



**A COMPARISON OF FINDINGS FROM
COMMUNITY HEALTH SURVEYS:
2001 AND 2006**

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INTRODUCTION AND BACKGROUND

The No. 1 cause of death in the United States is heart disease. Coronary heart disease, stroke, diabetes and some types of cancers are related to lack of physical activity and poor food choices. Data of the 10 leading causes of death for African Americans was found to be similar to the 10 leading causes of death in the nation. Research has documented the increased risk of chronic diseases among minority populations (Smedley, Stith, and Nelson, 2003). Minorities experience a disproportionately higher rate of chronic disease than Caucasian Americans. Based on the evidence and research it can be determined that most chronic diseases are serious, costly and controllable. Closing the gap is critical to creating communities of people who will experience a better quality of life. The 10 most prevalent risk factors for chronic diseases (obesity, smoking, drinking, drug use, fatty diet, lack of physical exercise, stress, salt or sodium, untreated high blood pressure and uncontrolled diabetes) are frequently found in minority populations.

Research has demonstrated that historically, the church has been the initiator of activities that have benefited the African American community. In addition to social, economic and political issues emerging from African American churches, the initiation of health-related activities that recognize the risk factors associated with chronic diseases has also been addressed. Addressing health issues in minority populations is now recognized as a priority in health promotion and health education. A study by Lewis and Green (2002) on health beliefs, behaviors and attitudes of African Americans also suggests the faith community is already a community that has strong bonds and comes together regularly to share a common purpose. Numerous venues are being investigated for the delivery of successful and sustainable programming into the various minority communities. In the African American community, one of the major emerging venues for programming is through the utilization of the faith community. (DeHaven, Hunter, Wilder, Walton and Berry, 2004)

In 1997, a University of Nevada Cooperative Extension (UNCE) faculty member was interested in assessing the health needs of the African American population living in Clark County Nevada, and in comparing local findings to national statistics. Data on the health status of African Americans in Clark County and the state of Nevada were sorely lacking. Cooperative Extension faculty collaborated with a local health center and a Methodist church with a predominantly African American congregation to develop a needs assessment and create an awareness of health risk factors. A focus group of church members gave input and tested the assessment tool. Faculty met with the local ministerial alliance to seek support of the project and plan future education programs.

Ideally, an assessment of health issues would use a random sample of the target population. However, since the African American population is widely scattered throughout Clark County, any type of random selection would be difficult. Therefore, a convenience sample from congregations of predominately African American churches was used to recruit survey participants.

Over a period of four months, the assessment was administered in six churches during Sunday morning worship services and, at an additional church and at several other events. Of the 501 respondents, 87percent completed all questions. At five out of the seven churches, faculty administered the assessment and was present throughout the worship service. These five churches collected a greater percentage of completed assessments than the other two churches where church leaders administered the assessment on their own.

Responses related to family health history, education and income were omitted more often than other questions. A few respondents wrote comments stating these questions were “personal” or “private business.”

The following is a brief summary of the 1997 needs assessment findings for the 447 completed surveys.

DEMOGRAPHICS:

<u>Gender</u>	<u>%</u>	<u>Age</u>	<u>%</u>
Females	60.6	46 – 65	35.8
Males	26.8	Over 65	14.8
No response	12.5	No response	49.4
<u>Education</u>		<u>Income</u>	
< 12 years	25.4	<\$15,000	17%
> 12 years	74.6	\$15,001- 20,000	15%
		\$20,001-30,000	19%
		\$30, 001-40,000	11%
		>\$40,000+	15%
		No response	24%

*Responses may not add up to 100% due to rounding of numbers

HEALTH STATUS:

Self	%	Family %
*Hospitalization	37.8	
Hypertension	40.8	56.0
Heart Disease	20.7	29.5
Diabetes	18.3	25.7
Stroke	10.7	18.8
Cancer	9.5	23.5

*for chronic diseases

Risk Factors: Overweight reported by 55.5 percent.

Perceives Risks Eighty-seven percent believed eating habits affected health.

Ninety-four percent believed exercise to be important.

Twenty-six percent reported eating 5 servings of fruit and vegetables.

UNCE faculty met with the ministers of the seven churches and seven health-related agencies to discuss plans based on these findings. Ministers were given summaries of the responses from their individual churches. A coalition, Community Partners for Better Health (CPBH), was formed as a result of this meeting. The churches and health-related agencies agreed to partner in this action.

CPBH and UNCE faculty began to collaborate to present health education and prevention programs through churches. This collaboration led to a grant proposal submitted to the Centers for Disease Control and Prevention (CDC) for its initiative focusing on health disparities, Racial and Ethnic Approaches to Community Health (REACH) 2010. A grant was awarded in 2000 for the development of a Community Action Plan (CAP) to address cardiovascular disease in the African American population in Clark County. Development of the CAP included administration of a Community Health Survey in 2001. Church focus groups were conducted using the data from the Community Health Survey. The coalition then prioritized strategies to address cardiovascular disease and its risk factors.

A second grant award from CDC was received in September 2001 to implement the CAP. A second Community Health Survey was administered in 2006 after five years of intervention (now titled "The Healthy Hearts Project"). The 2006 survey was conducted to provide evidence of impact in the community from the interventions, to provide data for programming and to secure future grants and funding.

Methods

The 2001 Community Health Survey was developed by The Senator Alan Bible Center for Applied Research (SABCAR) at the University of Nevada, Reno (UNR). The survey was a collaborative effort of UNCE, CPBH and SABCAR. It was administered by the Cannon Survey Center at the University of Nevada, Las Vegas (UNLV) in 10 churches after morning worship services on two consecutive Sundays. The seven churches assessed in 1997 also participated in the 2001 Community Health Survey. One church preferred the survey be administered at a Bible Study Group instead of morning service. The results of this survey were used to develop the CAP, which became the blueprint for "The Healthy Hearts Project". The goal of this project was to increase awareness of cardiovascular disease risk factors and to promote health behavior changes to lower the risk of cardiovascular disease.

