



# Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services

June/July 1998

## Women's Health

### Inside

Minority Health Perspective.....	3
Estrogen/Heart Disease Prevention..	4
Aging Minority Women.....	5
Depression and Older Asians.....	5
Obesity, Exercise and Body Image....	6
Domestic Abuse/HIV in Hispanics.....	8
Shrinking Teen Birth Rates.....	10
Federal Breast Cancer Committee...11	
Centers of Excellence for Women....11	
Women's Health Information.....	12
Publications.....	13
Resources.....	14
Meetings/Conferences.....	16

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OFFICE OF PUBLIC HEALTH AND SCIENCE  
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

## Minority Women's Health Initiative

### *Panel of Experts Address Equal Health Care for All Women*

By Jean Oxendine

**“W**omen are not well-served unless *all* women are served,” said Wanda K. Jones, Dr.PH, Deputy Assistant Secretary for Women’s Health and Director of the Office on Women’s Health (OWH), within the U.S. Department of Health and Human Services (HHS).

Serving the health care needs of all women is the reason behind OWH’s Minority Women’s Health Initiative, according to Dr. Jones. “We must do all that we can to be inclusive and considerate of the health needs of all of our sisters,” she said.

OWH has made a commitment to the Minority Women’s Health Initiative. New Centers of Excellence—funded by OWH—will focus on academic health centers and will serve minority women. OWH will support projects in the range of \$120,000 to \$190,000 per budget period—the rate at which the current Centers are funded.

In an effort to ensure that future physicians receive cultural competency training, OWH reviews the U.S. Medical Licensure Examination with faculty from the National Centers of Excellence in Women’s Health Working Group on Underserved Populations; reviews the Liaison Committee for Medical Education’s accreditation questionnaire for medical schools in the U.S., and surveys U.S. medical schools’ residency programs in internal medicine, pediatrics, family medicine, and obstetrics and gynecology.

The Minority Women’s Health Initiative, which began in January 1997, has three major functions: (1) convening a minority women’s health panel of experts; (2) supporting minority women’s organizations and projects; and (3) being involved in HHS minority initiatives,

said Elena Rios, M.D., advisor on regional and minority women’s health at OWH.

Support and hard work on all three areas of the initiative is evident at all levels of OWH. From the top with Dr. Jones, throughout OWH, a commitment has been made. Minority women have been made a priority.

### *Panel of Minority Women’s Health Experts*

The panel of minority women’s health experts was formed as a result of two national conferences: the joint HHS OWH/Office of Minority Health (OMH) leadership conference entitled, “The National Conference on Cultural Competence and Women’s Health Curricula in Medical Education,” held in October 1995, and the January 1997 conference, “Bridging the Gap: Enhancing Partnerships to Improve Minority Women’s Health.”

Selected from a nationwide nomination process, the minority women’s health experts include some of our nation’s leading doctors, administrators, government officials, and state directors, representing African American, Native American, Asian American and Pacific Islander, and Hispanic communities. The 31-member panel held its first meeting in November 1997, and is currently developing strategies to address the diversity in health needs and inconsistencies in health care delivery for women across the country.

The panel’s mission is to provide input to and serve as a resource for OWH in the development of minority women’s health initiatives. The panel also works to provide input to HHS on departmental initiatives, and to give recommendations to OWH on HHS

*...continued on next page*

**The Office of Minority Health Resource Center** provides free information on various health issues affecting U.S. minorities including cancer, heart disease, violence, HIV/AIDS and diabetes. Call us to learn about funding sources for minority health programs. *Closing the Gap* is a free monthly newsletter published by the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services. Address correspondence to: Editor, Closing the Gap, OMH-RC, PO Box 37337, Washington, D.C. 20013-7337. Or call OMH-RC toll-free, 1-800-444-6472.

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**Minority Women's Health...from page one**  
initiatives that enhance the health of minority women in the U.S.

According to Dr. Rios, the panel has already been called upon to share its expertise and provide comments on the Centers of Excellence and the Asian American Pacific Islander Initiative. In May 1998, the panel met with HHS Secretary Donna Shalala, Ph.D., U.S. Surgeon General David Satcher, M.D., Ph.D., and Peggy Hamburg, M.D., Assistant Secretary for Planning and Evaluation. The group also discussed priority issues for minority women.

**Supporting Organizations and Projects**

Through the Initiative, OWH supports organizations and projects that address minority women's health. "Our support is often through encouraging group collaboration and showing interest in the group's efforts," said Dr. Rios.

Providing conference support for minority women is another example of OWH's dedication to serving minority organizations and projects. OWH gives conference support—either directly or through the Regional Women's Health Coordinators—to organizations of minority women who are meeting.

"Conference support is bi-directional," said Dr. Jones. "When we support a conference, we get to know about that organization's activities and we can include them in the work we're

doing. We can solicit their expertise for activities in which we are involved."

**Participating in Minority Initiatives**

The third component of the Minority Women's Health Initiative is getting OWH engaged in the HHS's minority initiatives, said Dr. Rios. These include President Clinton's Initiative on Race, HHS's Hispanic Agenda for Action, Historically Black Colleges and Universities Initiative, Tribal Colleges and Universities Initiative, and the Asian American and Pacific Islander Initiative.

Dr. Jones stressed OWH's interest in partnering with other Federal agencies, both within HHS and in other parts of the government. She said it is important for federal agencies and organizations to work together in the area of minority health, and partnering should occur between other organizations, as well.

Through the efforts of OWH's Minority Women's Health Initiative, focus will now be placed on an area that, up until now, has not received the attention it deserves. The health of minority women is crucial to the entire family. With the commitment of the leaders in OWH, this initiative is more than a lot of good ideas, according to Dr. Rios. Ideas are now turning into action in this effort to make health care equal for all women.

*For more information, call OWH at (202) 690-7650. ❖*

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**Dr. Wanda Jones**

*Deputy Assistant Secretary for Health*

**I**n February 1998, Wanda K. Jones, Dr.PH, became the Deputy Assistant Secretary for Health of the U.S. Department of Health and Human Services. Prior to being selected for this position, Dr. Jones was the Associate Director for Women's Health at the Centers for Disease Control and Prevention.

As Deputy Assistant Secretary, Dr. Jones directs the U.S. Public Health Service's Office on Women's Health (OWH). The OWH was established in 1991 to improve the health of American women of all ages, races, and ethnicities by advancing and coordinating a comprehensive women's health agenda. Dr. Jones hopes to broaden OWH's agenda by improving outreach to other populations. "I want to support efforts that eliminate health disparities," she said. "I want our work to be inclusive of all women."

Dr. Jones received a degree in medical technology from Pennsylvania State University, and a doctorate in public health laboratory practice from the University of North Carolina. ❖

# Minority Health Perspective

## Improving the Health of Minority Women: The Role of Research

*Guest editorial by Vivian W. Pinn, M.D.*

*Associate Director of Research on Women's Health*

*Director, Office of Research on Women's Health, National Institutes of Health*

The Office of Research on Women's Health (ORWH) at the National Institutes of Health (NIH) is the catalyst and focal point for research related to women's health issues supported and conducted by the institutes and centers of the NIH. Because health status is the result of the complex interplay of genetic inheritance and lifestyle and environmental factors, the ORWH—through a coherent agenda on research—encourages biomedical and behavioral studies that seek to elucidate and mitigate the ways in which age, ethnicity, economic status, and lifestyle influence the health of women of all ethnic backgrounds and socioeconomic circumstances.

