERVICE (PHS)

TELEPHONE: 301-443-4130

DESCRIPTION:

This program assists States and localities in providing health assessments to newly arrived refugees and in addressing refugee health problems of public health concern.

PROGRAM: ADOLESCENT FAMILY LIFE/OFFICE OF ADOLESCENT PREGNANCY PROGRAMS (OAPP)/ OFFICE OF POPULATION AFFAIRS (OPA)

TELEPHONE: 301-245-6335

DESCRIPTION:

The objective of the Adolescent Family Life program is the development of effective alternative approaches to the multifaceted problems of adolescent pregnancy. The program supports demonstration projects that provide communities around the country with model programs for effective care services for pregnant adolescents and adolescent parents and prevention services to encourage postponement of adolescent premarital sexual activity.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: FAMILY PLANNING PROGRAM, TITLE X OF THE PUBLIC HEALTH SERVICE ACT/ OFFICE OF ADOLESCENT PREGNANCY PROGRAMS (OAPP)/OFFICE OF POPULATION AFFAIRS

TELEPHONE: 301-245-6335

DESCRIPTION:

This activity supports project grants for voluntary family planning projects that offer a broad range of acceptable and effective family planning methods and services including natural family planning methods and infertility services. Other program activities include grants and contracts for training of family planning services personnel, services delivery improvement research and family planning information and education.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

PROGRAM: INVENTORY OF DHHS ACTIVITIES CONCERNED WITH INFANT MORTALITY AND LOW BIRTHWEIGHT/OFFICE OF HEALTH PLANNING AND EVALUATION

TELEPHONE: 202-472-7906

DESCRIPTION:

In September, 1984 an Inventory of Department of Health and Human Services Activities Concerned with Infant Mortality and Low Birthweight was prepared under contract at the request of the Assistant Secretary for Health. A total of 119 programs are listed covering such areas as research, services, demonstration and evaluation projects.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES (OHDS)

PROGRAM: ADMINISTRATION FOR NATIVE AMERICANS (ANA)

TELEPHONE: 202-245-6546

DESCRIPTION:

The Administration for Native Americans (ANA) provides a Departmental focus for the special concerns of American Indians, Alaskan Natives, and Native Hawaiians.

ANA's Social and Economic Development Strategy (SEDS) concentrates on the executive functions and institutions of tribal governments and on reinforcing or developing systems required for achieving improved social development, economic progress, and service delivery.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES (OHDS)

PROGRAM: ADMINISTRATION ON DEVELOPMENTAL DISABILITIES (ADD)

TELEPHONE: 202-245-2897

DESCRIPTION:

The Administration on Developmental Disabilities (ADD) is the primary agency in the Office of Human Development Services for planning and implementing programs on behalf of disabled people. ADD works through State agencies to improve services to persons with developmental disabilities. The agency also is charged by law with leveraging, accessing, and coordinating service programs funded under other appropriations.

A major component of the program is the basis State grant-a-formula grant to States for planning, administration, and services.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

PROGRAM: ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES (HEAD START)

TELEPHONE: 202-755-7794

DESCRIPTION:

Head Start activities in the area of health includes:

- Preventive health screenings, examinations, and treatment services.
- Nutrition Services.
- Health education and information dissemination.
- Health/nutrition supplies and equipment.
- Staff (health coordinators, etc.).

Approximately 6% of Head Start's FY 84 funds were budgeted for health services (medical, dental, and mental health). An additional 6% of Head Start's FY 84 funds were budgeted for nutrition services. These data do not include the 59,441 handicapped children who are enrolled in Head Start.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

PROGRAM: COORDINATED DISCRETIONARY FUNDS PROGRAM/OFFICE OF POLICY DEVELOPMENT (OPD)/DIVISION OF RESEARCH AND DEMONSTRATION (DRD)

TELEPHONE: 202-245-6233

DESCRIPTION:

The HDS Coordinated Discretionary Fund Program is based on the principle that the well-being of the public is the responsibility of individuals, families, and the communities in which they live.

HDS is primarily interested in providing short-term funds for projects of immediate impact or which can become self-sustaining in a short period of time. The HDS Coordinated Discretionary Funds Program is not intended to provide funds for ongoing social services or to serve as a supplemental source of funds for local activities which need operating subsidies.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

PROGRAM: GERONTOLOGY TRAINING/ADMINISTRATION ON AGING (AOA)

TELEPHONE: 202-472-4224

DESCRIPTION:

Project grants are awarded to colleges and universities for development of gerontology programs offering specialized training to individuals prepared for careers in the field of aging.

