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Knowledge, Attitudes and Behavior of African American Undergraduate College Students Concerning Primary Preventative Health

Lionas Mayes

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The Edwin P. McCabe Honors Program

Senior Thesis

KNOWLEDGE, ATTITUDES, AND BEHAVIOR OF AFRICAN AMERICAN UNDERGRADUATE COLLEGE STUDENTS CONCERNING PRIMARY PREVENTIVE HEALTH

By
Lonias Mayes

1998

Langston University
Langston, Oklahoma

KNOWLEDGE, ATTITUDES, AND BEHAVIORS OF AFRICAN
AMERICAN UNDERGRADUATE COLLEGE STUDENTS
CONCERNING PRIMARY PREVENTIVE HEALTH

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Thesis Approved:



Thesis Committee Chairperson (Dr. Linda J. La Fleur)



Dean of the Honors Program (Dr. Jo Ann R. Clark)



Vice President for Academic Affairs (Dr. Jean Bell Manning)

Langston University

Abstract

KNOWLEDGE, ATTITUDES AND BEHAVIOR OF AFRICAN AMERICAN
COLLEGE STUDENTS CONCERNING PRIMARY PREVENTIVE HEALTH
By Lonias Mayes

Chairperson of the Supervisory Committee:
Mrs. Brenda Lewis
Department of Physical Therapy

African Americans' knowledge about primary preventive health and their attitudes toward primary preventive health influence their health behavior. Primary preventive health behavior is also affected by the individuals' definition of health and the significance they ascribe to their health status. Attitudes toward primary preventive health determine whether health assessment is important in preventing disease. African Americans have a myriad of views about health and general well being. The purpose of this study is to determine the relationship between primary preventive health knowledge, primary preventive health attitudes and primary preventive health behavior in African American undergraduate students. A survey will be conducted to measure these aspects of primary preventive health. The population of the study will consist of 100 African American undergraduate students from Langston University, age eighteen and older.

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GLOSSARY

African Americans. All persons of American or African birth who are of African and/or Caribbean decent

Attitude. A state of mind or feeling in regard to a person or thing

Behavior. Action, reaction or function under specified circumstances

Dynamic. Marked by energy and vigor

Health. Body integrity; ability to carry out daily activities; well being; ability to handle all types of stress and freedom from risk factors and untimely death.

Knowledge. Familiarity, awareness or understanding gained through experience or study

Morbidity. The rate of occurrence of a disease

Mortality. Frequency of number of deaths in proportion to a population

Primary preventive health. Avoiding potential and actual health risks and promoting health behaviors that promote wellness

Words in this glossary may be found in the American Heritage Dictionary or in the text Community Health Nursing.

Chapter 1

INTRODUCTION

DESCRIPTION OF THE SUBJECT

Health attitudes, behavior and knowledge are relative. These three components are the foundation, and often the determining factors, of an individual's health status. Attitude about health and the knowledge of health risks greatly affect the behavior of a person concerning his/her present condition. The perception that a person is healthy when in fact he or she is in danger of developing a serious health-threatening condition is indicative of a lack of health knowledge.

Attitude is a person's perception and subsequent reactions to oneself, counterparts, and environment. A person's attitude greatly influences his/her health status by drawing a thin line between ignoring and acting upon the knowledge of his or her potential condition. Each individual has a choice whether or not to pay close attention to their health status. All individuals have to make a decision whether or not to heed the advice of physicians or family members regarding family history of disease.

Knowledge is the familiarity, awareness or understanding gained through experience or study. In general, either people know a lot about their potential health condition or they do not know enough. Attitude determines whether a person who is ignorant about his/her health status will want to become more educated. However, knowledge is something that may be offered by parents and other loved ones, friends and teachers over an entire lifetime. A person must then decide how to use this knowledge to better him/herself. Bettering oneself may include a change in behavior or attitude or both. In the end, a person must think about what he or she knows and either improve upon it or settle with it.

A person's behavior reflects their attitude toward, and the knowledge about, themselves, their environment, and their counterparts. Even though it is often thought that behavior mirrors character, attitude and knowledge mold behavior more definitely. People behave toward their health in the ways they have learned how and know how. Their perception of health also greatly influences their behavior. Lack of health knowledge will lead persons to behave in such a way that may endanger their life.

Preventive health is divided into three parts: primary, secondary, and tertiary. Primary preventive health is a series of steps taken to prevent potential health problems before they present any

symptoms. Secondary preventive health is preventing present symptoms from becoming worse. Finally, tertiary preventive health is preventing a present condition from leading to death. This paper concentrates on primary preventive health, which demands the most personal concern and action. It takes the knowledge of one's health condition, family history, and potential health problems, a good attitude about health and appropriate health behavior to prevent disease in the primary sense.

BACKGROUND OF THE PROBLEM

African Americans are dynamic people. Their struggle to become Americans has been tremendous. There is a wide gap between the America most Blacks experience and that which most Whites experience. Health is no exception. Health status and race are closely related. Although the effects vary by gender and age (13), the impact of race differences is great in preventive health. Race has biological, historical and legal effects on one's health. Biological effects lead to misguided health practices and poor nutrition. Political effects influence social ties and coping patterns. Both legal and historical aspects of race influence medical care access and quality. Blacks do not feel as if they are in control of their health outcomes because they have limited psychosocial resources. All of these tend to

affect biological processes and health outcomes. The following is a flowchart demonstrating the relationship between race and health (13).