In 1985, a report issued by the Department of Health and Human Services' Secretary's Task Force on Black and Minority Health documented disparate disease prevalence, progression, and health outcomes for many diseases, such as cancer, diabetes, and cardiovascular disease, and excessive mortality for members of minority groups. Although questions remain as to why these disparities exist, access to diagnostic, preventive, and curative health services is certainly an important factor in understanding these differences. For example, a study done by the American Cancer Society Demonstration Projects to Reach the Underserved has shown that, at one site, women had to wait seven to eight months to get a mammogram for a suspicious clinical finding, and then required three to four additional visits for diagnostic work-up. Unfortunately, many minority women have reduced access to diagnostic and preventive procedures, such as mammography screening, because of socioeconomic constraints and a lack of adequate health insurance coverage.

While access to health care is an important contributor to health status, it is not the only factor that influences minority women's differential health status and outcomes. It is essential that we expand the science base that underpins medicine by increasing the medical community's understanding of sex and gender differences and the interplay of race and culture in illness, so that physicians will be able to provide reliable diagnoses and effective treatment and prevention strategies for all their women patients, regardless of the patients' racial, ethnic, or socioeconomic backgrounds. Research is essential to providing the scientific foundation for changes and improvements in health practices and health care policies.

If the disparities in health status and health outcomes for minority women are to be eradicated, then the knowledge about why these disparities exist is essential. To obtain that knowledge and have it affect health care delivery and public policy, study populations must include women and minorities so that such contributing factors can be identified and studied. Guidelines on the inclusion of women in clinical studies have been in place at NIH since 1986. In 1987, minority and other scientists at the NIH recognized the need to address the inclusion of minority populations, and in 1987 a policy encouraging the inclusion of minorities in clinical studies was first published. In 1990, the U.S.

General Accounting Office conducted an investigation into the implementation of the guidelines for the inclusion of women by NIH. The resulting report indicated that the implementation of the policy was lacking, slow, not well communicated, that gender analysis was not implemented, and that the impact of this policy could not be determined. The GAO study also indicated that there were differences in the implementation of the policy recommending the inclusion of minorities, and that not all institutes factored adherence to these policies into the scientific merit review.

Following the publication of the GAO report and the establishment, in September 1990, of the ORWH—which has a legislative mandate to ensure that women and minorities are included in NIH-supported clinical research—the NIH strengthened and revitalized its inclusion guidelines. The ORWH is now responsible for overseeing implementation of the revised inclusion guidelines and monitors the adequate inclusion of women and minorities in clinical trials to ensure their adequate representation in such NIH-supported studies.

Unfortunately, historical events—such as the Tuskegee Syphilis Study in which African American men were denied treatment so that researchers could study the natural progression of disease, and the health consequences associated with the use of DES and Thalidomide by pregnant women—have created biases and cultural barriers against medical research in many communities. To understand and overcome such barriers, the ORWH and the NIH have undertaken a wide variety of efforts, ranging from a 1993 workshop on recruitment and retention of women in clinical studies and an outreach publication that provides guidance to clinical investigators on programs that foster the participation and advancement of women and minorities in biomedical research careers.

The ORWH and the NIH recognize that the barriers to including women of all races and cultures in research can only be overcome through cultural sensitivity on the part of researchers; the participation of clinicians within communities and community groups in the planning and implementation of such research; and having researchers who are themselves from the communities they seek to include in studies. We also recognize that if we are to succeed in recruiting and retaining minority women in clinical trials, we need the help of community-based individuals and organizations and health professionals who are on the front lines of health care delivery. The NIH is relying on members of minority communities to be our partners in encouraging women, especially minority women, to help the medical community better understand the health of *all* women by serving as volunteers in both prevention and treatment studies. Only by ensuring the inclusion of women of all backgrounds and circumstances in clinical studies can we develop appropriate preventive and treatment interventions to improve the health and longevity of all women in the United States. ♦

# Effects of Estrogen on Women's Health

## *NIH looks at hormone replacement therapy to prevent heart disease*

By Jennifer Brooks

**H**ormone replacement therapies (HRT)—a common treatment for the symptoms of menopause—is also thought to reduce the risk for heart disease and other conditions that affect women over 60, including osteoporosis and endometrial changes. But HRT is not without controversy. Scientists have learned that HRT may actually increase the likelihood of breast cancer. A nationwide study by the National Heart, Lung, and Blood Institute (NHLBI), helps women understand the risks and benefits of HRT as they search for better quality of lives in their postmenopausal years.

Heart disease, the leading cause of death for both men and women, doesn't usually affect women until after age 60. Scientists believe the delay in the onset of heart disease may be because of a women's production of estrogen, which changes during menopause.

The Postmenopausal Estrogen/Progestin Interventions Trial, or PEPI, followed 875 healthy postmenopausal women for 3 years to see what affects different regimens of estrogen would have on high blood pressure and increased cholesterol—key risk factors for heart disease. Some women received estrogen alone, while others took a combination of estrogen and progestin, or a placebo.

The results of the study showed that all of the hormone therapies increased the levels of so called "good cholesterol", high-density lipoprotein (HDL), and lowered low-density lipoprotein (LDL), or "bad cholesterol". However, the best findings were with women who received estrogen alone. "When you add progestin to estrogen, you mask the benefits," said Elizabeth Barrett-Connor, MD, principal investigator, University of California, San Diego.

There was no increase in blood pressure or weight gained by any of the regimens. And all of the regimens lowered the levels of fibrinogen—which allows blood to clot more readily, thus increasing the risk of heart disease and stroke.

About a third of the women in the study had hysterectomies. But for the other women, the estrogen plus progestin therapies prevented hyperplasia—overgrowth of the uterine lining. However, women who took estrogen alone had a higher risk of hyperplasia.

HRT was also found to be affective in slowing the bone loss related to menopause. Even more promising is that it significantly increased bone mass.

Although the findings from the PEPI study showed HRT as good for reducing heart disease, as well as osteoporosis and other symptoms of menopause, there is still much

research to be done. "The PEPI trial was too small and too short to totally rule out a connection between hormonal therapy and breast cancer," said Dr. Barrett-Connor.

Doctors involved in HRT research are still awaiting results from other large clinical trials, such as NIH's Women's Health Initiative (WHI), to determine whether increasing HDL ultimately reduces a woman's chance of developing or dying from heart disease.

Started in 1991, WHI is the largest women's health research study ever done. The ten-year study tracks 160,000 postmenopausal women at 40 medical centers around the country.

A woman should talk to her doctor before deciding if HRT is right for her. She should discuss her risk for heart disease, cancer, osteoporosis, and go over her family medical history and other issues that may be important to her.❖

### **Five Leading Causes of Death of Elderly Minority Women (by number of deaths)**

- **American Indians/Alaska Natives:** heart disease, diabetes mellitus, malignant neoplasms, cerebrovascular diseases, unintentional injuries.
- **Hispanics/Latinas:** heart disease, diabetes mellitus, malignant neoplasms, unintentional injuries, cerebrovascular diseases.
- **Blacks/African Americans:** heart disease, diabetes mellitus, malignant neoplasms, unintentional injuries, cerebrovascular diseases.
- **Asian American/Pacific Islanders:** malignant neoplasms, unintentional injuries, heart disease, pneumonia and influenza, cerebrovascular diseases.
- **Whites:** heart disease, chronic obstructive pulmonary disease, malignant neoplasms, pneumonia and influenza, cerebrovascular diseases.

