



HEALTHY WOMAN

News from the Office of Women's Health

Illinois Department of Public Health • Rod R. Blagojevich, Governor • Eric E. Whitaker, M.D., M.P.H., Director

Health Concerns of Special Populations

Winter 2005

Overview – The Face of a Changing Illinois Population

Over the past 10 years, the population of Illinois has become increasingly diverse, with the percentage of racial/ethnic minorities steadily increasing, while the percentage of the majority Caucasian population steadily decreases. In Illinois, 12.3 percent of the population was foreign-born in 2000 (up 61 percent from 1990), compared to 11.1 percent of the U.S. population¹; in 2003, nearly 15 percent of the Illinois population was foreign-born with approximately 40,000 new arrivals each year.² Also, in Illinois, 19.2 percent of the population speak a language other than English in the home, compared to 17.9 percent in the United States.³ Immigrants come from almost 200 countries and speak more than 100 languages.⁴ Hispanics represent the fastest growing racial/ethnic group in Illinois; the growth expected to continue into the next decade.⁵ All counties in Illinois saw their Hispanic population increase during the 1990s and 99 percent of Illinois counties saw growth in the Asian population.⁶

This great diversity has many implications for the health care system. Increasingly, there is a need to tailor women's health programs so that they are culturally and linguistically appropriate to the needs of the specific populations being targeted for these programs. These women face many barriers as they attempt to access the health care system.

Mortality Differences

Health care workers must be aware that differences exist in the types of health issues that are of greatest concern to minority populations. The rate of death from all causes in Illinois differs between racial/ethnic groups with African-American women having the highest rate per 100,000 at 972.1, whites having the second highest rate at 714.5, while Hispanics and Asian American/Pacific Islanders have lower rates at 486.5 and 353.2, respectively. The leading causes of death differ a bit among the various racial/ethnic groups⁷ (See Table 3). Life expectancy also differs among the groups. In the United States, Hispanic women have the greatest life expectancy at 83.0 years, followed by Asian-American women at 81.5 years, white women at 79.9 years and African-American women at 74.7 years.⁸

Table 1. Race/Ethnicity Profile of Illinois Population; 1990 and 2000

Race/Ethnicity	1990 Percentage	2000 Percentage	Change Percentage
Non-Hispanic White	74.8	67.8	- 7.0
Black or African American	14.8	15.1	+ 0.3
Hispanic or Latino (any race) †	7.9	12.3	+ 4.4
Asian ††	2.5	3.4	+ 0.9
American Indian and Alaska Native	0.2	0.2	-
Native Hawaiian or other Pacific Islander	Z	Z	-
Two or more races	1.9	Z	+1.9

Z Number greater than zero, but less than one-half unit of measure.

† The largest Hispanic or Latino groups are Mexican (9.2 percent), Puerto Rican (1.3 percent) and Central American (0.3 percent).

†† The largest Asian groups in Illinois are Asian Indian (1.0 percent), Filipino (0.7 percent), Chinese (0.6 percent), Korean (0.4 percent), Japanese (0.2 percent) and Vietnamese (0.2 percent).

Source: U.S. Bureau of the Census, Census 2000

Table 2. County Rankings by Percentage Foreign Born

	Total Population	Percent Foreign Born
Cook	5,376,741	19.8
Kane	404,119	15.7
DuPage	904,161	15.3
Lake	644,356	14.8
Champaign	179,669	8.0
Cass	13,695	7.8
Boone	41,786	7.5
McHenry	260,077	7.2
Will	502,266	7.1
Winnebago	278,418	6.1

Source: U.S. Bureau of the Census, Census 2000

Major Health Concerns of Special Populations

African-American Women

African-American women have the highest mortality rate among Illinois females for all of the top five disease killers. Death rates among African Americans in Illinois are 38 percent higher for **heart disease** and 38 percent higher for **stroke** than the corresponding rates for whites.⁹ Factors contributing to such high rates of heart disease and stroke include the fact that 33 percent of Illinois African-American women have high blood pressure, 21 percent smoke and 35 percent of women age 20 and older are obese. In addition, 39 percent of Illinois African-American women do not get any leisure-time physical activity and only 77 percent have had their cholesterol screened in the past five years.¹⁰