EFFECT OF RACE ON HEALTH OUTCOMES

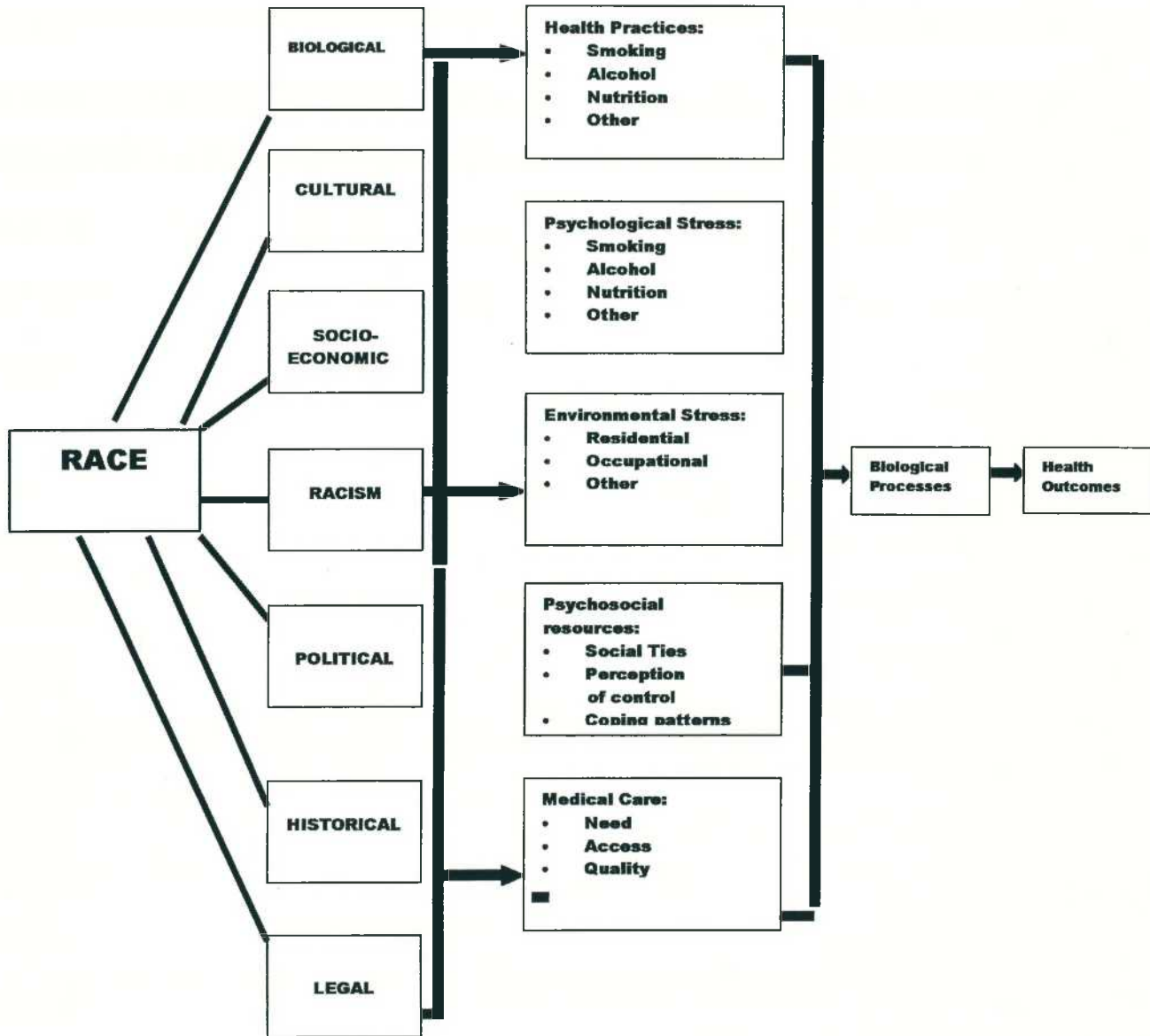


FIGURE 1

The relationship between health status and race has led to a discrepancy between the health status of Blacks and other minorities and that of Whites. The discrepancy cannot be totally based upon race differences, however. Each individual as a member of the human race is responsible for his or her health status. By determining the correlation between these three aspects of primary preventive health, and the depth, width and breadth thereof in African Americans, a solution may be approached to closing the gap in health status and death rate. The purpose of this study is to determine the correlation between knowledge, attitude and behavior of African Americans concerning primary preventive health, and to prove that the promotion of adequate health knowledge, good health attitudes and appropriate health behavior will elevate the health status of African Americans.

THE SOLUTION

The ultimate goal of this thesis is to promote African Americans to take control of their health status and bring it up to par. The author hopes to show how in the following pages.

The remainder of this thesis will include a historical background of the problem and establish the need for the study. It will also outline the research approach and results obtained during the study.

Chapter 2

REVIEW OF THE LITERATURE

OVERVIEW

Blacks in the United States are more likely to die sooner and of major disease than members of any other racial group. Nine years ago, it was found that death rates by age for all causes were sixty percent higher in Black men than in White men and six percent higher in Black women than in White women (13). African Americans can expect to die a full six years earlier than the national average age--seventy-five and a half years. "African Americans lead in the mortality rate from the nation's six biggest killers: heart disease, cancer, stroke, AIDS, accidental death, and homicide" (26). This gap in racial health status is indicative of many factors. "Racial differences in disease rates may reflect socioeconomic differences" although racial differences far outweigh socioeconomic ones and social class and income are secondary. There are "greater black-white differences [concerning disease incidence] in lower than in higher income persons" (13).

Another aspect is history and environment. In the past, Blacks were considered inferior. They were denied the best health care and education. Even now, African Americans are underrepresented in the upper echelon of American culture--in higher education and in the business world. Though Black America is advancing, it is still one of the poorest and most misunderstood races in America.

Though low economic status is linked with poor health status..we must also appreciate other factors, such as structural discrimination and institutional racism, that favor the disproportionate representation of African Americans in low-income groups. This ultimately results in poor health status (13).

It is likely that there are also biological factors that can help explain some of the disparities in the health status of racially diverse populations. The tendency to be at risk for certain diseases may be hereditary. According to many researchers and experts, heredity and body weight are closely linked. There is an eighty percent chance that if both of your parents are obese, you will be also (31).

"Biologists believe that in rare cases, obese people have a gene mutation that does not allow them to produce leptin, a hormone that tells the brain to stop eating" (9). It was suggested in one study that Blacks might have a kidney defect that limits their ability to process sodium, which plays a major role in the health of the heart (22). Dr, Richard Gillum,

who wrote an editorial in the New England Journal of Medicine (12), discovered that Blacks from different origins such as precolonial Africa and the West Indies exhibit different modalities of cardiovascular disease.