Toward the fifth year of The Healthy Hearts Project, UNCE and CPBH met with the Center for Program Evaluation (CPE) to discuss the need to evaluate the impact of the project. CPE, UNCE and CPBH worked together to revise the 2001 survey. The 2006 survey was administered by Community-Based Instructors of "The Healthy Hearts Project" in 15 churches over a period of four months. The 15 churches surveyed included 9 of the 10 surveyed in 2001. As in 2001, one church preferred to administer the survey during an evening Bible Study Group.

COMMUNITY HEALTH SURVEYS (CHS)

2001 N = 950

2006 N = 1370

Demographics

Gender

Table 1

Gender	2001	2006
Female	62.2%	64.1%
Male	25.7%	26.2%
No Response	12.1%	9.7%

In 2001, almost two-thirds (62 percent) of the sample were females and a slightly higher percentage (64 percent) were female in 2006. Over a quarter (26 percent) were males in both 2001 and 2006.

Age

The highest percentage of respondents reported their age between 55 and 64 years old in both years, but the mean age was slightly older in 2006 (mean = 50.2, 2001; mean = 51.4, 2006). In general, for both years, the largest age group represented, was those between 45 and 64 years of age.

Table 2

Age	2001	2006
18-24	5.1%	4.4%
25-34	9.3%	10.1%
35-44	17.6%	14.8%
45-54	18.7%	18.4%
55-64	20.7%	18.8%
65-74	13.3%	16.9%
75+	4.0%	4.8%
No Response	11.3%	11.8%

Table 3

Marital Status	2001	2006
Married	47.4%	42.6%
Divorced	16.8%	17.0%
Widowed	8.7%	9.4%
Separated	3.7%	4.2%
Unmarried Couple	12.3%	16.1%
Never Married	2.4%	1.7%
No Response	8.7%	9%

Marital Status

In both years, nearly half of the respondents were married, although the percentage was slightly smaller in 2006. Alternatively, a slightly larger percentage of respondents indicated they were part of an unmarried couple in 2006.

Education

In 2006, a higher percentage of respondents reported graduating from high school as their highest level of education and a higher percentage of respondents indicated earning a graduate degree.

Table 4

Education level	2001	2006
Elementary School	0.5%	1.1%
Junior High School	0.6%	2.8%
High School	29.2%	39.9%
College	32.7%	32.6%
Graduate Degree	8.7%	15.0%
No Response	28.3%	8.6%

Table 5

Employment*	2001	2006
Employed	52.9%	55.3%
Not working	5.4%	7.9%
Homemaker	3.9%	3.2%
Retired	22.7%	28.5%
Student	1.4%	3.5%
No Response	13.7%	1.6%

**2001 survey allowed one choice; 2006 survey allowed respondents to check all that applied*

Employment

A higher percentage reported being employed, not working, retired or a student than in 2001. This likely reflects the different response option in 2006, as the 2001 survey allowed one choice and the 2006 asked respondents to select all that applied.

Table 6

Household Income level	2001		2006
Less than \$10,000	8.1%	Less than \$10,000	10.0%
\$10,000-24,999	18.5%	\$10,000-24,999	14.5%
\$25,000-34,999	22.8%	\$25,000-39,999	22.6%
\$35,000-54,999	10.6%	\$40,000-54,999	14.5%
\$55,000-74,999	11.3%	\$55,000-69,999	10.2%
\$75,000+	11.8%	\$70,000+	13.0%
No Response	16.9%		15.2%

Income

While different response categories were used in 2006 as well, it appears a higher percentage of respondents reported higher levels of income. Finally, the sample was primarily African American in both years (83 percent, 2001; 88 percent, 2006) representing the target population.