Diseases of the heart are the major cause of death among minority women with the exception of Asian/Pacific Islander women. Mortality rates vary at the fourth and fifth leading cause of death among women of color.❖

# Caring for Our Aging Minority Women

*By Jean Oxendine*

**E**lderly minority women suffer from health problems that often go unnoticed and untreated, according to Marion Primas, Ph.D., Deputy Director, Office of Minority and Women's Health in the HHS Health Resources and Services Administration's Bureau of Primary Health Care. Like younger minority women, the older population of minority women—one of the nation's fastest growing groups—suffers from health problems in greater numbers than the general population.

According to the Administration on Aging (AoA), the older population, aged 65 years or older, numbered 33.9 million in 1996. They represented 12.8 percent of the U.S. population, or about one in eight Americans.

Older women outnumber their male counterparts. There are roughly 145 women for every 100 men. In 1996, about 15 percent of persons over age 65 were minorities; 7.9 percent were Black, 1.9 percent were Asian American or Pacific Islander, 4.7 percent were Hispanic, and less than one percent were American Indian or Alaska Native.

According to Dr. Primas, among the most critical health problems affecting older minority women, are:

- Heart disease, minority women are increasingly more prone to heart attacks;
  - Cancer;
  - Stroke;
  - Alzheimer's disease;
  - Mental illness, along with alcohol and drug abuse;
  - Osteoporosis, often leading to hip fractures;
- and other conditions including:
- Polypharmacy—taking too many or the wrong medications;
  - Lack of mammography screening;
  - Nutrition; and
  - Social isolation, socioeconomic status, and elder abuse.

In looking more closely at a few of these areas, we see that the risk of Alzheimer's disease (AD), increases with age, and the prevalence doubles every five years beyond age 65, according to a National Institutes of Health study. The study also shows that nearly half of all people age 85 and older have symptoms of AD. Not only does AD impact the health of the individual and her family, it takes an economic toll in the U.S. in health care expenses and lost wages of both patients and their caregivers. Best estimates show \$80 to \$100 billion go toward caring for AD patients every year.

Another area of concern is that elderly women often misuse over-the-counter (OTC) medications. Older persons experience two to three times more adverse drug reactions than do younger adults, most often from OTC drugs. One

reason is that older people use more medications and they consult more physicians, increasing the likelihood of duplication and drug interactions, according to the AoA. Despite this risk, older individuals are much less likely to receive counseling or directions than younger adults.

In 1995, only half of U.S. women were getting regular mammography checkups in accordance with established medical guidelines. "It is recommended that women over age 50 have one mammogram per year, and they should follow through with this recommendation," said Dr. Primas. Almost one in every ten women think they don't have to worry about breast cancer after reaching menopause. They think that with the decrease in estrogen levels, they are less likely to get breast cancer. But the truth is that older age means greater, not less, risk. The longer a woman lives, the more likely she is to develop breast cancer.

"The health of elderly minority women is something with which we should all be concerned," said Dr. Primas. The services are out there, at the federal, state, and local levels. Be proactive and show your loved ones that they can be healthy and that there are treatments for their problems. They do not have to live their older years in pain and suffering. Help is just a phone call away. ♦

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## Depression in Older Asian Women

*By Jean Oxendine*

**M**ental illness is another problem area for elderly women, with depression being their most prevalent mental health condition. "Elderly Asian American women, particularly Chinese, suffer from very high rates of depression and suicide," said Dr. Primas. At age 45, the rate for Chinese women begins to rise, and the rate for Japanese women 75 years and older is higher than that of White women of the same age group.

The problem of depression often goes unnoticed in the elderly, and tragically we often "expect" that older women will feel "down." The symptoms that elderly people describe are often memory problems, or physical problems, such as abdominal complaints and sleep disturbances, rather than emotional symptoms such as sadness.

Women should be especially concerned because they are almost twice as likely as men to develop depression. Women often have better ways of coping with depression than men. Women tend to take better care of themselves and use medical services more frequently than men. ♦

# New Obesity Guidelines: Minority Women at Risk

By Marisa Uργο

**W** overweight and obesity pose a major public health challenge,” said Dr. Claude Lenfant, Director of the National Heart, Lung, and Blood Institute (NHLBI) in a statement announcing the release of a new report on clinical guidelines for obesity. According to a new NHLBI report, 97 million American adults, or 55 percent of the population, are overweight or obese. Overweight and obesity are especially evident in some minority groups, as well as in those with lower incomes and less education.

The report, *Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in*

*Adults*, recalculates the traditional measurement of body-mass index, and in the process, reclassifies an extra 25 million Americans as overweight or obese—up from the 72 million that were diagnosed previous to the report’s publication in June 1998.

## How do minority women fare?

According to the U.S. Centers for Disease Control and Prevention, over 50 percent of all African American women are considered overweight, compared to 32 percent of Whites and 36 percent of all women. While this figure is cause for alarm in the African American community, there is another minority group with more

reason for concern. According to the American Heart Association (AHA), the highest prevalence of obesity are among Native Hawaiians and Native Americans. Almost 63 percent of Native Hawaiian women are obese, and over 61 percent of Yaqui Indians are overweight.

## What impact does overweight and obesity have on minority women?

This past June, the AHA listed obesity as a major risk factor for heart disease. Obesity now joins the list of serious health threats that include smoking, high blood cholesterol, high blood pressure and sedentary lifestyle.

The North American Association for the Study of Obesity agrees. “In addition to increased risk of heart disease, obese patients are known to have a greater chance of developing other serious medical complications, including type 2 diabetes, hypertension, cancer and premature death.”

The NHLBI report also makes the case for obesity control and prevention among U.S. minorities, stating, “the need for obesity prevention and treatment is particularly pressing in racial/ethnic minority populations because of the high proportion of overweight and obese persons in many such populations.” The report acknowledges that there are some data for African Americans, but little useful data and analysis exist on the effects of obesity on the health of other racial and ethnic minorities.

## Body image, attitudes, and exercise

The media often sends out conflicting messages of “thinness” and “fitness.” Body image, an individual’s perception of their body size and “look,” is often influenced by these messages. However, studies have shown that women from different

## Obesity: Facts and Figures

According to the *Women of color health data book: Adolescents to seniors*, published by the National Institutes of Health, Office of Research on Women’s Health:

- Obesity—a condition associated with diabetes, hypertension and cardiovascular disease—is a problem for many women of color and is related in part to their sedentary lifestyles and to the “diets of poverty” (high in fat and low in fruits and vegetables) that many consume.
- Native Americans are most likely to be overweight or obese, which is defined as excess body weight for height. Between 61 percent and 75 percent of all Yaqui Indian across all age groups were obese. Similarly, Native Hawaiian and American Samoan females were found to be overweight (63 percent and 66 percent, respectively).
- Among Hispanic women, Mexican women had the highest rates of obesity (48.2 percent), followed by Puerto Rican women (40.2 percent).
- Comparisons of Black/African American women (49.8 percent) and White Women (31.0 percent) revealed a large discrepancy in percentages. Fifty percent of Black/African American women and 31 percent of White women living in poverty in 1991 were obese, compared to 37 percent of Black/African American and 21 percent of the White women with incomes three times the poverty level.
- A decrease in obesity/overweight was found among Hispanic women with higher income levels.
- Asian women, in general, have the lowest rates of obesity. It is reported that among subpopulations, 26 percent of Filipino Americans, 18 percent of Japanese and 13 percent of Chinese women are obese.❖

racial and ethnic groups have different body images and ideal body types.

There have been a few studies on the attitudes of Hispanic and Asian women, but a considerable amount of research has been conducted using African Americans. According to the NHLBI report, “Black girls and women report: less social pressure to be slim, fewer incidences of weight-related discrimination, less weight and body dissatisfaction, and greater acceptance of overweight than their White counterparts.” For this reason, the report warns, “it is possible that weight control initiatives may elicit different reactions from Black and White women.”