Life style plays the most important role in health status. One theory that may explain why Blacks are susceptible to disease is diet-- traditional "soul food", inspired by the Southeastern United States cuisine, is high in fat and salt (22). Some of us also use smoking to relieve stress. The reasons why blacks are vulnerable to certain types of cancer include smoking, alcohol, consumption, diet, socioeconomic stress and lack of medical care (13).

"For some diseases, there is no proven cause for these inequalities--we can only take an educated guess. For other diseases, the answer is a combination of many factors, including poor access to medical care, poverty, discrimination and lack of research and awareness (22).

STATISTICS

There is ample documented evidence to support the claim that African Americans have poorer health than whites. Despite the recent advances in the reduction of mortality and morbidity, there are still disparities between African Americans and White Americans on every measure of illness and death (13). According to the 1997 report of the US Department of

Health and Human Services (27), the five leading cause of death due to disease are #1 Heart disease, #2 Cancer, #3 Cerebrovascular disease, #4 Human Immunodeficiency Virus (HIV) and #5 Diabetes Mellitus.

The Handbook of Black American Health (13) lists heart disease as the leading cause of death among Black Americans. Patterns of mortality and morbidity from cardiovascular disease display associates with race, age and gender. "Rates of death from cardiovascular causes among African Americans are among the highest in the industrialized world" (12). According to a publication published yearly by the United States Department of Health and Human Services (27), the condition is the same--in 1995, there were 198.8 deaths for every 100,000 Blacks due to heart disease second only to natural causes (695.8 per 100,000). In Black and White females, cardiovascular disease was the third leading cause of death, but it was fourth for Black and White men in 1989 (13). Over half of the deaths due to heart disease were attributed to coronary heart disease nine years ago. In 1995, diseases of the heart were the number one killers of males and females of all races of Americans who live in the continental United States. Heart disease caused an average of 39,321.5 deaths in Black males and females that year (27). "Contributing most to the growing gap in life expectancy of the two race groups [Black and White]

were trends in mortality for heart disease" (17). The Handbook states that the death rates caused by coronary heart disease are higher in Black females than in White females. The reasons for these rates are obscure because of some contradictory facts. The levels of low-density and very low-density lipoproteins (LDLs and VLDLs--"bad cholesterol") directly measure cholesterol levels in the blood. Cholesterol serum levels are also linked directly to heart disease risk. Blacks have higher levels of high-density lipoprotein ("good cholesterol") in their blood than Whites, which should help protect them from the risk of heart disease. The percentage of Blacks with high cholesterol serum levels (high levels of LDLs and VLDLs) was about the average for all ages in 1994--about nineteen percent (27). Black males have a forty- percent higher incidence of high blood pressure than White males (22), high blood pressure being an indicator of the onset of heart disease. About thirty-five percent of the Black population suffers from hypertension (27). "In many populations of Blacks with high prevalence rates for hypertension have surprisingly low prevalence rates of coronary heart disease" (13).

When addressing cardiovascular disease, one must also consider the incidence of cerebrovascular disease that usually leads to stroke. It is the third leading cause of death among Black Americans (27). In 1995, there were forty-five deaths in every

100,000 Blacks due to cerebrovascular disease--about 9,268.5 total. In The Handbook of Black Health, the stroke mortality rates are doubled in Blacks when compared to Whites. Stroke prevalence, hospitalization and risk factors are higher in Blacks than in Whites. There is a twenty-eight percent excess of mortality due to stroke in Blacks.

Cancer is the second leading cause of death among African Americans (22, 27).

This burden is borne disproportionately by Black Americans who have the highest overall age-adjusted cancer incidence and mortality rates of any population group in the United States (5).

There were 32,880 deaths among Black men and 27,723 among Black women in 1995 due to cancer (13). The same report stated that there were 171.6 deaths for every 100,000 blacks because of cancer. Cancer Facts and Figures 1997 (3) listed 62,200 total cancer deaths among African Americans so the totals are climbing (3). In a document entitled Cancer Facts and Figures 1998(2), the American Cancer society states that mortality rates are considerably higher in Blacks than in whites--up to two times higher. For men, cancer rates are sixteen percent higher for Blacks than Whites (3).

Breast cancer incidence rates have increased for both White and Black women (1). The US Department of Health and Human Services stated that there were 27.5

deaths per 100,000 Black women due to breast cancer (27). Even though it is widely known that incidence of breast cancer is higher in older women than in younger ones, Black women under the age of fifty have experienced an increase in the incidence rate for breast cancer. Mortality rates due to this type of cancer also showed interesting trends. While White incidence rates decreased by about five and a half percent between 1989 and 1992, they increased in the Black community by about 2.6 six percent over the same time period.

In Health United States 1996-1997 (27), the category "cancer" was divided into three other major parts according to number of deaths per 100,000 African Americans: respiratory system (49.9 deaths), colorectal (17.3), and prostate (34). Cancer Facts and Figures 1998 (2) also provides information and statistics about lung cancer, colon and rectum cancer, prostate cancer and uterine cancer. Since 1987, lung cancer has been the leading cause of death among women. In 1997, colorectal cancer was the third leading cause of cancer death in African Americans (15), but the incidence rates for colon cancer have begun to decline in Blacks (2). "Prostate cancer incidence rates are nearly two times higher for African American men than White men." Rates of uterine cancer in African American women have declined more rapidly in the last twenty-two years than they have for Whites, but in 1994, the

rate was still two times higher in Blacks. "Whites are more likely than African Americans to have their cancers diagnosed at an early stage" (1).

Human Immunodeficiency Virus is the fourth leading cause of death due to disease among African Americans (13). This virus, which leads to the complex condition called Acquired Immunodeficiency Syndrome, claimed 17,139 lives from the Black community in 1995. Blacks comprise thirty percent of the population of people infected with AIDS (30). As of January 1, 1993, 59,135 AIDS patients were Black men over the age of thirteen (22). According to risk factors for HIV, percentages of African Americans with AIDS are as follows: twenty-four percent are intravenous drug users, fifty-five percent are men who have sex with other men, six percent are men who have sex with men and use drugs and seven percent are heterosexuals (30).