Though African-American women in the United States have lower rates of **breast cancer** than do white women, they have the highest mortality rate from breast cancer of all population groups at 34.9 per 100,000. In Illinois, the breast cancer mortality rate for African-American women is approximately 36 percent higher than for white women.¹¹ This may be because tumors are often found at a later, more advanced stage or patients may not follow up after receiving abnormal test results. Obese women may have more difficulty noticing a lump or problems with accessing mammography services. Likewise, Illinois African-American women are also almost twice as likely as white women to be diagnosed with **cervical cancer** and almost three times more likely to die of the disease than white women.¹²

Diabetes is also a big killer of African-American women. African-American women in Illinois are more

likely to be diagnosed with diabetes when compared to whites of the same age (12 percent of blacks vs. 8 percent of whites)¹³ and are 1.8 times more likely to die of the disease.¹⁴ Factors contributing to diabetes include overweight/obesity and lack of physical activity as described in the previous section on heart disease.

Another major health issue for African-American women is **HIV/AIDS**. As of December 2000, African-American women in Illinois accounted for 72 percent of all AIDS cases among Illinois women, though they make up only 15 percent of the Illinois female population. The death rate from AIDS in African-American women in the United States is the highest of any group of American women at 13 per 100,000. In contrast, the death rate for white women was less than one death per 100,000.¹⁵ The two major forms of HIV transmission reported by Illinois women with AIDS in 2002 was heterosexual exposure (53 percent) and intravenous (IV) drug use (31 percent).¹⁶

Hispanic Women

Though Hispanic women in Illinois have lower rates of **heart disease** than black or white women, high rates of obesity (28 percent), physical inactivity (45 percent), and elevated blood pressure and cholesterol contribute to the disease. Only 64 percent of Hispanic women had their cholesterol screened in the past five years to detect the problem early so that preventive measures could be taken.¹⁷

Diabetes is a major health issue for Hispanic women. In Illinois, Hispanic women are 1.4 times more likely to have a diabetes-related death than whites.¹⁸ A greater percentage of Hispanic women in Illinois (16 percent) are diagnosed with the disease than any other group of women.¹⁹

Table 3. Five Leading Causes of Death and Mortality Rates (in parenthesis), Illinois Females, 2000

Non-Hispanic White	African American/Black	Hispanic	Asian American/ Pacific Islander
<i>All causes (714.5)</i>	<i>All causes (972.1)</i>	<i>All causes (486.5)</i>	<i>All causes (353.2)</i>
Heart Disease (207.3)	Heart Disease (291.7)	Heart Disease (130.9)	Heart Disease (105.4)
Cancer (174.9)	Cancer (220.3)	Cancer (98.7)	Cancer (81.0)
Chronic Lower Respiratory Disease (age 45 and over) (102.5)	Diabetes-related (109.6)	Diabetes-related (86.2)	Diabetes-related (49.0)
Diabetes-related (62.0)	Stroke (69.1)	Chronic Lower Respiratory Disease (age 45 and over) (39.5)	Stroke (38.5)
Stroke (57.6)	Chronic Lower Respiratory Disease (age 45 and over) (68.7)	Stroke (39.5)	Chronic Lower Respiratory Disease (age 45 and over) (25.5)

Source: Brett, K.M. and Haynes, S.G., *Women's Health and Mortality Chartbook, Healthy Women: State Trends in Health and Mortality*, U.S. Department of Health and Human Services and the U.S. Centers for Disease Control, August 2004

Hispanic women in the United States have the highest lifetime prevalence of *depression* (24 percent) among women. Hispanic teenagers are twice as likely (19 percent) to attempt suicide than either African-American (8 percent) or white (9 percent) girls.²⁰

Asian/Pacific Islander Women

In Illinois, Asian/Pacific Islander (API) women have the lowest rates of *heart disease* among women. However, it is still the leading cause of death for these women. In addition, there was variation in mortality rates in certain Illinois API groups such as Asian Indian and Vietnamese who had cardiovascular mortality rates approaching that of whites. Factors that may contribute to heart disease in Illinois API women include a lack of physical activity in approximately 44 percent of these women. Also, 27 percent of API women in the United States had not had a blood pressure screening in the past 12 months.²¹ Though stroke mortality rates for the Illinois API population in general are lower than for whites, stroke mortality for Vietnamese and Koreans surpasses that of whites.²²