Research seems to back this up. A 1992 study in *Ethnicity & Disease* showed that African American women “had an orientation to exercise that was more closely tied to recreational activities or to activities that could be integrated with their other social roles versus exercise as an activity primarily geared to weight control.”

The study concludes that African American women who are obese are concerned about losing weight for their health, not necessarily to be thin or physically attractive to men. Their body image is toward a full-figured, “healthy” woman, not thin, an image known to be the White “ideal.”

The study concludes, “such an assumption may be a barrier in attempting to work with overweight African American women who—although they may want to weigh less and be healthier—do not necessarily consider themselves unattractive or overweight, and may value cosmetic aspects of body weight less as their roles change over the lifespan.”

#### How do we get women to exercise?

“There is a role government can play,” according to Dr. Byllye Avery,

founder and president of the National Black Women’s Health Project in Washington, D.C. “I think we need city recreation,” said Dr. Avery. “We need activities going on at a time that makes sense—not 12 o’clock noon when everyone’s at work.” She said a holistic approach is necessary to getting minority women physically active. She said we should also consider questions like: who will take care of the kids while mom is out exercising?

#### How to Obtain Information

The report is available on the National Heart Lung and Blood Institute Web site, <http://www.nhlbi.nih.gov/nhlbi/nhlbi.htm>. Free nutrition information is also available through The National Institute of Diabetes and Digestive and Kidney Diseases <http://www.niddk.nih.gov/health/nutrit/nutrit.htm>. The National Black Women’s Health Project sponsors the Walking for Wellness Program, (202) 835-0117. ♦

## Are You Overweight? Calculate Your BMI

*Finding your BMI is simple. Just locate your height in inches in the far left column, then find your weight in pounds to the right of your height. Your BMI is the number underlined at the top of that row. According to the new obesity guidelines, any person with a BMI over 25 is overweight, and over 30 is obese.*

**Body Mass Index Table (by weight and height)**

Height/BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
73	144	151	159	166	174	182	189	197	207	212	219	227	235	242	250	257	265
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

# Impact of Domestic Abuse on HIV Prevention in Hispanic Women

By Susan R. Horwitz

The old adage “knowledge is power” may be true only when individuals are in a position to use the information they have acquired. Some Hispanic women who accept traditional gender roles and cultural values may have little control over their own sexuality, putting them at increased risk for HIV infection.

These women may be aware that condom use is highly effective in preventing the spread of HIV, but they may be powerless in convincing their men to use them, according to the December 1996 issue of *Woman Care News* from the Center for Women Policy Studies.

Moreover, if a woman insists that her partner use a condom, the implication may be that he, or even she, has been “unfaithful.” For women who are victims of domestic violence or who fear becoming such victims, negotiation of safer sex practices is even more difficult, thus magnifying the risks of becoming infected with HIV.

“The Center for Women Policy Studies has been dealing with issues of domestic violence for the past 25 years, and with issues of HIV/AIDS for the past 11 years, and there is a clear congruence between the two,” according to its president, Leslie Wolfe, Ph.D. “The pervasiveness of violence worldwide unfortunately is linked to an increase in HIV infection, which is truly a women’s epidemic.”

Theresa M. Zubretsky, director of Human Services, Policy and Planning, New York State Office for the Prevention of Domestic Violence, explains that battered women in general are at increased risk of contracting HIV because: (1) rape or sexual assault of victims by their abusers is a common controlling mechanism; (2) some abusers are afraid of their victims leaving and will therefore purposefully infect the

woman with HIV; (3) victims may be at risk for sexually transmitted diseases, including HIV, because their partners are involved in other sexual relationships; (4) a variety of health-related problems in domestic abuse victims can result from or worsen because of the violence, resulting in weakened immune systems, and therefore increased susceptibility for contracting HIV; and (5) victims may be blocked by their abusers from seeking medical care, which may have a negative impact on the victims’ health and put them at increased risk of contracting HIV.

Zubretsky’s list of risk factors was based on a 1997 Pennsylvania Coalition Against Domestic Violence publication, entitled, “Drugs, Alcohol and Addiction: a Resource Manual for Advocates Working to End Domestic Violence.”

A study published in *The National Newsletter on Family Violence* in Spring 1996 may help explain why AIDS prevention is so difficult for many immigrant women. Many of these women view AIDS as a “Western gay White man’s disease,” and are ashamed to even discuss such topics.

Language barriers, issues of confidentiality, and transportation problems make it difficult for immigrant women to utilize services and verbalize their concerns. Dependency on their husbands for basics such as food and shelter, as well as fear of continued violence, deportation, or loss of custody of their children, also inhibit many immigrant women from confronting their men about suspected extramarital relationships.

In the Hispanic community, women are influenced by “cultural attitudes, traditional values, and issues of subservience,” according to the article, “Sexual Silence: To battle AIDS, Hispanics must overcome cultural barriers,” in *Hispanic Maga-*

*zine*.

A 1993 study at the Center for AIDS Prevention Studies at the University of California San Francisco by Barbara V. Marin, Ph.D. and Cynthia A. Gomez, Ph.D., examined gender role beliefs among Hispanics. The study revealed condom use occurred less among Latino men and women who held more conservative or traditional views regarding sex. In addition, sexual coercion was also a factor impeding condom use. Seventy percent of the men in the survey said they insisted on having sex despite their partner’s disinterest. Women who were sexually coerced often felt unable to object.

“Strong beliefs in traditional values are really at the root of a lot of the issues in this domain,” according to Dr. Marin. “A man in this culture has a sense of needing to prove that he’s a man—always trying harder to prove it, but never really being able to—which brings about a sense of sexual entitlement.”

Religious mores also may influence many Hispanic women’s sexual disempowerment. According to a December 1995 article entitled, “Concern about AIDS in Minority Communities” in *FDA Consumer Magazine*, women who have been tolerating abuse or mistreatment by their husbands may be encouraged by the church and relatives to stay in the relationship and keep the family together. Some churches’ opposition to contraception also helps limit condom use.

Many Hispanics may also view life fatalistically, and feel that contracting AIDS may be “their own cross to bear.” Problems of HIV prevention become even more difficult in certain Hispanic populations, such as migrant farmworkers.

An article in the *Journal of the International Association of Physicians*

in *AIDS Care*, July 11, 1996, indicates the incidence of HIV in seasonal and migrant farmworkers is thought to be up to ten times higher than in the general population. Forty-two percent of the women surveyed at a Farmworker Women's AIDS Conference used their own monogamy and their expected fidelity of their partners as protection against HIV. Since, by definition, migrant workers are highly mobile, many of the women were ignoring their husbands' or partners' other sexual relationships—often with female sex workers or with other men, according to the article. Women did not speak up because they had seen other women farmworkers being physically abused, losing their homes, being denied economic support, or being abandoned when they confronted their husbands or partners.

In an article entitled, "Gender and Sexual Risk Reduction: Issues to Consider," Hortensia Amaro, Ph.D., professor of Social and Behavioral Sciences at Boston University, cites the work of Dr. Marin and Dr. Gomez in connection with "women's experience of fear and abuse." Women who use drugs or whose partners are addicted to drugs, "experience violence and abuse as part and parcel of everyday life," according to Dr. Amaro.