Under its Historically Black Colleges and Universities (HBCU) Initiative, AOA has funded projects at Spelmen College and Cheyney State University to provide training for older Blacks in health promotion. AOA also has funded efforts by Meharry Medical College to ensure gerontological/ geriatric training for health professional students.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

PROGRAM: TITLE III OF THE OLDER AMERICAN'S ACT PART B - NUTRITION SERVICES /ADMINISTRATION ON AGING (AOA)

TELEPHONE: 202-245-0727

DESCRIPTION:

The objective of this program is to provide older Americans with low cost nutritious meals and with appropriate nutrition education and other appropriate nutrition services. Meals may be served in a congregate setting or delivered to the home. The nutrition portion of this program is funded on a Federal/State matching basis at a ratio of 85-15.

Additionally, the AOA has underway an initiative to increase minority participation in Older Americans Act programs. States have developed action plans which are in progress during 1985.

OFFICE OF THE ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES

PROGRAM: TITLE IV, OLDER AMERICAN'S ACT, GRANTS TO INDIAN TRIBES FOR SUPPORTIVE AND NUTRITION SERVICES/ADMINISTRATION ON AGING (AOA)

TELEPHONE: 202-245-1826 or 202-245-0011

DESCRIPTION:

Funds are available through grants to eligible Indian tribal organizations to promote the delivery of services comparable to services provided under Title III programs for Indians not served by Title III programs. These services include services necessary for the welfare of older Indians such as: water services, road clearing, nutrition services, and any other services authorized under Title III. Funds may also be used for the alteration, lease, or renovation of a facility to be used as a multipurpose Indian senior center and for staffing the center.

OFFICE OF THE SECRETARY

PROGRAM: ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (ASPE)

TELEPHONE: 202-245-6102

DESCRIPTION:

Assessment of Indian Health Service Systems Capabilities. The purpose of this project is to develop general specifications suitable for use in a cost accounting system to support the use of DRGs in management of IHS hospitals. The end product will be an RFP for use in the procurement of such a system.

Analysis of DHHS Financial Support to and the Socio-Economic Condition of Indian Tribes. The purpose of the project is to exploit a data base on Indian Tribes developed by ASPE/PS. The analysis will provide information on American Indian tribes across a variety of socio-economic, demographic, and financial assistance variables.

PROGRAM: OFFICE FOR CIVIL RIGHTS/OFFICE OF THE DIRECTOR

TELEPHONE: 301-426-4232

DESCRIPTION:

OCR activities focus on selected investigations and reviews. A number of compliance reviews of State agencies resulted in agreements that will enhance service accessibility for minorities and the handicapped on a statewide basis. Other activities are provided below:

Project Reviews. Project reviews focus on identified issues, often under a single jurisdiction. The reviews are intended to generate change in practices, policies, and procedures on an expedited basis.

Outreach and Technical Assistance. During FY 1984 OCR greatly expanded its non-case related outreach and technical assistance initiatives as part of its effort to increase the number of recipients complying voluntarily with civil rights requirements.

Older Americans Project. During FY 1984 OCR initiated a special project aimed at helping States to reduce discrimination against senior citizens and to improve services provided to these citizens. Specific changes that have taken place in some of the project's states include:

- Increasing the range of meal choices for cultural groups with different food preferences.
- Moving of nutrition sites to locations that are more accessible to the minority elderly.

Refugee Resettlement Project. This outreach and voluntary compliance project addresses discrimination in the delivery of health care services to Southeast Asian refugees. As part of the project OCR has:

- Established networks and relationships with State Refugee Coordinators, Regional Offices of Refugee Resettlement, Mutual Assistance Agencies, voluntary agencies, and beneficiary communities.
- Established language banks to provide qualified interpreters on a 24-hour basis to health care providers.
- Assisted beneficiary groups in developing a service needs assessment.
- Provided technical assistance to health care providers to help them to serve the refugee community more effectively.
- Disseminated Indo-Chinese translations of basic OCR information documents to various refugee groups and State Refugee Agencies.

SOCIAL SECURITY ADMINISTRATION

PROGRAM: HEALTH-RELATED PROGRAM/DISABILITY INSURANCE/OFFICE OF DISABILITY MEDICAL EVALUATION (ODME)

TELEPHONE: 301-594-1761

DESCRIPTION:

SSA conducts two disability programs--Title II Disability Insurance (DI) and Title XVI Supplemental Security Income (SSI). Both programs are income replacement programs and not directly related to the provision of health services. The former is based on an earned right derived from employee-employer payments into a Disability Trust Fund. The latter is based on need and is a welfare-type program paid from Federal (and State) general tax funds.

Survey of the Non-Federal Community

SURVEY OF NON-FEDERAL ORGANIZATIONS

Introduction

The Task Force conducted a nationwide survey of approximately 300 individuals and organizations that represent health-specific professional, scientific, and service groups. The survey was intended to elicit information on ways the Department might improve the health status of minority Americans.