Physical Status

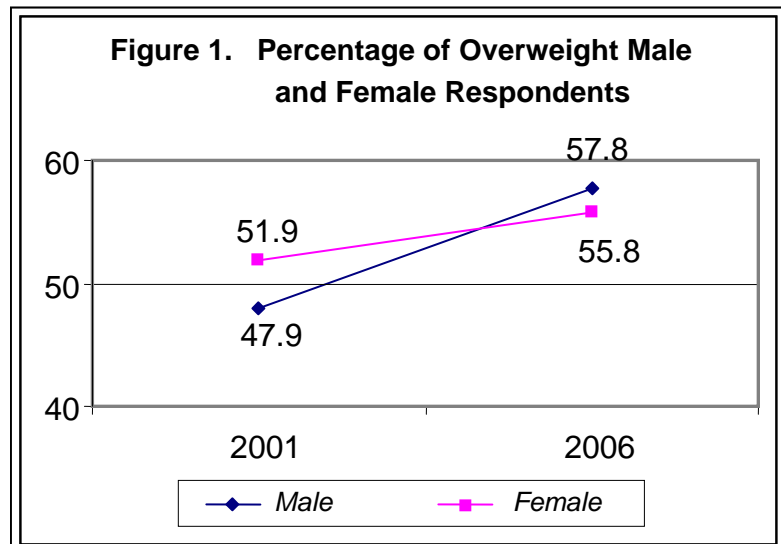
Table 7. Height, Weight, and BMI

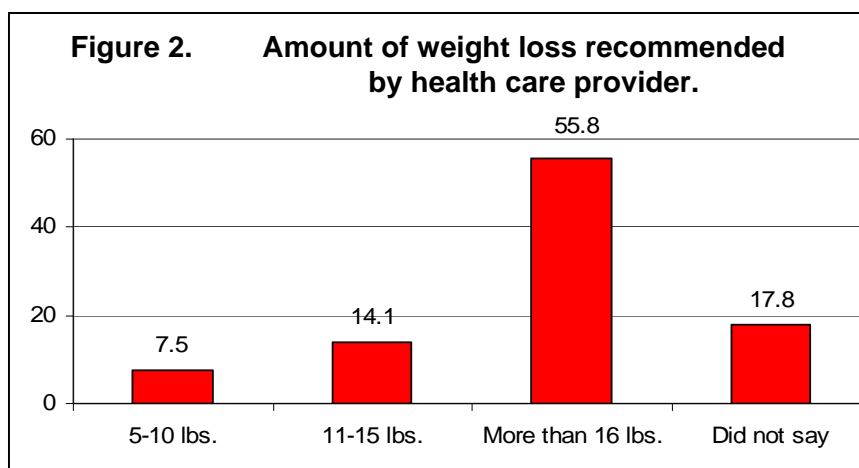
	2001			2006		
	All	Male	Female	All	Male	Female
Height	5'6"	5'11"	5'5"	5'6"	5'11"	5'5"
Weight	175	195	165	180	198	170
Mean BMI	28.7	28.5	28.8	29.7	29.3	29.8

Respondents were asked to report their height and weight without shoes. Body Mass Indexes (BMIs) were calculated using the formula used by the CDC. Based on self-reports, both the 2001 and 2006 samples reported the same mean heights, but the 2006 sample reported slightly heavier mean weight (Table 7, above). The mean BMI was also one full point higher in 2006 than in 2001. While both male and female participants' BMIs increased, greater percentages had BMIs indicating they were overweight. A greater percentage of male participants appeared to be overweight in 2006 than 2001.

Percentage Overweight Using BMI Measurements

Approximately 5 percent more female participants reported they were overweight in 2006 than in 2001. Almost 10 percent more male participants reported being overweight in 2006 compared to 2001. The percentage of overweight male participants surpassed the percentage of overweight female participants (Figure 1).





The 2006 survey included additional questions concerning weight. In 2006, almost half (41 percent) of the respondents indicated their doctor had told them they were overweight. For most, the doctor gave specific recommendations for how much weight they should lose (Figure 2) and the highest percentage (56 percent) indicated their doctor recommended losing more than 16 pounds. Most respondents (80 percent) indicated they are trying to lose weight and more than half (55 percent) reported they have exercised in the last month. Approximately the same percentage (53 percent) indicated they have changed their diet to lose weight.

Physical Activity

Table 8. Participation

	2001	2006
Participated in physical activity in the past month	59.3%	58.2%
*Participants trying to lose weight	66.0%	61.3%
Average number of times per week	3.78	3.52
*Participants trying to lose weight	3.72	3.43
Average amount of time spent each time	1 hr 9 min	1 hr 37 min
*Participants trying to lose weight	1 hr 5 min	1 hr 21 min

Questions about physical activity were included on both the 2001 and 2006 survey. Overall, physical activity participation did not change significantly from 2001 and 2006 (Table 8). Of those respondents trying to lose weight, a smaller percentage reported engaging in physical activity. The average number of times per week respondents exercised also decreased slightly in both the total sample and of those who indicated trying to lose weight. However, the average time spent engaged in physical activity did increase slightly from 2001 to 2006.

Lifestyle Behavior

Table 9. Smoking Behaviors and Alcohol Use

Smoking frequency	2001	2006
Smoke every day	11.3%	9.1%
Smoke some days	5.2%	4.6%
Not at all	73.0%	79.3%
Trying to quit	2001	2006
Smokers who smoke every day	63.0%	62.3%
Smokers who smoke some days	29.3%	33.3%
Alcohol use in the past 30 days	2001	2006
One or more drinks	40.0%	32.9%
Average number of drinks	1.85	1.88
Number of times respondent had 5 or more drinks	1.48	1.48

Questions about respondents' smoking and alcohol use were also included on both the 2001 and 2006 surveys. A slightly larger percentage of respondents indicated they did not smoke at all in 2006 than in 2001, but approximately the same percentage reported trying to quit smoking (Table 9, above).

Access to Health Care

The 2006 version asked about respondent access to health care providers. They were asked to mark which barriers have prevented them from seeing a health care provider within the past year, if any (Table 10). More than half indicated none of these barriers applied and 23 percent did not respond. The largest barrier was lack of insurance (10 percent) followed by financial reasons (9 percent) including not being able to afford the co-pay or meet the deductible.

Table 10. Access to Health Care Check-Ups

Barriers	2006
Lack of transportation	2.6%
Lack of insurance	9.7%
Physician was not available	2.6%
Finances (co-pay, deductible)	8.5%
Other	3.6%
None	56.3%
No Response	23.0%

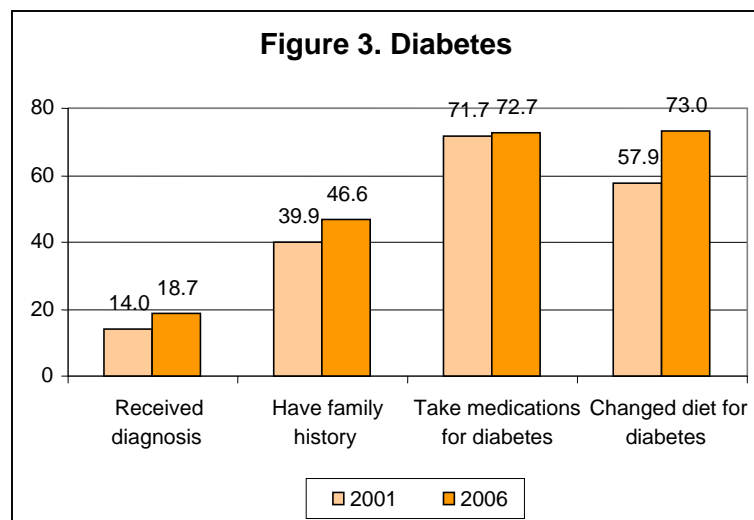
*Participants were able to check more than one response

Health Care Insurance

The percentage of respondents reporting they have health insurance remained virtually unchanged from 2001 to 2006. However, the percentage of respondents who indicated they did *not* have health insurance increased 2% (Table 11). Remaining respondents did not respond.