Cancer mortality rates are especially high in Illinois API women. Among these women, cancers of the stomach, liver and intrahepatic bile duct were significantly higher than for their white counterparts.²³ A main issue with regard to cancer mortality in this group is the fact that API women have the lowest screening rates among the major racial/ethnic groups. Often API women only seek health care when they are very ill, after they have first tried herbal remedies. Only 72 percent had received a Pap smear in the past three years, which is the lowest percentage among all racial/ethnic groups.²⁴

Suicide is a major issue for API women in the United States. In 2000, API women had the second highest rate of suicide at 3.0 per 100,000 following American Indian/Alaska Native women. API women 65 years of age and older had the highest rate of all women at 5.4.²⁵ API women have a tendency to internalize conflicts, which may lead to mental health issues and suicide. These women are expected to resolve these issues on their own and therefore often do not seek help.

Access To Care Issues

Minority women face many barriers to accessing quality health care. Some of the major barriers are described below. However, it is important to note that the following are generalizations only; each person's experience is unique. Some or all of the barriers may occur in any given situation.

Low Income and Low Education Level

While minority women are found in all socioeconomic levels, they are more likely to have low incomes and to live in poverty than are white women. In addition, they often have less formal education and thus, as a whole, have lower paying jobs than their white counterparts and experience higher unemployment rates. In 2003, 24 percent of African-Americans were in poverty in the United States, followed by 23 percent of Hispanics, 12 percent of Asians and 8 percent of whites.²⁶

Lack of Health Insurance

In Illinois, Hispanic women have the lowest rate of health insurance at just under 70 percent, followed by black women at 81 percent. In contrast, more than 90 percent of Illinois whites and Asian/Pacific Islander women have health insurance.²⁷ Those without health insurance often wait until a situation is critical before they seek health services. They tend to go to emergency rooms more frequently than others, since the situation is often critical by the time they seek help and since emergency rooms will not turn them away. Health issues that may have been successfully treated if identified earlier are often found at a later stage when they are more difficult to treat or when it is impossible to prevent mortality.

Reasons for lower health insurance rates among these groups include higher rates of unemployment, lower income, lack of documentation and a five-year waiting period for eligibility for Medicaid for legal immigrants who entered the United States after August 22, 1996.

Non-Citizens Lacking Documentation

Immigrants who enter the country illegally lack a Social Security number and other documentation necessary to access health services or to acquire health insurance. Even where clinics accept undocumented persons, many fear that residential or other information will be shared with federal immigration authorities and that they will be deported. Due to this fear, many do not even try to access services.

In addition, there are many mixed status families where some family members have documentation, while others do not. This can mean that even those with proper documentation do not receive services. For example, a mother who is undocumented may have a child who is eligible to be covered by KidCare. However, she may never fill out the KidCare application for her child, since she is afraid that her information may be needed to apply and that this information will be shared with immigration authorities.

Language Barrier

Issues of language are among the most prevalent barriers keeping immigrants and refugees from receiving adequate health services. In many instances, staff members who are not fluent in the language or family members are asked to translate medical information given by a physician to a patient. When this occurs, medical treatment is compromised. For instance, a teenage son or daughter may be asked to convey to his/her mother that she has breast cancer. In this case, the child may not fully translate the information so as not to upset the parent or because it may be inappropriate to discuss the breast in their culture. The teenager is placed in a very difficult and stressful situation and may not convey the information adequately. Situations such as these are far too common in the health care system. For example, a study conducted by the National Council of La Raza revealed that less than half of Spanish-speaking Latinos are provided with adequate interpretation services and about half report communication problems with physicians as being a barrier to accessing health care.²⁸

Title VI of the 1964 Civil Rights Act (68 FR 47311) stipulates the following:

“No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” The Language Assistance to Persons with Limited English Proficiency Guidance under Title VI states that any state or local agency, private institution or organization, or any public or private individual that 1) provides health, or social service programs, and 2) receives funding from the U.S. Department of Health and Human Services directly or through another recipient/covered entity must ensure that people with limited English proficiency (LEP) have meaningful access to their health service programs and activities by providing language assistance services.²⁹

The Illinois Language Assistance Services Act (210 ILCS 87/10) makes the provision of language assistance to persons with limited English proficiency mandatory under penalty of a fine (\$100 to \$250 per violation).