The survey asked four questions:

(1) From the perspective of your organization and the people you represent, what are the three most critical health disparities between minority and nonminority Americans?

(2) For the disparities you identified, what appear to be the most significant contributing factors?

(3) Highlighting specific examples known to your organization, what kinds of health programs in the minority community have been most successful? What has been the key element of that success?

(4) Within the confines of the current Department of Health and Human Services' (DHHS) programs and policies, how might DHHS better address the disparity in the health status of minority populations?

The following represents a summary of the 125 survey responses received by April, 1985.

Summary of Responses

The plight of many minority people in need of health care is captured in this excerpted comment:

> "Preventive care is often a luxury that time rarely affords minority people. One is inclined to ignore a cough, a lump in the breast, or even an advancing pregnancy when the demands of daily existence are overtaxing. These ceaseless demands for employment, housing, food, clothing, legal help, public assistance, etc., are sufficient to ensure that many illnesses or conditions reach a critical point before health care is sought."

Socioeconomic issues influencing health status were frequently cited as contributors to the disparity. These included: the prevalence of poverty among minority groups, low income, unemployment, lack of health insurance, and inability to pay deductibles or

copayment costs of insurance. Another aspect mentioned frequently by respondents was the reduction in Government funding for health care services and programs for minorities.

Many respondents believe that the major health disparities could be reduced through improved access to health care services and programs. These need to be designed and operated to be culturally sensitive to the specific minority population being served. The types of services most often advocated by respondents were health education and disease prevention programs.

Suggestions for improving health care services and programs for minorities were:

- Continued support for existing successful health programs.
- Minority-specific research and data collection.
- Prevention and health education programs that incorporate bicultural/bilingual services.
- Minority participation in policy development.
- Education and training programs.
- Improved access to health care through modification of third-party payer systems.

Specific Issues

From the perspective of your organization and the people you represent, what are the three most critical health disparities between minority and nonminority Americans?

For the disparities you identified, what appear to be the most significant contributing factors?

The responses to the first two questions are reported together because of the linked nature of the majority of responses received. The most critical disparities identified by the respondents were in the areas of:

- Access to health care.
- Chronic diseases.
- Pregnancy and birth disorders.
- Availability of data.

Access to Health Care

Problems concerning minority access to health care cut across all responses. Some respondents cited access to health services as a primary disparity, while others identified access as a secondary issue or a contributing factor to the primary disparities. For example, chronic disease conditions were often mentioned as a disparity; however, access to proper health care was listed as a strong contributor to the prevalence of this disparity.

Two major areas of concern in health care access for minorities were:

- The lack of certain types and numbers of services and programs.
- Barriers to existing services.

In addition, the need for generally improved access, quality, and utilization of services such as primary care, screening, detection, treatment, follow-up, and public (health) education programs were frequently cited. Current health services' research and promotion were pinpointed as inappropriate or inadequate for identifying, communicating with, convening, and involving minorities through community-based groups, such as: schools, churches, Health Maintenance Organizations (HMOs), worksites, and voluntary health groups. In addition, the paucity of screening and health education programs was identified as a leading cause of delayed diagnosis and the poor prognosis for medical problems.

Specific problems of access to health care included:

- Lack of health care for mothers and children.
- Lack of access to services for early detection of diseases such as cancer, hypertension, and diabetes and other specialty health care.
- Inability of non-English speaking people to use freely the health care system because of language and cultural barriers.
- Less access to, and inappropriate use of, health services.
- Poor quality of health care.
- Underutilization of existing health resources because of a lack of knowledge and motivation.
- Lack of physicians in rural areas.

- Problems with health care facilities, including affordability, location, hours of operation, and transportation to and from the facilities.

The major theme of these responses pointed to a need for more health education programs tailored to the minority group being served, on the following issues: prenatal and infant care, proper nutrition and weight reduction, management of chronic illnesses, family planning and sex education, and alcohol and drug abuse counseling. Respondents often stressed the need for programs that emphasize preventing disease and promoting good health and good health practices.

Chronic Diseases

Hypertension (high blood pressure), cardiovascular disease, cerebrovascular disease, cancer, and diabetes were most often cited as specific diseases that contribute to the health disparity. Most respondents believed that, if adequate screening programs were available and utilized, more chronic diseases experienced by minorities could be detected early. Respondents also believed that effective patient education and follow-up programs would help to reduce illness and death.

Pregnancy and Birth Disorders

Pregnancy-related concerns such as infant mortality, low birthweight infants, and prenatal, perinatal, and postnatal care were cited by many respondents as major issues.

Access to proper health care was again cited. In the view of most respondents, early and adequate prenatal care and counseling is unavailable or underutilized among minority populations. Also, access to high technology techniques was seen as inadequate, creating a higher incidence of complications of pregnancy and birth.