Opening a discussion of condom use by their partners creates yet another conflict and sets up these women for potential abuse. Women who have been sexually or physically abused may increasingly turn to alcohol and other drugs to help themselves cope. Violence and drug use further compromise a woman's position as negotiator with her partner for safer sex.

The obvious need for the development of new HIV/AIDS prevention

strategies becomes even clearer when reviewing the impact the disease has had on the Hispanic community.

According to the year-end edition of the 1997 HIV/Surveillance Report from the Centers for Disease Control and Prevention (CDC), Hispanics are represented disproportionately in the statistics. Of the 641,086 cumulative number of HIV and AIDS cases reported to the CDC through December 31, 1997, Hispanics comprised 115,354, or 18 percent of these cases, while representing only 9 percent of the total U.S. population. Of the 102,383 cumulative HIV and AIDS cases in females reported to the CDC through the end of 1997, some 20,800, or 20 percent were among Hispanics.

Miguelina Maldonado, director of Government Relations and Policy, National Minority AIDS Council, views behavioral research as an important part of work in HIV/AIDS prevention in order to learn "which strategies have been effective when targeting the heterosexual population, where women are at high risk for HIV infection."

Previous studies, which have focused primarily on gay men and on women who inject illicit drugs, do not address this issue. Maldonado adds, "prevention campaigns need to be culturally appropriate and use the appropriate vernacular, whether in English or Spanish.

For effective intervention, targeted campaigns need to be multi-layered, ongoing, and consistent." Maldonado also asserts that prevention messages have more impact when they focus on regional populations, such as Hispanics in the northeastern U.S. or Hispanics in the Southwest, rather than on the nation as a whole. These messages must consider differences among groups, such as their history of immigration, length of stay

in the U.S., literacy, and economic conditions.

Maldonado cautions, however, that we are only doing half the job when prevention strategies place the burden only on women, since "women's decisions are moderated by the attitudes of their male sexual partners.

While it would be important to use interventions that build self-esteem in young women, it is hard to take control of your sexual behavior when you are socialized by your culture and family to assume a subordinate role." Maldonado emphasizes the need for more intensive intervention with heterosexual young men.

Looking at the socialization of young men in different ethnic and racial groups may help with the development of strategies for teaching safer sex negotiation skills. Finally, Maldonado advises that there is no blueprint for HIV/AIDS prevention in Hispanic communities.

Counselors should consider information they have about a particular community and see if it applies to individuals. Health educators need to tailor their prevention strategies to meet the needs of couples with decent communication and of couples with a history or threat of domestic abuse.

"We are at the very beginning stages of working towards HIV/AIDS prevention, which is not just about using condoms, but about transforming the ways men and women relate to each other," explained Dr. Marin.

Dr. Wolfe agrees HIV prevention isn't just about condom use. "I would like to see sexuality education in every single school, not just about plumbing and mechanics, but about men treating women with respect, about men being taught that equality with women is good, and that a 'real' man is nurturing, loving, and caring." ♦

# Teen Birth Rates Down in All States

## *Black teen rates reach record lows*

*By Jennifer Brooks*

**G**ood news! For the first time in over a decade, the national teen birth rate has dropped significantly in all 50 states. African American teens experienced the sharpest decline in birth rates during the same period. Although rates for Hispanic teens fell, they are now higher than other groups, according to a 1998 report from the Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS). The findings were discussed during HHS's Healthy People 2000 Progress Review for Women, held May 1998 at the National Institutes of Health in Bethesda, Maryland.

According to Clay E. Simpson, MSPH, Ph.D., Deputy Assistant Secretary for Minority Health, making life better for our youth was essential. "Many teenagers had nothing to do after school. Where we've put in playgrounds and organized the community to provide youth with something to do that is productive, that in itself helped reduce the rates," Dr. Simpson said during the Healthy People 2000 satellite conference.

The most recent data showed that between 1991 and 1996, teen birth rates declined 5 to 12 percent for White, American Indian, Asian, Pacific Islander and Hispanic girls ages 15 to 19. The preliminary U.S. teen birth rate in 1996 was 54.7 live births per 1,000, down 12 percent from 1991 when the rate was 62.1. But the largest decline by race since 1991 was for Black teens.

The overall rate for Black teenagers fell significantly between 1991 and 1996. Once the highest, the Black teen birth rate, age 15 to 19, dropped 23 percent—making the rate the lowest ever reported for that group. Hispanics now have the highest teen birth rates in the country.

According to NCHS, Black teens had the greatest reductions in birth

rates—91.7 per 1,000 births—in both 15-to-17 and 18-to-19 years age groups. The rate for older black teens, 18 to 19 years, dropped 16 percent. Hispanic teenage birth rates had very little change during 1991 and 1995, before declining 5 percent between 1995 and 1996.

Teenage pregnancy rates have also declined in the U.S. from 1991 to 1994, and has continued to fall since then, according to NCHS. This figure is based on the continued decline in the teenage birth rate and preliminary data that show a drop in abortions among teenagers since 1994.

"The reasons are very complex," said Helen Rodriguez-Trias, Ph.D., co-director of the Pacific Institute for Women's Health. "We're not seeing only the impact of programs that make family planning more accessible to young people...or programs dealing with sex education alone. We're also looking at cultural changes as to what young people see for themselves," said Dr. Rodriguez-Trias. "The way to sustain this positive trend is to improve young people's quality of lives by closing the gaps between rich and poor, young and old," she said.

Contributing to the decline in teen birth rates are indications that teenagers nowadays are less likely to be sexually active, and sexually active teens are more likely to use contraception, according to NCHS.

There has been success in lowering the birth rate for both young and older teens. "We must give teens hope. But its too early to celebrate. We still have among the highest rates of teen births for a developing nation in the world," said Thomas Kring, Ph.D., Acting Deputy Assistant Secretary for Population Affairs in HHS.

Findings from the report show that although teen birth rates declined in all states, many states still have high numbers of births by teenagers. For

example, in 1995—the most recent year state-specific rates are available—Vermont had a 28.6 per 1,000 birth rate while the rate was 105.5 per 1,000 births in the District of Columbia. According to NCHS, given that birth rates for Hispanic and Black teenagers are more than double the rates for non-Hispanic White teens, states with relatively high proportions of Hispanic and/or Black teenagers have higher overall teenage birth rates.

The recent declines in U.S. birth rates reverse the 24 percent rise in births by all teenagers from 1986 to 1991. But birth rates today are still higher than they were just prior to that period when the rate was at its lowest point—50 to 53 births per 1000 teens age 15 to 19. In 1957, the U.S. experienced its highest teen birth rate at 96 births per 1,000 women ages 15 to 19. But most teens who gave birth during the 1950s, 60s and 70s were married, unlike the majority of teen mothers today who give birth out-of-wedlock.

There are some significant health consequences for teenage childbearing. For example, teen mothers are much less likely than older women to receive prenatal care during their first trimester, or throughout their pregnancy. Also, teenage mothers are more likely to smoke and are less likely to gain adequate weight during pregnancy, thus putting their babies at increased risk of low birth rate, serious and long-term disability, and mortality during the first year of life.

*The report on teenage birth rates is the first in a series of statistical summaries by NCHS designed as an easy-to-read presentation of the key data and facts on critical public health issues. The report can be downloaded from the NCHS home page at: <http://www.cdc.gov/nchswww>. Copies are also available at (301) 436-8500. A similar report on the 40-year low birth rate for single Black women was released by NCHS in June 1998.❖*

# Federal Coordinating Committee on Breast Cancer

*By Jennifer Brooks*

**M**ade up of senior level representatives from each department within the federal government, the Federal Coordinating Committee on Breast Cancer (FCCBC) has only one mission: to fight breast cancer. "We get together all the agencies across the federal government to see what they're all doing about breast cancer," said Susan F. Wood, Ph.D., Assistant Director for Policy at the Public Health Service's Office on Women's Health (OWH). "We discuss how to get agencies together in more productive and efficient ways."