Table 11. Health care insurance coverage

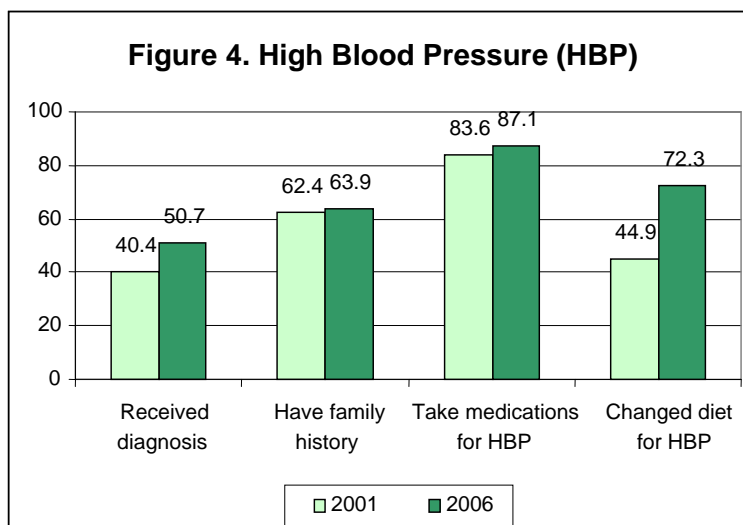
Health Care Insurance	2001	2006
Yes	78.4%	79.1%
None	8.4%	10.4%
No Response	13.2%	10.5%

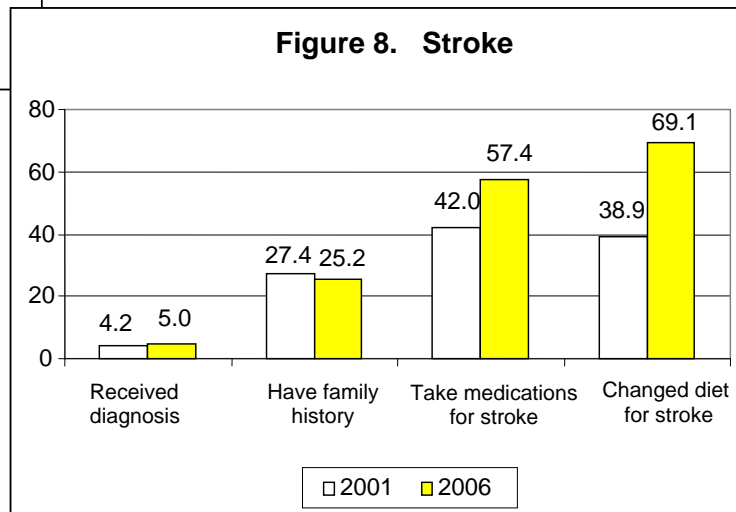
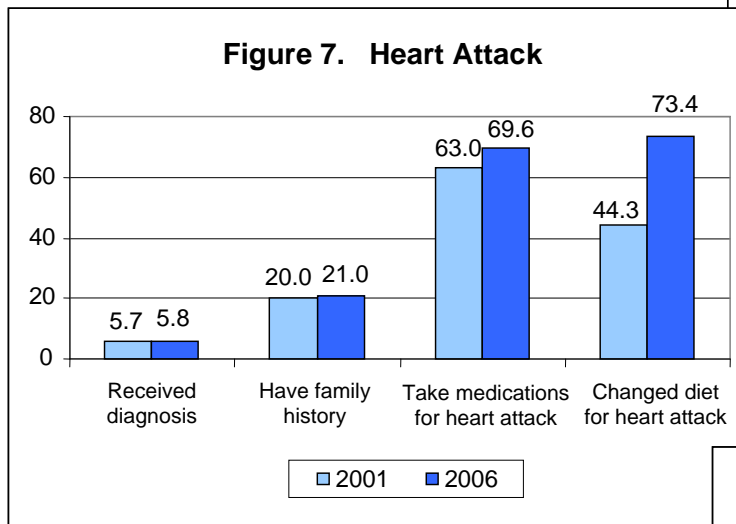
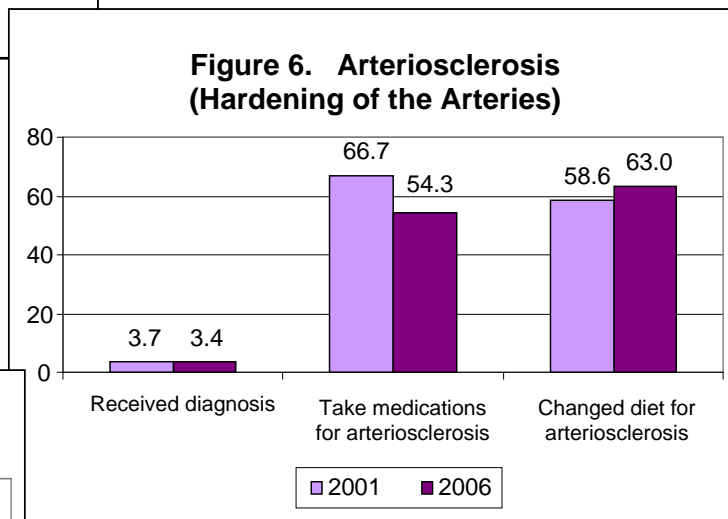
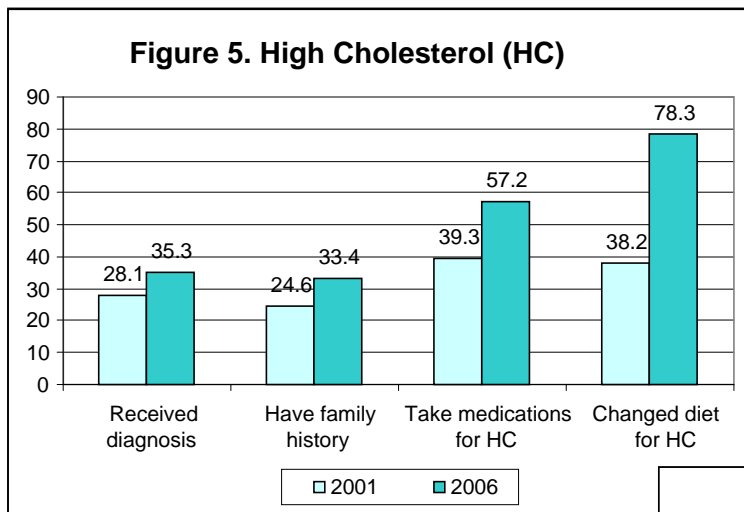