Many factors that contribute to pregnancy and birth disorders were believed to be manageable with proper access to appropriate, adequate, and early care. Such care includes regular prenatal checkups, nutrition counseling, management of any chronic health problems, and postnatal care for infants and mothers. Access to family planning services was often mentioned as potentially helpful in reducing low birthweight and infant mortality.

Availability of Data

Inadequacy of data on minorities was cited as a major barrier to developing effective health care strategies and programs. The lack of data for Hispanics and Asian/Pacific Islanders was cited most often.

Other Disparities

Respondents noted a number of other areas of disparity:

- Homicide, suicide, and unintentional injuries; alcohol and drug abuse; and problems related to stress.
- Inadequate education.
- Poor nutrition.
- Underrepresentation of minorities in the health professions.
- Problems related to environment, such as housing and unsanitary living conditions.
- Discrimination, deterioration of the family structure, lack of support services and recreational facilities, and low self-esteem.

The quality of education that many minorities receive and their lower educational attainment have a substantial impact on their socioeconomic status, in the opinion of respondents. Educational deficits were believed to be caused by such factors as insufficient parental guidance, lack of encouragement to achieve, and lack of emphasis on education in general. Low educational attainment is seen as both a result and a cause of low socioeconomic status.

Poor nutrition was cited by respondents as affecting nearly every aspect of health, particularly in diseases such as diabetes and hypertension and in relation to pregnancy and birth.

Too few minorities in health care professions was mentioned as contributing to the cultural insensitivity that is said to exist in many health care facilities. Factors cited for underrepresentation include a lack of educational opportunity and financial and political resources for training of minorities in health care professions.

Environmental concerns expressed by respondents included inadequate housing, unsanitary and unsafe working and living conditions, exposure to hazardous chemicals and materials in the worksite and in homes, and the danger of lead poisoning in children.

Elements of Successful Programs

Highlighting specific examples known to your organization, what kinds of health programs in the minority community have been most successful? What has been the key element of that success?

Certain common elements seemed to contribute to the success of many health programs described by the respondents. These key elements include:

- Community involvement and outreach.
- Program focus on comprehensive services, including disease prevention and health promotion.
- Program ability to improve minority access to health services.
- Cultural sensitivity to the group being served.

Examples of health programs that have been successful in minority communities included: community outreach; hypertension control; maternal and child health care; family planning; health education, promotion, and prevention; bicultural and bilingual health care; and Medicare and Medicaid. In general, improved access to medical care was cited as a key element of a program's success; however, success was by no means limited to this element alone.

All groups representing Blacks, Hispanics, Native Americans, and Asian/Pacific Islanders addressed community-based health programs. They cited comprehensive health services, such as dental care, social services, public health education, outreach, and prevention programs, as essential components to community health programs. The key element of success for these programs was that they were accessible and affordable. Other elements of success for community health programs included cultural sensitivity, networking with other agencies in the community, and control of health programs by community boards.

Hypertension Detection and Follow-up Programs and maternal and child health care programs were regarded as successfully demonstrating these qualities.

All groups emphasized health education, promotion, and prevention programs as successes in minority communities, based on experience with planning and delivery of services.

All groups cited Medicare and Medicaid as successful programs. Respondents attributed success to improved accessibility and availability of quality health care to the socioeconomically deprived. Financial assistance and Government funding were also perceived as increasing opportunities for minority employment in the health care field; otherwise, such employment may not have been possible.

Suggestions for Action

Within the confines of the current Department of Health and Human Services programs and policies, how might DHHS better address the disparity in health status of minority populations?

Respondents proposed a variety of specific ways that DHHS might better address disparities in health status of minority populations, including the following:

- Continue to support or fund existing health programs that have been successful.
- Improve data collection and interpretation of data regarding specific minority groups.
- Direct resources to prevention activities for high-risk minority populations.
- Increase funding for health education programs and research on health disparities.
- Incorporate bicultural/bilingual services into health programs.
- Network with private medical and social communities.
- Develop public education programs and other programs encompassed by the 1990 Objectives for the Nation.
- Increase minority participation in policy development, education, and training programs, thereby increasing equal opportunity for minorities.
- Increase accessibility to quality health care.
- Encourage third-party payers to include coverage for health promotion/disease prevention.

All groups recommended that DHHS target programs to populations and geographic areas with the highest rates of mortality and morbidity. They placed particular emphasis on the need to provide adequate funding for health education, prevention, and research for poor and minority populations and to support minority health programs within the community.

In addition, minority groups indicated that DHHS might address the health disparities of minority populations more effectively by making appropriate use of viable and successful community programs and institutions, including families, churches, schools, small businesses, and others.

All minorities who responded to the survey endorsed minority participation in policy development.

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