The FCCBC has developed an inventory of federal breast cancer programs and initiatives, and is identifying areas for collaborative activities. "We have identified underserved women to see if what they need is prevention, outreach, access to services, or research," said Dr. Woods.

FCCBC's activities are coordinated by OWH. Its Supplement Funding Program awarded \$2.7 million in September 1997 to fund 22 projects, with 50 percent of funding directed to programs that address the needs of underserved populations.

FCCBC's funding went toward projects that increase knowledge about the causes of breast cancer, improve early detection, treatment, and prevention of the disease, and bring lifesaving outreach and education programs to many underserved women across the nation.

Among the many projects funded through the Supplement Funding Program was the Breast Cancer Education

Program for Native American Women. Through a cooperative agreement with the Office of Minority Health, the Association of American Indian Physicians (AAIP) was able to develop and establish a home page on the AAIP Web site that provides accessible, user-friendly information on breast cancer for American Indian women.

An ongoing activity of the committee is the development of a World Wide Web site, which will include information on all federally sponsored breast cancer programs. The site will provide a central gateway to easily accessible, accurate, and current information—via the Internet—on federal breast cancer projects, said Elizabeth Carey of OWH. The site will also provide links to these agencies. A prototype has already been developed and work on the site will continue until its anticipated launch in September.

The committee is also planning a workshop to highlight federal activities on breast cancer. Representatives from federal and state health agencies will come together to discuss forming new and strengthen existing collaborations to help eliminate racial, socioeconomic, and age disparities in breast cancer services and health outcomes. The workshop, "Partnering to Eliminate Disparities: Opportunities for Collaboration in Federal Breast Cancer Programs," will convene on September 28, 1998.

*For more information, please contact Dr. Susan Wood or Elizabeth Carey at OWH, (202) 690-7650.❖*

## Centers of Excellence in Women's Health

**S**ix National Centers of Excellence in Women's Health, located at U.S. academic institutions, were established in October 1996 to serve as demonstration models which can be evaluated and duplicated throughout the nation.

The centers foster recruitment, retention and promotion of women in academic medicine.

The centers integrate health care services, research programs, public education and health care professional training, and forge links with health care services in the community.

"Our nation can't afford to give anything less than its best efforts for women's health," said HHS Secretary Donna E. Shalala in a press statement. "These centers of Excellence are just one step in a broad cooperative effort to improve our health research and services for women, and to improve the career prospects for women in the health professions."

Women served by the centers have all their health care needs met in one place by having access to comprehensive services and resources. The centers also have a multi-disciplinary research agenda across medical specialties; focus medical education on gender differences in the causes, treatment and prevention of disease; and use new information to the public and health care providers.

Up to six new Centers of Excellence will be established in 1998 with special emphasis on serving minority populations. Existing centers are located at Allegheny University of the Health Sciences, Philadelphia; Magee-Women's Hospital, Pittsburgh, PA; Ohio State University Medical Center in Columbus, OH; University of California at San Francisco; University of Pennsylvania in Philadelphia; and Yale University, New Haven, CT.

*For more information, contact the OWH at (202) 690-7650.❖*

# Research Made Easy: The National Women's Health Information Center

By Jean Oxendine

Where can you go to find information on minority women's health without spending hours looking? The answer may be right at your fingertips. By calling their toll-free phone number or browsing their Web site, the National Women's Health Information Center (NWHIC) can provide you with access to more than 80 federal health clearinghouses and hundreds of private sector organizations resources.

A free service of HHS's Office of Women's Health (OWH), the NWHIC covers a variety of topics, some exclusive to women's health issues, and others that affect both men and women.

This is the "women's health central" for federal and private sector information about women's health for the public, health care professionals, medical researchers, educators, and women in the military, according to Suzanne Haynes, M.D., Assistant Director for Science at OWH. The NWHIC World Wide Web site can help you link to, read, and download a wide variety of women's health-related material developed by HHS, other federal agencies, and private sector resources. From the Web site, you can access and download general or specific women's health information and link to OWH's Web site.

The NWHIC can also be accessed through an information and referral telephone line which has information specialists available to clarify information needs and identify the most appropriate federal and private sector resources. And, when possible, they can contact federal agencies on behalf of callers to order documents from diverse federal organizations—thus saving callers time. The toll free telephone line (1-800-994-WOMAN) can be accessed from 8 a.m. to 9 p.m. Eastern time, Monday through Friday,

excluding federal holidays.

If you require more specialized information, they can direct you to other federal toll-free lines where you will find specialists trained to answer specific health questions.

The NWHIC is updated each week, according to Dr. Haynes. "We have to be in there changing it all of the time. Many topics, such as the 'What's New?' section are constantly evolving," she said.

The NWHIC Web site offers three major categories through which women can retrieve health information. These are: "Frequently Asked Questions" (FAQ's), "Health Information," and "What's New?" There is also a section titled, "References," which provides directories and listings of clearinghouses and hotlines, as well as databases of health information and other references. The Health Information category allows women to search the Web site using key words.

The FAQ section provides general information for women on each subject matter and is not race-specific. As a follow up, each FAQ refers users to the "For More Information" section which lists organizations, Web sites, and clearinghouses. Often of interest to minority women in the FAQ section are: diabetes; diet and nutrition; exercise and high blood cholesterol; HIV/AIDS and STDS; smoking; and syphilis.

The "What's New" section provides information on upcoming conferences and announcements, and the "Current Events" section lists the most up-to-date information. A "Reference" section lists resources on topics, such as directories and publications on women's health, including minority women's health issues.

The NWHIC will be publicized through a series of mini-launches at various women's health meetings and symposiums, according to Dr. Haynes.

"One exciting development with the NWHIC will take place next year," she said. OWH will partner with the American Heart Association to create a "Health Risk Appraisal." Through the Web site, women will enter their age, racial/ethnic group, and their degree of willingness to change their habits to improve their health. They will then receive individualized, culturally sensitive feed back listing steps they should take to improve their health. "The response will be tailored for each woman," said Dr. Haynes.

The NWHIC is available to address the unique health concerns of women from all races. Visitors to the Web site and callers should be aware that material contained in the NWHIC is intended to help educate and inform the public about women's health issues, but it isn't a substitute for medical advice from a health care professional.

The NWHIC is a joint project of the OWH and the Defense Women's Research Program of the U.S. Department of Defense.

You may access the NWHIC on the World Wide Web at: <http://www.4woman.org>, or by using the toll-free telephone number, 1-800-994-9662. ♦

**CRC Publishing Company** carries resources for Native American grantseekers that describe corporate, foundation, and religious grants and how to apply for them. *The Multicultural Grant Guides: Native American Series*, the *National Directory of Philanthropy for Native Americans*, and the *Corporate and Foundation Fundraising Manual for Native Americans* can be ordered by contacting: CRC Publishing Company, P.O. Box 22583, Kansas City, MO 64113, (816) 361-2059.

## Publications: Women's Health

**Being There! (Pamphlet)** provides a realistic message of self advocacy and hope for African American women with breast cancer. Copies of this brochure can be obtained free of charge through the American Cancer Society, 2265 Como Ave., St. Paul, MN 55108, 612-644-1224.