It is important that those hired or contracted to give language assistance have adequate training or are accredited in cross-cultural medical language.

Translation of written documents may vary depending on the size of the population being served and the size of the agency or provider. As part of its overall language assistance program, an agency or provider must develop and implement a plan to provide written materials in languages other than English to communicate effectively. However, even when written translations are not dictated by need, agencies and providers must still provide oral interpretation of written documents, if necessary, to ensure meaningful access for persons of limited proficiency in English.

Here are some examples of practices that may violate state and federal laws concerning those with limited English proficiency (LEP):

- Providing services to LEP persons that are more limited in scope or are lower in quality than those provided to other persons;
- Subjecting LEP persons to unreasonable delays in the delivery of services;
- Limiting participation in a program or activity on the basis of English proficiency;
- Providing services to LEP persons that are not as effective as those provided to those who are proficient in English; or
- Failing to inform LEP persons of the right to receive free interpreter services and/or requiring LEP persons to provide their own interpreter.

Lack of Culturally Competent Staff

Many health facilities serving minority populations lack staff members who are culturally competent. In some cases, there is a need to employ staff of the same ethnicity or of the same gender to ensure that those patients feel comfortable enough to seek services. For example, women from some nations or religious groups do not feel that it is right to go to a male doctor and will not seek services if a female doctor is not available. In other cases, the patient may be willing to go to a provider who is not from her own culture, but the provider may talk down to the patient, or is not familiar about disease, cultural or other issues that affect health or self care in the culture. Therefore, the patient may not heed the physician's advice. For example, it may be necessary to allow the patient to incorporate some traditional practices from her culture (e.g., herbal remedies) along with modern medical procedures in order for the patient to agree to move forward with a procedure. It is also important for medical staff to understand that some diseases, such as mental illness or HIV, may be stigmatized by the cultural group; in such

circumstances, presenting the issue in an appropriate manner can mean the difference between the patient seeking or not seeking treatment.

Each organization should strive to implement structural changes and education to ensure that staff members are culturally competent (See next page on Assessing Your Organization's Cultural Competency).

Other

There are other factors that limit access to health care for many minority women:

- A mistrust of the health care system. Past experiences of abuse, such as with the syphilis trials in Tuskegee, have led many African Americans to fear clinical trials and refuse to participate. Since few minority women participate in research studies, resulting data on disease states or therapies are often inadequate or inaccurate for specific minority groups.
- Cultural values about health lead minority women to seek traditional, ancestral or spiritual healing first and Western medicine only when other interventions fail.
- Racial, ethnic, gender or other forms of discrimination can interfere with appropriate diagnosis and treatment.
- Lack of transport or child care.
- Lack of knowledge about existing services and resources or how to navigate the system. For instance, if a woman is accustomed to going to a clinic without an appointment in her country of origin, she may not understand the need to make an appointment, or why the doctor is not available on certain days.

Best Practices

Federally qualified health centers (FQHCs) have been a successful means of providing high quality care and cost-effective treatment to the underserved and underinsured. FQHCs include community health centers (CHCs), migrant health centers, health care for the homeless programs, public housing primary care programs, and urban Indian and tribal health centers that meet certain federal requirements and receive federal operating grants under Section 330 of the Public Health Service Act. There are 31 FQHCs in Illinois with 213 service delivery sites serving more than 646,000 patients.

One FQHC that has overcome many barriers to bring quality health services to the economically, linguistically and culturally disenfranchised is Alivio Medical Center. Alivio operates two health centers and a school-based clinic on Chicago's lower west and southwest sides, serving the

predominantly Latino neighborhoods of Pilsen, Little Village, Heart of Chicago and Back of the Yards. All of the staff working at Alivio, including all administrators, providers and technicians, etc., are bilingual and bicultural. Payment is on a sliding scale. Last year, the three facilities served 15,500 people. Services include perinatal, pediatrics, family and adult medicine, obstetrics, gynecology and midwifery, laboratory, nutrition classes and counseling, individual and family counseling, case management, Special Supplemental Nutrition Program for Women and Children (WIC) and KidCare enrollment.