Diagnosed Health Conditions

Respondents were asked to indicate if they have ever been diagnosed with diabetes, high blood pressure, high cholesterol, arteriosclerosis (hardening of the arteries), a heart attack or a stroke (Figures 3-8). They were also asked if they had a family history of the disease (except arteriosclerosis), if they were taking medication and if they had

changed their diet for each of these conditions. The percentage reporting they had received a diagnosis for diabetes, high blood pressure and high cholesterol from 2001 to 2006 increased, as did their reports of their family history. Reports of taking medication did not change noticeably across the conditions. A greater percentage of respondents did report changing their diet for each condition, but this is likely due to a major change in the way the question was worded in 2006.





The Healthy Hearts Project Programs and Activities

To help determine which programs and activities would best fit the need within the community, the 2001 survey asked how likely it would be for participants to participate in a variety of activities and programs. These responses were used to design “The Healthy Hearts Project”. The 2006 version of the survey asked about actual participation in the same categories of activities and programs, including all of the specific Healthy Hearts programs and activities implemented between 2001 and 2006. The following section reports the likelihood of participation based on 2001 responses and actual participation in the various activities in 2006.

Exercise Classes. Almost half of the respondents said they would be very likely to engage in some form of exercise class in 2001 (Table 11). In 2006, more than one-fourth indicated they had participated in some form of exercise class with other respondents mentioning specific Healthy Hearts physical activities.

Table 12. Exercise Class Participation

Likelihood of Participation	2001
Very Likely	44.0%
Participation in Exercise Classes	2006
*Tour de Church Walking Club	7.8%
*Git.Fit. Exercise Program	14.4%
*Blast with a Splash! (Aquacize)	4.0%
Other Exercise Classes	26.2%

*The Healthy Hearts Project

Table 13. Stress Reduction/Management Class Participation

Likelihood of Participation	2001
Stress Reduction Classes—Very Likely	24.2%
Stress Management Classes—Very Likely	23.7%
Participation in Stress Reduction/ Stress Management Classes	2006
*Tone Stretch Relax Classes	11.8%
Other Stress Reduction Classes	9.2%
Stress Management Classes	9.4%

*The Healthy Hearts Project

Stress Reduction and Management. The survey also addressed potential programs related to stress reduction and management (Table 13). Almost one-half of the respondents indicated they would be very likely to participate in a stress reduction or management class, and approximately 30.4 percent indicated they have participated in a stress reduction class. Since the 2006 survey, “The Healthy Hearts Project” has added an additional

stress reduction class, but this class was not included on the 2006 survey as it was still in the planning phase and had not yet been implemented.

Diabetes. More than 20 percent of the respondents indicated they were very likely to participate in a workshop or seminar on diabetes and about 20 percent actually participated in The Healthy Hearts Project diabetes workshop or some other class related to diabetes (Table 14).

Table 14. Diabetes Class Participation

Likelihood of Participation	2001
Very Likely	21.1%
Participation in Classes	
*Ounce of Prevention Diabetes Class	9.9%
Other Diabetes Classes	9.6%

*The Healthy Hearts Project

Table 15. High Blood Pressure Class Participation

Likelihood of Participation	2001
Very Likely	26.4%
Participation in Classes	
*Hypertension: Stop it! Control it! Class	10.7%
Other High Blood Pressure Classes	11.7%

*The Healthy Hearts Project

High Blood Pressure. More than 25 percent of the respondents indicated they were very likely to participate in a workshop or class on high blood pressure and just over 22.4 percent participated in “The Healthy Hearts Project” class on high blood pressure or some other relevant class (Table 15).

Low Fat/Salt Food Preparation Courses. More than one-fourth indicated they were very likely to participate in a class on preparing low fat and low salt foods and more than 28 percent indicated they had participated in such a class, including “The Healthy Hearts Project” class (Table 16).

Table 16. Low Fat/Salt Food Preparation Class Participation

Likelihood of Participation	2001
Very Likely	26.3%
Participation in Classes	
*Food for Health and Soul class	13.3%
Other healthy food preparation classes	14.6%

*The Healthy Hearts Project

Lectures/Seminars about Lifestyle Changes. Other activities in which respondents expressed an interest included lectures or seminars regarding overall lifestyle changes. Almost one-third of the 2001 respondents indicated they would be very likely to participate in such an opportunity and about 27 percent had participated in at least one of such opportunities, including two sponsored by The Healthy Hearts Project (Table 17).