**The Black Women's Health Book: Speaking For Ourselves (Book).** Copies are available from Seal Press, 3131 Western Ave., Ste. 410, Seattle, WA 98121; 800-754-0271, (fax) 206-285-9410. (Fee). Internet: <http://www.sealpress.com>

**Body & Soul: The Black Women's Guide to Physical Health and Emotional Well-Being (Book).** Copies are available from Harper Collins Publishers, 1000 Keystone Industrial Park, Scranton, PA 18512; 800-242-7737. (Fee).

**Controlling High Blood Pressure: A Woman's Guide (Pamphlet).** Copies are available from the National Heart, Lung, and Blood Institute, PO Box 30105, Bethesda, MD 20824-0105, 1-800-575-9355. Order #55-820.

**Current Issues in Women's Health, Second Edition: An FDA Consumer Special Report.** This report details a range of health issues that affect women of all ages. Copies are available from the Superintendent of Documents, PO Box 371954, Pittsburgh, PA 15250-7954. 202-512-1800. S/N 017-012-00367-2. (Fee).

**Facts About Endometriosis (Pamphlet).** Copies are available from the National Institute of Child Health and Human Development, 31 Center Dr., Rm 2A-32, Bethesda, MD 20892-2425, 301-496-5133.

**For Women of All Ages: A Physical Therapist's Perspective on Women's Health (Para las Mujeres de Todas las Edades) (Pamphlet).** Copies are available from the American Physical Therapy Association, PO Box 25278, Alexandria, VA 22313. 1-800-999-2782. Order #PR-38 (English), #PR-170 (Spanish). (Fee).

**Get Real: Straight Talk About Women's Health (Manual).** This kit consists of a 27-minute video, facilitator's guide, fact sheets, and promotional posters, all of which may be copied or reproduced. Contact: the Office on Women's Health, DHHS, 200 Independence Ave., SW, Rm 730B, Washington, DC 20201, 202-690-7650, (fax) 202-690-7172.

**Having a Pelvic Exam and Pap Test (Pamphlet).** Copies are available from the Cancer Information Service, 800-422-6237.

**HIV/AIDS and African American Women (Fact Sheet).** Copies are available from the National Black Women's Health Project, Public Education/Policy Office, 1615 M St., NW., Ste 230, Washington, DC 20036. 202-835-0117.

**A Mammogram Saved My Life (Pamphlet).** Copies are available from Education Programs Associates, Inc., 1 West Campbell Ave., Ste 40, Campbell, CA 95008-1039. 408-374-3720. 1-500. Order #PB2596 (English), Order #PB2597 (Spanish). (Fee).

**Manual for Medical Interpreters in Obstetrics and Family Planning (Manual).** This manual is part of a 16-hour training program to assist in the development of Spanish-language interpreters in the field of Obstetric and Family Planning. Copies are available from Spa Med Publications, 1412 E. Garfield Ave., Glendale, CA 91205.

**The Pap Test: It Can Save Your Life (Pamphlet).** Copies are available from the Cancer Information Service, 800-422-6237, National Cancer Institute; 31 Center Dr. MSC 2580; Bldg. 31, Rm 10A16; Bethesda, MD 20892-2580.

**Salud: A Latina's Guide to Total Health-Body, Mind and Spirit (Book).** Copies are available from Harper Collins Publishers, 1000 Keystone Industrial Park, Scranton, PA 18512. 1-800-242-7737. (Fee).

**Woman to Woman: A Leading Gynecologist Tells You All You Need to Know About Your Body and Your Health (Book).** Copies of this publication are available from Amazon.com Books, 549 South Dawson, PO Box 81410, Seattle, WA 98108-1310, 1-800-201-7575, e-mail: [orders@amazon.com](mailto:orders@amazon.com). Web site: <http://www.amazon.com>. ISBN: 0-525-94297-1. (Fee).

**The Women's Complete Healthbook (Book).** Copies are available from Philip Lief Group, Inc., 6 West 20th St., 11th Floor, New York, NY 10011. 800-650-2692. (Fee).

**What Should You Know If Your Pap Test is Abnormal (Booklet).** Copies are available from Education Programs Associates, 1 West Campbell Ave., Bldg. D, Rm 40, Campbell, CA 95008, 408-374-3720. 1-500. Order #PB2669 (English), Order #PB2670 (Spanish). (Fee).

**You Can Make A Difference When It Comes to Breast Cancer (Pamphlet).** Copies of this publication are available from EPA Associates, 1 West Campbell Ave., Ste 40, Campbell, CA 95008-1039. 408-374-3720. 1-500. Order #PB2592 (English), Order #PB2593 (Spanish). (Fee).

## Resources: Women's Health

**African American Breast Cancer Alliance (AABCA)** was founded by Black women who have had breast cancer. AABCA is a member-supported advocacy group for women with breast cancer, their families and the Black community. Contact: PO Box 8981; Minneapolis, MN 55408, 612-825-3675.

**American Menopause Foundation, Inc.** provides support and assistance on issues concerning menopause. Contact: 350 Fifth Ave., Ste. 2822; New York, NY 10118, 212-714-2398, Fax 212-714-1252.

**Camden City Hispanic Women's Resource Center, Hispanic Health and Mental Health Association of Southern New Jersey**, has been designed with the purpose of helping the Camden City Hispanic women develop different skills. The services include counseling; education; assessment and training; pre-employment preparation; job development and placement; and information on supportive services such as transportation, allowances, books, arrangements for child care, and emergency loan fund. Contact: 2700 West Field Ave.; Camden, NJ 08105, 609-365-7393.

**Caribbean Women's Health Association, Inc. (CWAH)** was established to inform, educate, and mobilize the public of crucial health related issues affecting the Caribbean Community. Contact: 2725 Church Ave.; Brooklyn, NY 11226, 718-826-2942.

**Consortium For Young Women** was formed as a cooperative network of girls/young women serving organizations and individuals to address the unmet needs of females ages 5-25. The Consortium provides a range of coordinated programs and services to benefit a multi-ethnic population of young women in cultural arts, education, employment, health, and recreation. Contact: PO Box 51085; East Palo Alto, CA 94303, 415-323-8500.

**Endometriosis Association** is a self-help organization of women with endometriosis and others interested in exchanging information about endometriosis, offering mutual support and help to those affected by endometriosis, educating the public and medical community about the disease, and promoting research related to endometriosis. Contact: 8585 North 76th Place; Milwaukee, WI 53223, 414-355-2200, 800-992-3636.

**Helping Our Women (HOW)** is a non-profit resource and referral center for women with chronic and life threatening illness. Contact: PO Box 1376; Provincetown, MA 02657, 508-487-4357

**Hispanic Women's Health Support Group** provides the format for addressing health-related issues relevant to Hispanic women. Contact: PO Box 5891; Bridgeport, CT 06610-0891, 203-367-5091.

**Lyon-Martin Women's Health Services** provides quality, affordable, non-judgmental, comprehensive health care for women by women. Lyon-Martin is committed to serving all women: with a focus on lesbians and special outreach to women of color, low-income, older women, and women with disabilities. Contact: 1748 Market St., Ste 201, San Francisco, CA 94102, 415-565-7667; 415-565-7683 (TDD).

**Melpomene Institute for Women's Health Research** is a nonprofit, membership organization that helps girls and women of all ages link physical activity and health through research, publication and education. Contact: 1010 University Ave.; St. Paul, MN 55104, 612-642-1951; (fax) 612-642-1871; Web site: <http://www.melpomene.org>.