Community members attest to the fact that they feel welcome at Alivio, whose staff treats them with dignity and respect. One way that Alivio has achieved success is through a program that trains and employs lay community health workers, or *promotoras de salud*, who act as liaisons between the health care provider and the community. Since they are residents of the community that Alivio reaches, they understand the need of the residents and the residents trust them. By sharing their own experiences and personal values and beliefs, *promotoras de salud* are instrumental in providing health education, removing the myths surrounding certain tests and conveying the importance of a healthy lifestyle.

For more information on FQHCs and lay health worker programs, contact –

Federally Qualified Health Center Information Resource

www.cms.hhs.gov/providers/fqhc/

Illinois Primary Health Care Association

312-692-3000 or 217-541-7300

www.iphca.org

For more detailed information on health disparities among racial and ethnic populations, please contact –

Illinois Department of Public Health

Center for Minority Affairs

217-782-4977

Institutes of Medicine (IOM) of the National Academies

202-334-2352

www.iom.edu

U.S. Department of Health and Human Services (U.S. DHHS)

202-619-0257 or Toll Free 1-877-696-6775

www.hhs.gov

Assess Your Organization's Cultural Competency

Following are some questions an organization should consider and address to improve the cultural competence of the organization and staff:

1. Do your board members and staff reflect the ethnic/cultural characteristics of the population you are serving?
2. Has the administration adopted a mission statement and goals that incorporate a commitment to ethnic/cultural competence and diversity at all levels of the organization?
3. To what degree are there strategies in place to actively recruit and retain a culturally diverse administration, management and support staff?
4. Are the ethnic and cultural practices of minority staff accommodated through a) time off for religious observance/holidays, b) dietary/cafeteria preferences, or c) other means?
5. Are staff members educated regarding the special needs and characteristics of the ethnic/cultural groups in the targeted community with regard to a) cultural beliefs, b) adherence to treatment regimens or dietary requirements, c) integration with patient preferences for alternative therapies, d) gender roles or e) other issues?
6. Is career development training or mentoring available to minority staff?
7. Are there adequate human resource policies and procedures in place to address concerns or complaints concerning unfair treatment in the area of ethnic/cultural issues?
8. Are there programs and activities that are ethnically/culturally appropriate to the minority groups the organization is reaching? Are these programs adequately funded?
9. What service linkages exist with community groups (e.g., community advocacy groups, local/state provider associations, ethnic/cultural newspapers/media, churches or business groups) for the minority group/groups the organization is servicing? Are these groups involved in decision making, planning and evaluation of the organization's services?
10. Do you have a policy for providing interpreters/translators who are trained/accredited in cross-cultural medical language? Are signs and other written materials available in the languages that are most commonly used by clients?
11. Do you have an organized way to collect data on the ethnic/cultural characteristics of patients/clients and their perception of your services?
12. Does your organization have programs designed to address the needs of hearing or sight-impaired patients or clients? For the physically disabled? For the mentally disabled? For gay/lesbian patients or clients?

Source: *The questions above were selected and adapted from "Conducting a Cultural Competence Self-Assessment" developed by Dennis Andrulis of the State University of New York Downstate Medical Center, Brooklyn, N.Y., in collaboration with Thomas Delbanco of the Beth Israel Deaconess Medical Center in Boston, Laura Avakian of the Massachusetts Institute of Technology in Boston and Yoku Shaw-Taylor of the Public Health Foundation in Washington, D.C.*