Diabetes Mellitus is the fifth leading cause of death for Blacks. "Diabetes mellitus, one of the diseases targeted for increased research focus among minorities, continues to have devastating consequences on the African American population" (13). The disease affects about 1.8 million African Americans. Diabetes claimed 10,402 lives in 1995 (27). According to Dixon and Wilson (10), among individuals between the ages of forty-five and sixty-four, the incidence for diabetes is 50.6 percent

higher in Blacks than Whites. Blacks' death rate due to complications of diabetes is 132 percent higher than that of Whites. There are two types of diabetes mellitus: Type I--Insulin Dependent Diabetes Mellitus (IDDM) and Type II--Non-Insulin Dependent Diabetes Mellitus (NIDDM).

For African Americans, the peak age for diagnosis of IDDM is approximately fifteen to nineteen years of age while NIDDM occurs more frequently after age fifty-six, when it is three times more common than in the white population (13).

Ninety to ninety-five percent of diabetes cases are type II among Blacks (28). Blacks also suffer complications more frequently due to diabetes than do Whites. "Retinopathy, neuropathy and stroke appear to be more frequent in African Americans than in Whites with diabetes" (13).

Studies reveal that there are things we can do to prevent these internal mishaps. First, we can avoid the poisonous substances that destroy the inner workings of our bodies. Second, we can stretch our muscles and move our bodies, while enjoying sports that strengthen our healthy cells. Third, we can choose activities, friendships and work environments that keep our minds calm and peaceful, making it easier for us to maintain a positive state of health (22).

The above quote is talking about prevention. Our efforts should not be toward getting well once we are already sick. We should strive to prevent

disease before it occurs. Most of the health problems that plague African Americans and for which they are at higher risk are preventable (23). In order to prevent disease, Blacks must have adequate knowledge about health, healthy attitudes and compliant behavior.

KNOWLEDGE

"Disparities in the health status of the African American and White populations have been and continue to be realities in the United States" (13). Although the biggest barrier to improving Black health is lack of access to health care (10), one can be empowered to control his or her own health. Education is the key. Once a person has accomplished this, they can then be empowered to take care of their own health (22). Limited research in the area of minority health promotion reduces the amount of written knowledge necessary to understand the causes of minority health problems. However, the condition of one's health is beyond the control of governmental and health care policy (13). Empowerment, as defined in the Handbook of Black American Health (13), is the process of helping a group of people to take control of factors that affect their health.

How does the Black community begin empowerment? We must become more educated about our health. Dr. G. Edmond Smith believes that a lack of awareness and

deficient health education contributes to a high morality rate allows unhealthy behavior to continue unabated (24). Health education has been defined as "any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health" (13). The key words in the definition are "experiences" and "voluntary adaptations of behavior". These two work together to lead to a more positive health status. Dr. Barbara M. Dixon and Josleen Wilson, authors of Good Health for African Americans (10), wrote, "We African Americans have our own traditions, life experiences, and health risks." Therefore, the knowledge of health that Black Americans have must be tailored to their culture and beliefs. Then we must change our behavior to reflect our knowledge. We should learn about our bodily processes--how does the body work? What kind of signs does it give when something is wrong?

In order for Blacks to prevent disease, they must be aware of the risky behavior in which they are involved. "Education begins with knowing risk factors" (15). Dixon and Wilson (10) list ten black risk factors that are not unique to the African American but which affect African Americans differently and more devastatingly than any other racial group. They are:

TEN BLACK RISK FACTORS

Obesity
Smoking
Drinking
Drug use
Fatty diet (high in saturated fat and cholesterol)
Lack of physical exercise
Stress
Salt
Untreated high blood pressure
Uncontrolled diabetes

Through education, Blacks can begin to take charge of the diseases that plague their race (24).

ATTITUDE

"Good health is a state of mind" (22). The perception of one's health is proven to motivate, or demotivate, preventive health actions. The concept of health is derived partly from the individual's ideas (14). In a document entitled Health status of Minorities and Low-Income Groups—Third Edition (28), the US Department of Health and Human Services states that, "Whites are over forty percent more likely than Blacks to judge their health as excellent and eighteen percent more likely to judge their health as good."

Blacks have misconceptions about disease and risky behaviors that endanger their health. For example, large women are not seen as unhealthy, but rather as nurturing and are widely accepted in the Black community (31). Even though young black

females may be protected from eating disorders by cultural attitudes toward obesity (20), 71.5 percent of Black women are preoccupied with a desire to be thinner and sixty-four percent are preoccupied with fat on the body (31). In an article entitled "Dying to be Thin" (6), Browne writes,

African American women are at risk for and suffer from eating disorders in equal proportions to their White counterparts. [They] have adopted similar attitudes towards body image, weight and eating as their White counterparts, thus contributing to their high risk for these disorders.

"A few studies show that poor self-assessed health leads to more disability" (11). According to Ferraro, Farmer and Wybraniec, disability helps shape how people interpret their health status. In their study, they asked questions like: Do blacks have more rapid increases in disability and poorly assessed health? Do Blacks have steeper declines in self-assessment of health? Health assessment or one's health attitude may lead to incident morbidity due to disease. During their ten-year study, Ferraro, et. al. discovered that African Americans began the study in poorer health than White Americans did and their health problems grew worse. Blacks manifested larger declines in self-assessment of health than Whites. "The finding that health problems led to poor health assessments which in turn, led to more health problems, suggests a vicious cycle" (11).

BEHAVIOR

"Too many of us use drugs and alcohol; we don't eat right; we fail to seek medical care soon enough; we don't follow medical instructions" (11). Many African Americans wait until symptoms arise before seeking medical advice (15). Poor compliance with recommendations for health management is at the top of the list of factors that keep Blacks in poor health (25). Dr. Smith said that many of his obese patients only eat one or two large, high-fat meals a day. Blacks generally have poor dietary habits and are very inexperienced in diet management (25). At the beginning of a seven-year study entitled CARDIA, for Coronary Risk Development in Young Adults, Black men and women weighed more, had greater fat intake and were less physically fit than Whites in the same study. After seven years, the increase in weight was greatest among African American women (18). "The lifestyles and daily habits of vast multitudes of people lead directly to dietary imbalances, hypertension potential, high cholesterol and a host of other health dangers" (7). Alvin Burns also states that a problem in preventive health care is fostering behavioral compliance over a long period of time. It all comes down to one thing—our behavior. How we apply knowledge and direct our attitudes molds our state of health more than anything else does.