**National Asian Women's Health Organization (NAWHO)** is a non-profit, community-based health advocacy organization committed to improving the overall health status of Asian women and girls. Contact: 250 Montgomery St., Ste 410; San Francisco, CA 94104, 415-989-9747; (fax) 415-989-9758; e-mail: [nawho@aol.com](mailto:nawho@aol.com).

**National Black Women's Health Project (NBWHP)**, a health advocacy organization, is committed to improving the health status of Black women through self-help and empowerment. Contact: 1211 Connecticut Ave., NW, Washington, DC 20005, 202-835-0117; (fax) 202-833-8790.

**National Center for Education in Maternal and Child Health** leads a national effort to collect, develop, and disseminate information and educational materials on maternal and child health. Contact: 2000 15th St., North, Ste 701; Arlington, VA 22201-2617, 703-524-7802; ; e-mail: [info@ncemch.org](mailto:info@ncemch.org); Website: <http://www.ncemch.org>.

**Resource for Health Policy Information on the Internet**  
The Kaiser Family Foundation Web site now features the "Daily Reproductive Health Report" and the "Daily HIV/AIDS Report." The reports are designed to keep the public in touch with the latest reproductive health and HIV news—highlighting legislative, political, legal, scientific and business developments. The site also lists upcoming events and conferences on reproductive health and HIV/AIDS issues. Browse the site at: <http://www.kff.org>.

**National Latina Health Organization/Organizacion Nacional de la Salud de la Mujer Latina (NLHO)** combines direct service program approaches with a strong public policy/public education and health advocacy component. Contact: PO Box 7567; Oakland, CA 94601, 510-534-1362; (fax) 510-534-1364.

**National Latina Institute for Reproductive Health (NLIRH)** enhances the quality of life of Latinas nationwide, especially their reproductive health, through advocacy; networking; impacting public policy; and information, education, and communication. Contact: 1200 New York Ave., NW, Ste 300; Washington, DC 20005, 202-326-8970. (fax) 202-371-8112.

**National Women's Health Network** provides up-to-date information on women's health issues, and seeks to protect the health of women by providing information on the risks of certain medications, and the on the latest research on cancer and birth control methods. Contact: 514 10th St., NW, Ste 400; Washington, DC 20004, 202-347-1140.

**National Women's Health Resource Center (NWHRC)** is a national clearinghouse for women's health information, providing women with comprehensive information to help them make informed decisions about health-related options. Contact: 5255 Loughboro Rd., NW; Washington, DC 20016, 202-537-4015; <http://www.healthywomen.org>.

**National Women's Resource Center for the Prevention and Treatment of Alcohol, Tobacco, and Other Drug Abuse and Mental Illness** provides information about alcohol, tobacco, and other drug abuse and mental illness services for women. Contact: 515 King St., Ste 410; Alexandria, VA 22314, 800-354-8824, 703-836-8761, (fax) 703-836-7256; Web site: <http://www.nwrc.org>

**Native American Women's Health Education Resource Center. Native American Community Board** offers health education information and activities for women, and provides a facility in which women can organize around issues of concern and consciousness raising. Contact: PO Box 572; Lake Andes, SD 57356, 605-487-7072.

### **Controlling High Blood Pressure**

The Alliance for Aging Research and the National Heart, Lung, and Blood Institute have put together an easy-to-read guide for older women on controlling high blood pressure. The publication, *Controlling High Blood Pressure: A Guide for Older Women*, can be ordered in English or Spanish by calling 1-800-282-9126. The *Health for Your Heart* publication, (*Salud para Corazón*), can also be obtained by calling 1-800-282-9126.

**New Self-Care Guide Addresses Women's Issues**  
The American Institute for Preventive Medicine has developed the "HealthLife Women's Self-Care Guide," which enables women to make informed decisions about their health. By presenting 25 of the most common women's health problems, the guide allows women to chart a course toward good health and easier medical decision making. Contact: 30445 Northwestern Hwy., Ste. 350, Farmington Hills, MI 48334; 810-539-1800.

**New Mexico Commission on the Status of Women** is a state agency dedicated to providing information, recognition, referral, and advocacy for women, particularly displaced homemakers. Contact: 2401 12th St. NW-207N; Albuquerque, NM 87104, 505-841-8920, 1-800-432-9168.

**Office on Women's Health (OWH), Department of Health and Human Services** is the government's champion and focal point for women's health issues works to redress inequities in research, health care services, and education that have placed the health of women at risk. Contact: 200 Independence Ave., SW, Rm. 730B; Washington, DC 20201, 202-690-7650, (fax) 202-690-7172.

**The Philadelphia Black Women's Health Project (PBWHP)** is a community based non-profit organization dedicated to promoting women's involvement in their personal health care as well as that of their loved ones. Contact: 1231 North Broad St., Rm 3G; Philadelphia, PA 19122, 215-232-1115, (fax) 215-232-2847.

**Women in Crisis, Inc.** provides HIV/AIDS prevention programming, education, training and resource materials primarily targeted to Black and Latina women and their families. Contact: 360 West 125th St.; New York, NY 10027, 212-316-5200

**The Women's Center** is a comprehensive resource for women and families in the Washington, DC metropolitan area. The Center responds to more than 80,000 requests each year for psychotherapy, career, financial and legal counseling, educational and referral services. Contact: 133 Park St., NE; Vienna, VA 22180, 703-281-2657.

**Women's Health Information Network (WIN), Asian Pacific Islander American Health Forum.** WIN was designed to disseminate health and health care information to low-income, Asian and Pacific Islander (A/PI) women in California so they can make informed choices about accessing health care services. The goal of the WIN project is to improve access to health care to underserved segments of A/PI women and their families in California. Contact: 942 Market St., San Francisco, CA 94102, 415-954-9988.

**DEPARTMENT OF  
HEALTH & HUMAN SERVICES**  
Public Health Service  
Office of Minority Health Resource Center  
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## *Closing the Gap*

### Meetings & Conferences: 1998

**Jul. 31-Aug. 2:** "Clinicians and Domestic Violence: Victim or Victor?" held in Arlington, VA, sponsored by the Clinical Regional Advisory Network. Contact the NWHIC at 1-800-994-9662.

**Aug (TBA):** "Domestic Violence: A Public Health Issue," sponsored by the Missouri Department of Health. Held at three sites in Kansas City, St. Louis and mid-Missouri, and will be up-linked to multiple sites around the state. Call NWHIC, 1-800-994-9662.

**Sept. 9-12:** 2nd Annual Rural HIV/AIDS conference held in Albuquerque, NM. Sponsored by National Rural Health Association. Contact: (816) 756-3140.

**Sept. 16-19:** The North American Menopause Society 9th Annual Meeting in Toronto, Canada. Contact: (216) 844-8748.

**Sept. 21-23:** National Conference on the Family, Addictions and Relationships in New Orleans, LA. Sponsored by the Institute for Integral Development. Contact: (719) 634-7943.

**Oct. 28-31:** Fifth Biennial Texas-Mexico Border Health Symposium, "Projects that Work," sponsored by the University of Texas System. The symposium will be held on South Padre Island, TX. Contact: (956) 381-3687.

**Nov. 6-8:** Older Women's League National Convention, "Bridging Generations: OWL 2000 and Beyond," held in Washington, DC. Contact: (202) 783-6686, ext. 220.

**Nov. 12-15:** National Perinatal Association Annual Clinical Conference & Exposition, "Caring for Community/The Horizon for Health," held in Providence, RI. Contact (813) 971-1008.

**Dec. 6-9:** National STD Prevention Conference held in Dallas, TX, sponsored by the Centers for Disease Control and Prevention. Contact the CDC at (404) 639-8260.