Sources

- ¹ U.S. Bureau of the Census, *Census 2000*.
- ² Siegel, W. and Kappaz, C., *Strengthening Illinois Immigrant Policy: Improving Health and Human Services for Immigrants and Refugees, Illinois Immigrant Policy Project, 2003*.
- ³ U.S. Bureau of the Census, *Census 2000*.
- ⁴ Siegel and Kappaz, 2003.
- ⁵ Ward, 2004; Herring, 2000.
- ⁶ Siegel and Kappaz, 2003.
- ⁷ Brett, K. and Haynes, S., *Women's Health and Mortality Chartbook: State Trends in Health and Mortality, U.S. Department of Health and Human Services (DHHS), U.S. Centers for Disease Control and Prevention, August 2004*.
- ⁸ *The Health of Minority Women, U.S. Department of Health and Human Services at www.4woman.gov*.
- ⁹ *Illinois Department of Public Health (IDPH), 1992*.
- ¹⁰ Brett, K. and Haynes, S., August 2004.
- ¹¹ IDPH, 2003.
- ¹² *Ibid.*
- ¹³ *National Women's Health Indicator Database, U.S. DHHS at www.4woman.gov*.
- ¹⁴ Brett, K. and Haynes, S., August 2004.
- ¹⁵ *The Health of Minority Women, U.S. DHHS*.
- ¹⁶ *National Women's Health Indicator Database, U.S. DHHS at www.4woman.gov*.
- ¹⁷ Brett, K. and Haynes, S., August 2004.
- ¹⁸ *Ibid.*
- ¹⁹ *National Women's Health Indicator Database, U.S. DHHS at www.4woman.gov*.
- ²⁰ Brett, K. and Haynes, S., August 2004.
- ²¹ *Ibid.*
- ²² IDPH, 1997.
- ²³ IDPH, 2000. *The data for stomach, liver and intrahepatic bile duct cancers must be interpreted cautiously because of the small sample size of this group.*
- ²⁴ Brett, K. and Haynes, S., August 2004.
- ²⁵ *The Health of Minority Women, U.S. DHHS at www.4woman.gov*.
- ²⁶ DeNavas, W., Proctor, B. and Mills, R., *Income, Poverty and Health Insurance Coverage in the United States: 2003, U.S. Census Bureau, 2004*.
- ²⁷ Brett, K. and Haynes, S., August 2004.
- ²⁸ *Hispanic Health Fact Sheet, National Council of La Raza, p. 4*.
- ²⁹ *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, U.S. Department of Health and Human Services on www.hhs.gov/ocr/lep/revisebledp.html*.
- ³⁰ *Language Assistance to Persons with Limited English Proficiency (LEP) Fact Sheet, U.S. Department of Health and Human Services*.



Governor Announces 2005 Women's Health Mini-Grants

Gov. Rod R. Blagojevich recently announced 26 women's health mini-grant awards to local health departments and community-based non-profit organizations totaling \$100,000. The grants will support community health awareness events or walking campaigns. Seventeen of the grantees will be hosting health awareness seminars that will focus on issues such as access to health care, breast and cervical cancer, depression, diabetes, heart disease, obesity/overweight, nutrition, physical activity, menopause, stress management, depression, anxiety, osteoporosis and sexual health. Nine of the grantees will be coordinating "Women Out Walking (WOW)" programs, which will set up teams of women who participate in a 12-week walking challenge. The majority of the mini-grants target specific minority groups. Below is a list of the women's health mini-grants for fiscal year 2005:

Women's Health Awareness Mini-Grants

Aurora Primary Care Consortium, Aurora (Hispanic)
 Chinese Mutual Aid Association, Chicago (Chinese)
 Department of Women's Justice Services, Chicago (African-American and Hispanic)
 Elizabeth Ann Seton Program, Springfield (Hispanic)
 Grundy County Health Department, Morris (Caucasian, some Hispanic)
 Korean American Community Services, Chicago (Korean)
 La Voz Latina, Rockford (Hispanic)
 Macon County Health Department, Decatur (White, some Hispanic)
 Montgomery County Health Department, Hillsboro (Caucasian)
 Ogle County Health Department, Oregon (Caucasian)
 Sinai Community Institute, Chicago (African-American)
 Soyland Access to Independent Living, Decatur (Hispanic)
 Springfield Department of Health, Springfield (Caucasian)
 St. James Hospital, Chicago Heights (African-American)
 Y-Me National Breast Cancer Organization, Chicago (African-American)
 YWCA of Alton, Alton (Caucasian, some Hispanic, some African-American)
 YWCA of Elgin (Laotian)