Table 17. Lifestyle Change Seminar or Workshop Participation

Likelihood of Participation	2001
Very Likely	29.6%
Participation in Classes	
*"Loving Your Heart" Conference	6.5%
*Physicians Seminars	7.2%
Other Lectures/Seminars	13.0%

*The Healthy Hearts Project

Table 18. Participation in Other Health Related Opportunities

Internet Message Boards	
Very Likely (2001)	14.2%
Participated (2006)	5.0%
Online Support Groups	
Very Likely (2001)	12.8%
Participated (2006)	3.1%
Community Garden	
Very Likely (2001)	12.0%
Participated (2006)	1.8%
Overeaters Anonymous	
Very Likely (2001)	13.2%
Participated (2006)	1.5%
Alcoholics Anonymous	
Very Likely (2001)	8.6%
Participated (2006)	2.0%
Smoking Cessation Classes	
Very Likely (2001)	9.2%
Participated (2006)	1.4%

Other Health Related Opportunities. Other opportunities were included on the 2001 survey that did not lead to Healthy Hearts programming, but were included in 2006 to find out if people had participated in these activities. Respondents initially showed the greatest interest in Internet message boards and of the other opportunities listed, message boards had the highest percentage of respondents in 2006 who indicated participating in them (Table 18).

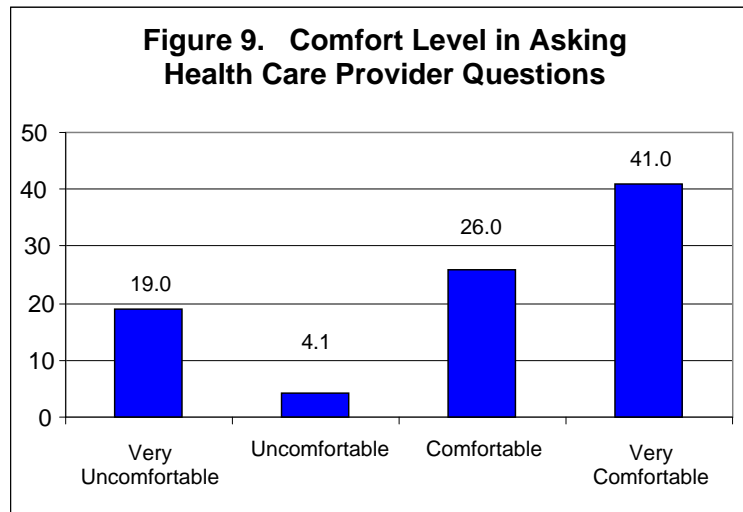
Visits to Health Care Provider

Respondents indicated how long it has been since their last visit with a health care provider and if they had been checked for various diseases and risk factors. A higher percentage in 2006 than in 2001 indicated visiting one within the last year with a higher percentage of respondents reporting they were tested for diabetes, high blood pressure and high cholesterol in 2006 than in 2001 (See table below). This could at least partially explain the higher percentages reporting diabetes, high blood pressure, high cholesterol and family histories of the diseases and risk factors.

Table 19. Health Care Check-Up

Last visit with health care provider	2001	2006
Within the last year	71.2%	76.1%
1-2 years ago	7.6%	7.6%
2-3 years ago	2.3%	2.8%
3-5 years ago	1.8%	1.2%
5 or more years ago	2.7%	2.3%
Have been checked for...	2001	2006
Diabetes	49.2%	57.0%
High Blood Pressure	68.1%	72.4%
High Cholesterol	56.7%	65.2%

In 2006, two-thirds of the respondents indicated they were comfortable or very comfortable asking their health care provider questions (Figure 9). Moreover, most respondents indicated their health care provider helps them understand instructions (82 percent) and responds to their questions satisfactorily (80 percent). These questions were not included on the 2001 version of the survey.



Sources of Health Information

In both years, respondents were asked to list their top three sources of health information from a provided list. The top two sources included books or pamphlets and health care providers in both years, although the percentages indicating these as sources decreased in 2006. While church was not in the top three in 2001, the percentage of respondents indicating the church is a preferred source of health information increased almost 10 percent and was the top third choice in 2006 (Table 20).

Table 20. Current Sources of Health Information

Sources of Health Information	2001	2006
Books or Pamphlets	54.2%*	46.7%*
Friends	26.1%	29.6%
Neighbors	6.7%	6.3%
Family Members	25.3%	27.7%
Community Organizations/Agencies	11.2%	11.9%
Health Care Providers	57.4%*	45.3%*
Church	27.3%	36.7%*
Magazine Articles or Newspapers	36.2%	34.5%
Television or Radio	38.7%*	35.9%
Internet	13.1%	17.1%
Other	5.6%	5.6%

*Top three responses for each year

Table 21. Preferred Sources of Health Information

Sources of Health Information	2001	2006
Books or pamphlets	46.8%*	42.3%*
Friends	15.6%	19.6%
Neighbors	4.8%	5.1%
Family members	20.6%	22.4%
Community organizations/agencies	15.9%	17.0%
Health Care Providers	57.9%*	47.3%*
Church	31.7%*	47.3%*
Magazine Articles or Newspapers	30.3%	28.8%
Television or Radio	30.8%	29.3%
Internet	14.1%	15.3%
Other	3.2%	2.8%