PREVENTION

Changes in lifestyle and personal habits enhance health (16). Preventive health care, as defined by Dr. Alvin Burns, is any activity performed by an individual who believes himself to be healthy to prevent disease (7). "The 'Preventive Model' focuses on the individual decision-making process for the purpose of adopting positive health behavior conducive to health" (22). People are better off when they are given responsibility and are encouraged to take an active role in their health management (25). If we prevent the things that kill us, quality of life will improve and the average life expectancy may rise because people will be healthier in mind and in body.

There are many reasons why people do not prevent disease before they experience symptoms. These barriers to prevention can be placed into five categories: system factors, motivation, concerns about procedures, time conflicts and memory or consistency (29). System factors relate to access to medical care, institutional racism and institutional process that are often time consuming and impractical (29, 13 and 22). Motivation is often stifled because of transportation problems and lack of knowledge. Many African Americans are afraid of certain procedures, and results certainly add stress. Feelings of distrust often prevent African Americans

from taking part in healthy intervention programs (24). Finally, Blacks do not always see medical care as a priority in the budget—it is often an extra. Therefore, setting time aside for one's health is often neglected. Many Blacks site a lack of reminders, such as those in the media, about needed health services (29).

“A solid health promotion theory should be based on knowledge about self-regulation—why people acquire harmful habits, how these habits operate and how to modify them to enhance human health” (16). Health care administrators are becoming increasingly aware of the impact culture has on health. “Health is a culturally determined concept” (14). Black health problems are different from those of other racial groups. Therefore, the approach to successful prevention and treatment must also be different (10). When an approach is made to the prevention of disease in the Black community, there are things that are so culturally engrained that they cannot be changed. A good prevention program will be able to consider these aspects and work around them and with them to accomplish its goal.

School based health promotion is the best and most logical place to start in efforts to enforce good habits over bad ones (16). Health habits and belief systems established during adolescence are among the most crucial because of their profound

effect on lifestyle and health status in adulthood (20).

SOLUTIONS

Now that the problem has been addressed and defined, what should be done? How do African Americans prevent disease? The following are some simple steps to begin on the track toward better health:

1. The first step is to learn some medicine—learn how the body works (22).
2. Find out which life style habits are detrimental.
3. Slowly begin to change risky behavior.
4. Keep track of your weight, blood cholesterol levels, glucose levels, etc.
5. Keep someone accountable to their health as they do the same for you—get a partner. “The Black [community] must become a collaborator before programs can effectively meet the needs of the [community]” (13).
6. Do not ignore symptoms or signs of disease—CHECK IT OUT!

Lifestyle changes may be the most difficult aspect of disease prevention. The MedAccess

Corporation has compiled a list of specific lifestyle changes that will assist an individual in improving the status of their health (19).

1. Do not smoke. If you smoke, quit. Smoking is the most preventable disease risk (22).
2. All kinds of physical activity will help you feel better and maintain a healthy weight.
3. The Dietary Guidelines for Americans are the work of a group of health and nutrition experts. These guidelines help all Americans over the age of 2 years choose foods that are good for the body. They are:
 - a. Eat a variety of foods. Eating various foods helps your body get all of the nutrients it needs.
 - b. Balance the food you eat with physical activity - maintain or improve your component weight.
 - c. Choose a diet with plenty of grain products, vegetables and fruit. These foods offer a lot of minerals, vitamins, and fiber with fewer calories. These high-fiber foods give bulk important for regularity. Besides tasting great, vegetables and fruits may also protect against some cancers and may lower blood cholesterol.
 - d. Choose a diet low in fat, saturated fat, and cholesterol. The American Heart Association recommends that adults take in less than 30% of

calories from fat and less than 300 milligrams of cholesterol. To lower the fat and cholesterol, eat leaner meats, remove the skin from poultry, and eat low-fat dairy foods and low fat baked goods.

- e. Choose a diet moderate in sugars. Too many sweets add extra calories and weight. To satisfy a sweet craving, enjoy the flavor of fresh fruits instead.
- f. Choose a diet moderate in salt and sodium. Too much sodium in the diet may raise blood pressure in some people. Watch your use of the salt shaker at the dining table. Processed and canned foods typically have a lot of added salt. Choose more fresh foods and select unsalted or low-salt foods. Learn to cook in new ways, using herbs and spices instead of salt.
- g. If you drink alcoholic beverages, do so in moderation. (Source: USDA, DHHS).

You can make progress one guideline at a time.

- 4. Reduce your risk for HIV by having only one partner while practicing safe sex, by abstaining from sex and/or by not shooting drugs.
- 5. Do not use illegal drugs of any kind.
- 6. See a clinician if you are experiencing four or more of the following signs of depression:

"Take charge of your health and live a longer and healthier life" (19). This means assuming responsibility for your health so that the health status of African Americans may increase.

Chapter 3

METHODOLOGY

DESIGN

This was a correlative study based on qualitative and quantitative data. A three-part survey was employed to collect the quantitative data. The qualitative data were collected and used in the literature review. The purpose of this study was to determine the correlation between health knowledge, attitude and behavior and relate it to undergraduate African Americans.

SETTING

Data were collected from students who were enrolled in one of two English classes or in Human Anatomy class, or who were acquaintances of the researcher. Most of the students surveyed were African American undergraduates.

SUBJECTS

The inclusion criteria were undergraduates who were enrolled in one of two English classes or Human

Anatomy class at Langston University. They also included acquaintances of the researcher. The researcher attempted to survey as many African Americans as possible, but none of the surveys was discarded.

VARIABLES

There were six independent variables chosen by the author. They were age, sex, race, knowledge, attitude and behavior. Age, sex and race were determined from the demographic questions in the survey. Health knowledge, attitude and behavior were determined by forty-five questions that were divided into three respective sections labeled accordingly.

The qualitative data was collected during extensive research. The researcher examined hundreds of pages of statistics and used them to illustrate the validity of the study.