Women Out Walking (WOW) Mini-Grants

Arab American Family Services, Palos Hills (women of Arab descent)
 Cass County Health Department, Virginia (Caucasian, some Hispanic)
 Coles County Health Department, Charleston (Caucasian)
 Douglas County Health Department, Tuscola (Caucasian, some Hispanic)
 Lee County Health Department, Dixon (some Hispanic women)
 Provena Hospital, Aurora (Hispanic)
 Rock Island County Health Department, Rock Island (Caucasian primarily)
 Stephenson County Health Department, Freeport (some Hispanic)
 University of Illinois Extension – Schuyler County, Rushville (some Hispanic)



Illinois WISEWOMAN Program Serves 20 Counties

In 2001, the Illinois WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) program was funded as a cooperative agreement with the U.S. Centers for Disease Control and Prevention (CDC), the Illinois Department of Public Health's Office of Women's Health (IDPH-OWH), the University of Illinois at Chicago (UIC) and the Cooper Institute (CI) of Dallas, Texas. One of 15 such programs being funded by CDC in the nation, WISEWOMAN strives to improve the cardiovascular health of low-income women ages 40-64, who participate in the Illinois Breast and Cervical Cancer Program (IBCCP).

After the participants have been screened and are medically cleared to participate in the program, they are randomly selected to be in the intervention or the control group. Both the intervention and control group receive educational pamphlets about cardiovascular disease, nutrition and physical activity. In addition to the educational pamphlets and screenings, women in the intervention group participate in a 13-week innovative and interactive program with weekly sessions on nutrition and physical activity. In these weekly sessions, intervention participants learn how to improve their eating and physical activity habits, gain basic problem solving skills and learn goal setting and stress management skills as well as the importance of maintaining a supportive and healthy environment. The program is being offered in English and Spanish.

From December 2003 to June 2004, the Illinois WISEWOMAN program conducted a pilot project at the DuPage County Health Department in Wheaton. A total of 71 women (32 English participants and 39 Hispanic participants) were screened and received medical referrals if needed.

In November 2004, the Illinois WISEWOMAN program expanded to 19 additional counties through three new lead agencies: Fulton County Health Department, Stephenson County Health Department and St. Mary's Good Samaritan Hospital in Centralia.

WISEWOMAN staff are currently recruiting participants throughout the 20 counties for a new cycle of the program. For more information on the Illinois WISEWOMAN program, contact LaRhonda Williams at 217-524-6088.

New Women's Health Database Available

The U.S. Department of Health and Human Services has just made the National Women's Health Database available on the Internet: <www.4woman.gov>. It contains national, state and county level data and is an excellent resource.

New Osteoporosis Report and Materials from the U.S. Surgeon General Available

The U.S. Surgeon General's Report on Bone Health and Osteoporosis was released in October 2004 and can be found at this Website: <www.surgeongeneral.gov>.

Educational materials including a consumer appropriate booklet, Power Point presentation, fact sheets, posters and more also are available on the site.



SAVE THE DATES

May 8-14, 2005

National Women's Health Week

May 10, 2005

Women's Health Fair

James R. Thompson Center, Chicago

May 12, 2005

Women's Health Fair

Illinois State Capitol, Springfield

Healthy Woman newsletter is published quarterly by the ILLINOIS DEPARTMENT OF PUBLIC HEALTH. Story ideas, suggestions and comments are welcome and should be forwarded to Lisa Keeler, editor, Illinois Department of Public Health, Office of Women's Health, 535 W. Jefferson St., Springfield, IL 62761; or call 217-524-6088.

Rod R. Blagojevich, Governor
Eric E. Whitaker, M.D., M.P.H., Director
Illinois Department of Public Health
Sharon Green, Deputy Director
Office of Women's Health

Generally, articles in this newsletter may be reproduced in part or in whole by an individual or organization without permission, although credit should be given to the Illinois Department of Public Health. Articles reprinted in this newsletter may require permission from the original publisher.

The information provided in this newsletter is a public service. It is not intended to be a substitute for medical care or consultation with your health care provider and does not represent an endorsement by the Illinois Department of Public Health. To be included on the mailing list, call 1-888-522-1282.

TTY (hearing impaired use only),
call 1-800-547-0466