*Top three responses for each year

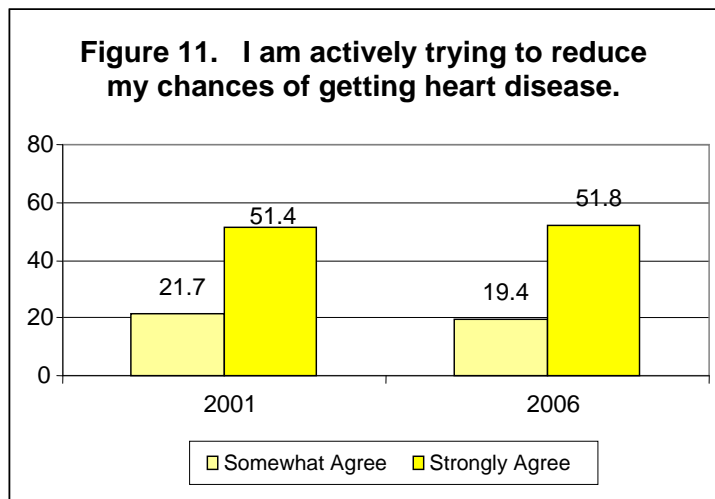
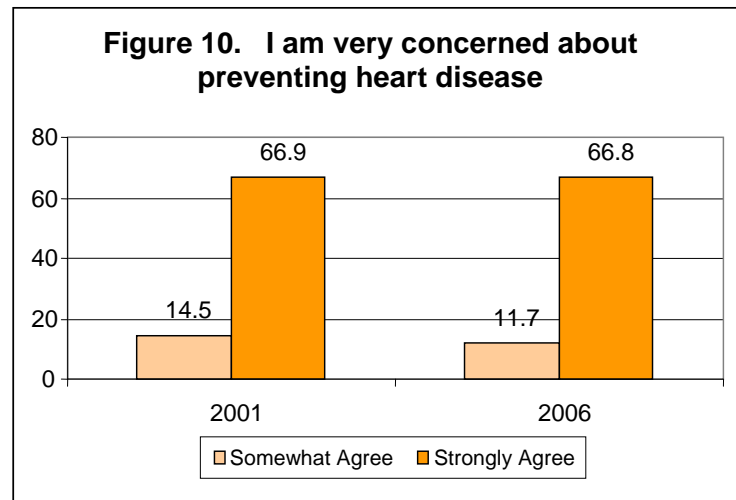
The respondents were also asked in both years to indicate their top three preferences for receiving health information. The top three preferred sources were the same for each year but as a preferred source, the church was tied with health care providers as the No. 1 preferred source in 2006.

Health Beliefs and Perceptions

Two sections of the survey addressed health beliefs and perceptions of various factors in one's environment and the influence these have on health. Related to beliefs, respondents rated five items on a five-point response scale, ranging from strongly disagree to strongly agree. Two items were worded negatively but strong disagreement indicated more positive beliefs about their health.

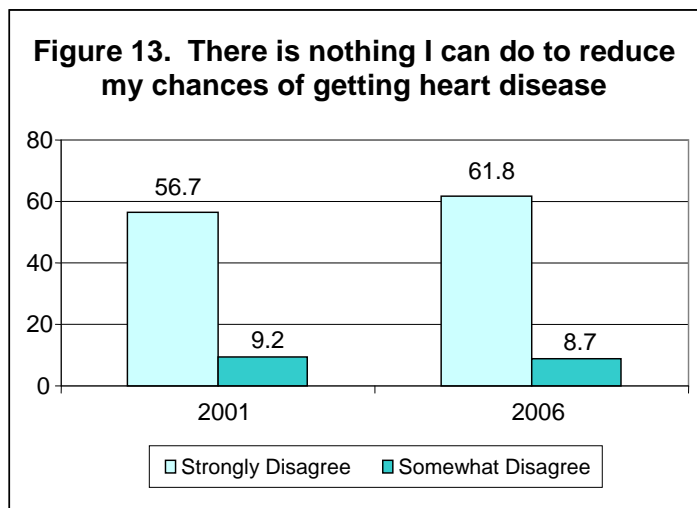
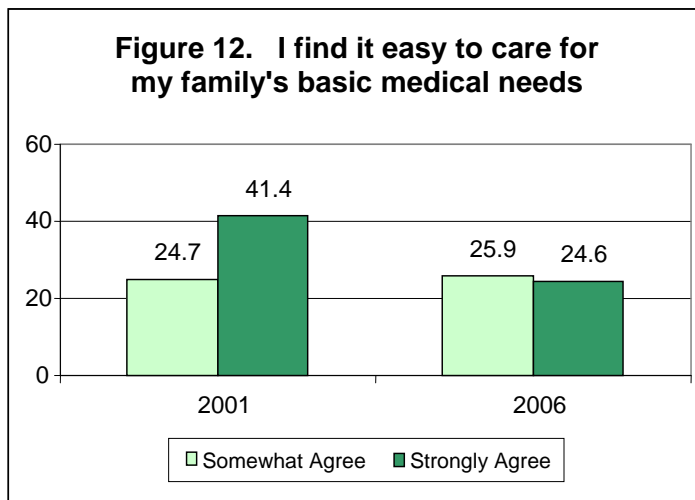
Of the positively worded statements where strong agreement indicates a positive attitude towards one's health, the responses did not change from 2001 to 2006. Overall, it seems most respondents have positive attitudes and beliefs about their health with the exception of their perceived ability to care for their family's basic medical needs.

Two-thirds of the respondents strongly agreed they were very concerned about preventing heart disease (Figure 10).



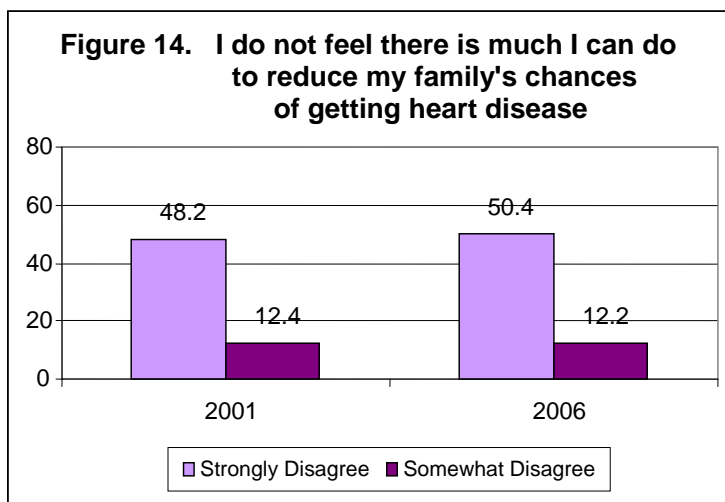
Just over half of the respondents strongly agreed they were actively trying to reduce their chances of getting heart disease (Figure 11).