CONTENT VALIDITY

The questions in the survey were derived from the on-line health quizzes of the MedAccess Corporation (19). Some questions in the knowledge, attitude and behavior sections were altered to facilitate coding, but MedAccess authored the demographics section.

PROCEDURE

The prospectus of this study was reviewed and approved by the Honors Advisory Council of Langston University. Permission to administer this instrument on the main campus of Langston University was secured through the Langston University Office of Academic Affairs (See Appendix).

Two professors gave access to their students and allowed data collection in their classrooms during class time. In two English classes and one Human Anatomy class, undergraduate students participated in the study. The purpose of this study was explained orally and in written form. Each participant was given a written informed consent form, which was to be marked before the survey was begun.

At the beginning of administration, the researcher briefly explained the study. Instructions for completing the survey were explained orally, but they were also printed at the beginning of each section. The students were informed that completing the survey was completely voluntary and that it was anonymous. In the case that the participant was an acquaintance of the researcher, the purpose of the study was known ahead of time and the participant began to answer the questions immediately.

Each participant was given a survey packet containing (a) a title page, (b) an informed consent sheet, (c) a demographics section, (d) a health knowledge section, (e) a health attitude section, and (f) a behavior section. If the participant was a member of one of the classes, they completed it in class in about ten to fifteen minutes. If the participant was not in class, he or she took time to complete the survey on the spot, or they were given permission to take it home to complete it. Each student expressed consent to participate in the study by checking the box on the informed consent. After completion, the surveys were returned to the researcher. The participants' privacy and confidentiality were maintained by requesting that no name be written on the survey, and by receiving completed surveys in random order.

DATA ANALYSIS

Each item and its answers were coded. Coding consisted of assigning one-word labels to each question and answer. The answers given in the complete surveys were then tallied into the categories that were coded. Once each tally mark was counted, a total for each answer was recorded. The researcher surveyed 100 undergraduates, but only ninety-five completed the surveys correctly and fit

the inclusion criteria. Out of this ninety-five, percentages were calculated for each answer.

Chapter 4

RESULTS

SAMPLE

One hundred undergraduates responded to the survey. Ninety-five filled it out correctly and completely and fit the inclusion criteria. 59% were female and 41% were male. 80% of respondents were African American; the rest were white (8%), African (5%), Hispanic (1%), and those of other racial backgrounds (6%). Figure 2 lists demographic information gathered in the survey results.

16% of respondents had a family history of Coronary heart disease. 49% had a history of high blood pressure. 39% of the participants had relatives with diabetes mellitus (either type). The history of cancer in the families of the respondents is represented as follows: breast cancer, 11%; prostate, 6%; other cancers, 18%. Families of respondents affected by lung disease and other conditions were 3% and 12%, respectively. 16% of participants had a history of obesity.

DEMOGRAPHICS

<u>CATEGORY</u>		<u>o</u> <u>o</u>
AGE	18-25	94%
	26-30	6%
	36-45	1%
	> 45	1%
SEX	FEMALE	59%
	MALE	41%
RACE	BLACK	80%
	WHITE	8%
	AFRICAN	5%
	HISPANIC	1%
	OTHER	6%
CLASS	FRESHMAN	62%
	SOPHOMORE	23%
	JUNIOR	13%
	SENIOR	2%
WEIGHT	< 99 lbs.	4%
	100-110	2%
	115-120	7%
	121-125	1%
	126-130	8%
	135-140	22%
	141-150	7%
	151-160	12%
	161-170	7%
	171-180	11%
	181-190	5%
	190-200	3%
	>200	12%
HEIGHT	4'0-4'11"	3%
	5'0-5'11"	80%
	6'0-6'11"	16%
	> 7'0"	31%

FIGURE 2

KNOWLEDGE

It was found that health knowledge was average among respondents. 73% of the respondents were unaware that high blood pressure, diabetes mellitus and cancer affect more African Americans than whites. 62% of the students did not know that breast cancer occurs in both men and women. The percentage of people who knew that the number one killer of Blacks is heart disease was almost equal to the amount that did not know: 47% and 43% respectively. It was interesting that although most respondents were not aware of the status of heart disease in America, most were educated on the risk factors of the disease. 81% of the participants answered that avoiding saturated fat in foods reduces the risk for heart disease; 85% were aware of the importance of physical exercise. Almost all of the respondents (84%) knew that family history of disease is the strongest indicator of disease risk.

The most correct answers came from items about diabetes mellitus. Only a small amount (21%) were not aware that there are two types of diabetes mellitus, and only 17% thought that Blacks are in the lower percentile for developing diabetes. A large percentage (87%) could define diabetes.

Although 16% of the respondents cited a family history of coronary heart disease, only 9% said that

they were at risk for the disease. 41% believed that they are at risk for high blood pressure while 49% had a family history of it. These trends continued for all of the other conditions: diabetes mellitus, cancer, liver disease and lung disease. Figure 3 lists the trends of family history of disease and perception of disease risk.

FAMILY HISTORY VS DISEASE RISK

FAMILY HISTORY	PERCEIVED RISK
HEART DISEASE 16%	HEART DISEASE 9%
CANCER 35%	CANCER 22%
HIGH BLOOD PRESSURE 49%	HIGH BLOOD PRESSURE 42%
DIABETES 39%	DIABETES 33%
LUNG DISEASE 3%	LUNG DISEASE 3%

FIGURE 3

ATTITUDE

Health attitudes varied among respondents. Surprisingly, however, 84% of participants said that they would change their behavior if it were detrimental to their health. 78% believed that they could reduce their risk for disease. Only 5% did not feel that they had the power to reduce disease risk. About 70% of participants felt that regular physical activity and a healthy diet were very important. Maintenance of ideal weight was very important to 67% of the respondents, although 27% of females and 24% of males were overweight. The importance of health status was evident for 93% of respondents. Most respondents were not content with their health status as it pertained to their weight—56% were not at ease with their weight as it related to health status. 43% were content with their weight even if they were overweight.

One of the most interesting items on the survey was item number eight in the attitude section. It read, "Smoking marijuana is not as harmful as smoking cigarettes." This was a true/false question to which a 34% answered true and 66% answered false.