In 2001, more than 40 per cent indicated they strongly agreed they find it easy to care for their family's basic medical needs, and in 2006, this percentage dropped to 25 per cent (Figure 12).



A slightly higher percentage of respondents strongly disagreed there is nothing they can do to reduce their chances of getting heart disease in 2006 than in 2001 (Figure 13).

Also, a slightly higher percentage of respondents strongly disagreed there is not much they can do to reduce their family's chances of getting heart disease (Figure 14).



Respondents were asked to indicate whether various environmental factors were a positive, negative or neutral influence on their health (Table 22). None of the perceptions changed significantly from 2001 to 2006 except others' expectations, which were responded to as a positive factor on one's health by a greater percentage of respondents in 2006 than in 2001. The highest percentage of respondents indicated their knowledge of how to take care of themselves as a positive factor related to their health in both 2001 and 2006, followed by one's ability to shop for and prepare healthy foods and one's home environment. One's church was rated as a positive factor by almost two-thirds of the respondents in both years. Few respondents indicated any of the factors listed had a negative impact on their health. Slightly more than 10 per cent of respondents in both years indicated their job or place of work (13 per cent 2001 and 2006) and the amount of money they have (11 per cent, 2001; 13 per cent, 2006) as negative impacts on their health in both years.

Table 22. Percentage of respondents indicating each factor as a positive health influence

Environmental Factor	2001	2006
My knowledge of how to take care of myself	75.8%	73.1%
My ability to shop for and prepare healthy foods	67.8%	68.8%
My home environment	69.5%	67.4%
The church I attend	67.5%	65.8%
The amount of time I have to take care of myself	65.2%	65.2%
The support and encouragement I receive from others	57.9%	62.5%
The type of food we eat at home	64.6%	61.7%
The availability of affordable health care	56.5%	58.5%
The safety of my neighborhood	53.2%	53.4%
The availability of affordable, healthy foods in my community	48.1%	53.5%
The amount of money I have	43.7%	43.1%
What others expect of me	36.9%	42.0%
My job and place of work	42.0%	40.2%

Conclusion

As the report is reviewed, it should be noted that the data were collected from people who attended church as well as attended specific churches on the appointed Sunday where the survey was administered. Thus, these data might not be representative of the more than 124,000 African Americans living in Clark County.

The Community Health Surveys revealed few changes in the health of the community from 2001 to 2006. It is worth noting that Clark County is an ever-changing community and this change spills over to the faith community as well. The rate of African American population growth during the life of the project was 10.6 per cent. Newer members of the community who may have participated in the survey may not have yet participated in Healthy Hearts programming.

Compared to 2001, a greater percentage of respondents in 2006 received a diagnosis of diabetes, high blood pressure and high cholesterol, all risk factors for cardiovascular disease. In addition, more respondents were overweight and the weight of men increased faster than that of women. Respondents reported their doctors recommended they lose weight and the weight loss recommendation was more than 16 pounds for 56 per cent of the respondents. More people reported a diagnosis of hypertension and a family history of hypertension than any other chronic disease, similar to both the 1997 and 2001 results. Hypertension is a risk factor for stroke, heart disease and kidney disease. Researchers have long reported a higher incidence of hypertension among African Americans than the general population (Smedley, Stith, & Nelson, 2003).

One might get the impression that few members of the target community were participating in "The Healthy Hearts Project". However, respondents might not have been aware that a specific program was offered by "The Healthy Hearts Project" or recognized the name of the project when it was listed on a survey. Due to frequent administrative changes, two of the churches where the survey was administered did not offer Healthy Hearts programming. Yet respondents from every church that conducted the survey indicated participating in at least some Healthy Hearts activities, demonstrating the overall reach of the project. Since Healthy Hearts programming was not exclusive to the churches, respondents might have participated at other locations. The results of the 2006 survey also showed an increase in the percentage of community members who preferred to receive information from the church. This further supports the decision of the investigators to partner with churches to create awareness and educate the African American community in Las Vegas.

Over the life of The Healthy Hearts Project, we can point to many positives. Respondents reported listening to their health care providers, taking their medication and changing their

diet and exercise behaviors to improve their health. They also reported feeling comfortable with their health care providers. While the number of times participants exercised decreased slightly, the amount of time reported exercising increased. In addition, smoking and alcohol use decreased, although light-to-moderate drinking is not necessarily a health risk for most people. Another positive finding of the 2006 survey was more people visited a health care provider within 12 months when compared to the 2001 survey and were tested for important risk factors to cardiovascular disease. As more people visited a health care provider, more were tested as a part of an annual physical. This would partially explain why more respondents received diagnoses of diabetes, high blood pressure and high cholesterol.

“The Healthy Hearts Project” developed and grew in partnership with the community it served. The relationships established through “The Healthy Hearts Project” have long-range implications for this community and promote continued partnerships among the University, local government, health-service agencies and the community. This project is an example of a successful disease-prevention, health-promotion model that can be adapted and modified by communities with the goal of continuing to diminish health disparities.

REFERENCES

Dehaven, M.J., Hunter, I.B., Wilder, L., Walton, J.W., & Berry, J. (2004). Health programs in faith-based organization: Are they effective? *American Journal of Public Health*. 94, 1030-1036.

Lewis, R.K. & Green, B.L. (2000). Assessing the health attitudes, beliefs and behaviors of African Americans attending church: A comparison from two communities. *Journal of Community Health*. 25, 211-224. (2007 Mar 22).

Smedley, B., Stith, A., & Nelson, A. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington D.C.: National Academies Press

Centers for Disease Control and Prevention, (2007). BMI-Body mass index. Retrieved March 27, 2008, from Centers for Disease Control and Prevention Web site:
http://www.cdc.gov/nccdphp/dnpa/bmi/adult_BMI/about_adult_BMI.htm

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