African American risk was very important to 63% of participants, somewhat important to 33% and not important to 5%. Individual risk was very important to 77% of respondents and not important to 6%. 18%

said that individual disease risk was somewhat important. The health of future generations was important to 99% of the respondents.

BEHAVIOR

It was discovered that good behavior does not always accompany a good attitude. Although 72% of the students stated that diet and exercise was very important, only 57% actually exercised regularly and only 29% ate three times a day. As far as diet constitution goes, only thirty-eight out of ninety-five respondents tried to avoid saturated fat in their diets. Surprisingly, however, more than half of the respondents (52%) ate salt and sweets sparingly and 64% of the students ate plenty of vegetables, fruits and grains.

Respondents' commitment to self-examination and health screening was not high. 52% of females surveyed performed breast self-examinations at least once a month. Only 25% of male participants stated that they had testicular exams at least every other month. While 74% of respondents were sexually active, only 44% had regular tests for sexually transmitted diseases. The amount of people who knew that pap smears could detect cervical cancer was equal to the amount of females who had them regularly, 79%.

54% said that they read literature on disease and conditions for which they were at risk. Only 20% felt that they could ignore personal disease risk; 80% were aware of these conditions and refused to ignore them. Stress was a hot issue for the students—78% of respondents stated that they applied unneeded stress to their lives.

SUMMARY

Whether or not the correlation was positive, the relationship between health knowledge, attitude and behavior is obvious in the above results. Many of the students are knowledgeable about health but their attitudes toward health and their health behavior does not reflect the depth of knowledge they claim to have. The perception of disease risk does not add up to the risky behavior these students are involved in. Finally, the importance these students place on the health risks of their race and their personal risk is dangerously low.

CHAPTER 5

DISCUSSION

The ultimate goal of this thesis is to promote African Americans to adopt healthier lifestyles. Through the data that was collected, the researcher was able to get a glimpse of the lifestyles of the participants, and derive some conclusions from the findings.

It was difficult to determine a correlation between all three aspects of primary preventive health for many reasons. A correlation between knowledge and behavior was especially difficult because the average amount of knowledge was not reflected in the behavior. Many respondents were aware of health risks, disease status and family history. However, the amount of participants that actually complied with this knowledge was not parallel. For example, more three-quarters of the respondents stated that they were aware of the role of diet and exercise in preventing heart disease. However, only 57% actually exercised regularly and only 29% ate right. The researcher expected that a lack of knowledge would lead to these behavior patterns. The opposite actually occurred.

This finding may be explained by the attitudes of the respondents. 20% of respondents stated that they felt justified to ignore health risk and 16% stated that they would not change their behavior if it were necessary. The knowledge of present health condition and risky behavior is apparently fostering good health attitudes. The answers to the item that questioned each participant's motives in changing behavior (See Appendix --Item 14 "Attitude") indicated that most participants did not feel that their lifestyles were detrimental to their health status. In fact, only 27% of respondents claimed that they engaged themselves in risky behavior. Generally, the respondents did not think that their behavior was detrimental their health.

Correlating attitude and behavior was simpler. 56% of the respondents were discontent with their weight. A total of 51% of participants were overweight for their height. The discontent could have been for a variety of reasons, but the researcher has drawn the conclusion that these participants were aware of their overweight status. Another area of interest was in the area of illegal drugs. The only item in the attitude section pertaining to illegal drugs was about marijuana (See Appendix --Item 8 "Attitudes"). 66% were unaware that marijuana affects the body in many of the same ways as cigarettes do, and are just as dangerous. Compared to the mere 27% that were involved in risky

behavior, one could conclude that smoking marijuana was not perceived as detrimental to the health of these respondents.

The researcher was unable to correlate all three aspects of preventive health because of the discrepancies described above. Behavior did not generally reflect knowledge and attitude. Although attitude was indicative of behavior, it could not adequately be related to knowledge. Knowledge and attitude could not be correlated with behavior. This is because the knowledge base and the attitudes appeared to be healthy, but this did not lead to healthy behavior.

CONCLUSION

In conclusion, this study revealed in greater detail the information gathered in the literature review. It further alludes to the reasons for the poor health status of African Americans in general. The researcher wishes to encourage the adaptation of the suggestions listed in Chapter 3. This research may be expounded upon in many ways. The lack of research in the area of African American health is an indication of the need for more research projects such as the one described here.

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APPENDICES

APPENDIX I: SURVEY

The Knowledge, Attitudes, and
Behavior of African American
Undergraduate Students Concerning
Primary Preventive Health

Survey of Undergraduates Age 18 and
Over

Author: Lonias M. Mayes
Thesis Committee Chairperson: Mrs.
Brenda Lewis

INFORMED CONSENT

The purpose of this study is to determine the correlation between knowledge, attitude and behavior concerning preventive health in African American undergraduates.

You are under no obligation to complete this survey, as it is completely voluntary. If you choose to complete it, please be as honest as possible in your answers. This survey is confidential and your identity is not needed for the study.

If you understand the above statement please check the box below and proceed.

I understand the above statement and wish to proceed.

Demographics

Circle the letter that best represents your answer.

1. What is your age range?
 - a. 18-25
 - b. 25-35
 - c. 35-45
 - d. 45 and older

2. Are you:
 - a. Male
 - b. Female

3. What is your race?
 - a. African American
 - b. Islander of African decent
 - c. African
 - d. Hispanic (any decent)
 - e. White
 - f. Other

4. What is your classification?
 - a. Freshman
 - b. Sophomore
 - c. Junior
 - d. Senior
 - e. Graduate Student

5. Where do you live?
 - a. On-Campus (Dormitories)
 - b. On-Campus (Apartments)
 - c. Off-Campus (Apartment)
 - d. Off-Campus (House)

6. Is your annual household income from all sources:
 - a. Less than \$10,000
 - b. Less than \$15,000
 - c. Less than \$20,000
 - d. Less than \$25,000
 - e. Less than \$35,000
 - f. Less than \$50,000
 - g. Less than \$75,000
 - h. \$75,000 or more

7. About how much do you weigh without shoes?

- a. Less than 100 lbs.
- b. 100-110 lbs.
- c. 115-120 lbs.
- d. 120-125 lbs.
- e. 125-130 lbs.
- f. 135-140 lbs.
- g. 140-150 lbs.
- h. 150-160 lbs.
- i. 160-170 lbs.
- j. 170-180 lbs.
- k. 180-190 lbs.
- l. 190-200 lbs.
- m. 200 or more

8. How tall are you without shoes?

- a. Less than 4'0"
- b. 4'0"-4'11"
- c. 5'0"-5'11"
- d. 6'0"-6'11"
- e. 7'0" or taller

9. Do you have a family history of:

- a. Heart Disease
- b. High blood pressure
- c. Diabetes
- d. Breast cancer
- e. Prostate cancer
- f. Other cancers
- g. Lung disease
- h. Obesity
- i. Other life threatening conditions

Knowledge

Circle the letter that best represents your answer.

1. High blood pressure, diabetes and cancer affect the same number of blacks as it does whites.
True/False
2. Heart disease is the leading killer of men and women in the US.
True/False
3. Saturated fats (mainly animal fats) raise your blood cholesterol level more than anything else does in your diet.
True/False
4. Regular physical activity can reduce your chances of getting heart disease or diabetes.
True/False
5. A blood pressure greater than or equal to 140/90 is generally considered high.
True/False
6. One of the strongest risk factors in developing cancer, diabetes and heart disease is a family history of them in a first relative.
True/False
7. Breast cancer occurs in both men and women.
True/False
8. Women do not have to perform breast self-examinations until after their first mammogram.
True/False
9. Men should perform testicular examinations regularly.
True/False
10. Pap smears are not effective in detecting cervical cancer.
True/False
11. Sexually transmitted diseases can increase your chance of developing cervical cancer.

True/False

12. There are two types of diabetes mellitus.

True/False

13. Blacks are in the lower percentile for developing diabetes.

True/False

14. Diabetes mellitus is a disorder in which your body fails to make insulin or doesn't make enough.

True/False

15. Are you a risk for any of the following:

- a. Cardiovascular disease
- b. High blood pressure
- c. Diabetes
- d. Cancer (any type)
- e. Lung disease
- f. Liver disease

ATTITUDE

Circle the letter that best represents your answer.

1. Do you feel that you can reduce your risk for developing life-threatening conditions such as cardiovascular disease, diabetes mellitus and cancer?
 - a. Yes
 - b. No
 - c. Don't Know/Not Sure

2. How important is healthy diet and regular physical activity to you?
 - a. Very important
 - b. Somewhat important
 - c. Not important

3. How important is maintaining your ideal weight?
 - a. Very important
 - b. Somewhat important
 - c. Not important

4. How important is your family history of disease?
 - a. Very important
 - b. Somewhat important
 - c. Not important

5. Your health status is:
 - a. Very important
 - b. Somewhat important
 - c. Not important

6. You are content with your health status although you know you should lose weight.
True/False

7. I smoke without considering others around me.
True/False

8. Smoking marijuana is not as harmful as smoking cigarettes.
True/False

9. I can ignore my risk for cancer because I am low-risk.
True/False
10. Regular exercise would be worth the time and effort to maintain my health.
True/False
11. My workload and/or the amount of stress my body and mind undergo do not influence my health.
True/False
12. The depth of knowledge I have of African American risk for certain conditions and diseases is:
a. Very important
b. Somewhat important
c. Not important
13. The depth of knowledge I have of my risk for certain conditions and diseases is:
a. Very important
b. Somewhat important
c. Not important
14. Would you change your behavior if it were detrimental to your health?
a. Yes
b. No
c. Don't Know/Not sure
15. How important is it to you that future generations have excellent health?
a. Very important
b. Important
c. Not important
d. Don't Know/Not Sure

BEHAVIOR

Circle the letter that best represents your answer.

1. Are you always aware of the nutrient content of the food you eat?
 - a. Yes
 - b. No
 - c. Don't Know

2. How often do you eat three meals a day?
 - a. Every day
 - b. Every other day
 - c. On the weekend
 - d. Seldom
 - e. Never

3. Do you exercise regularly?
 - a. Yes
 - b. No
 - c. Don't Know

4. Do you try to avoid saturated fat (animal fat) in your diet?
 - a. Yes
 - b. No
 - c. Don't Know

5. Do you try to eat salt and sweets sparingly?
 - a. Yes
 - b. No
 - c. Don't Know/Not Sure

6. Do you engage in activities such as smoking, drinking, having multiple sex partners, using illegal drugs, etc.?
 - a. Yes
 - b. No
 - c. Don't Know/Not Sure

7. How often do you perform testicular exams?
 - a. Once every two years
 - b. Once a year
 - c. Never

8. How often do you perform breast self-examinations?
- a. Once every two months
 - b. Once a month
 - c. Never
9. Are you sexually active?
- a. Yes
 - b. No
 - c. Don't Know/Not sure
10. Do you have annual pap smears?
- a. Yes
 - b. No
 - c. Don't Know
11. Do you have tests regularly for sexually transmitted diseases if you are sexually active?
- a. Yes
 - b. No
 - c. Don't Know
12. Does your diet consist of plenty of vegetables, fruits and grain products?
- a. Yes
 - b. No
 - c. Don't Know
13. Do you read literature on conditions and diseases for which you are at risk?
- a. Yes
 - b. No
 - c. Don't Know
14. Do you ignore serious health conditions that you know you have a risk for?
- a. Yes
 - b. No
 - c. Don't Know/Not Sure
15. I apply unneeded stress to myself.
True/False

*Some items derived from the on-line health quizzes
hosted by the MedAccess Corporation, 1996. URL
www.medaccess.com*

APPENDIX II: LETTER OF INTENT

March 17, 19981

Dr. Jean Bell Manning, Vice President of Academic Affairs
Langston University

Dear Dr. Manning,

Subject: Survey Approval

My name is Lonias Mayes. I am a senior Biology major, and I am currently working on my undergraduate thesis. This letter is in regards to securing permission to administer my survey on the main campus of Langston University. Enclosed is a copy of the survey. Please make your decision as soon as possible so that I can complete my study in time for graduation. Thank you.

Sincerely,

Lonias Mayes
Enclosure (1)