for which Surveillance, Epidemiology, and End Results data are available) continue the trend of a stable incidence rate and a declining mortality rate that began in 1989.1,2 It is well accepted that regular mammography can reduce the risk of death from breast cancer, especially in women 50 years old or older, and it appears that early diagnosis as a result of this procedure may account for the decreasing rate. According to Donna Shalala, secretary of the US Department of Health and Human Services, “it is important that we reach every American woman with this message. And it is especially important that we reach racial and ethnic minority women throughout our country because breast cancer mortality among these women is disproportionately high.”3 Thanks in large part to the efforts of the Breast and Cervical Cancer Early Detection Program of the Centers for Disease Control and Prevention, the screening gap among minority women has been narrowing.4 Reported use of mammography “in the prior 3 years” among Hispanic women 50 years of age or older increased from 17.7% to 44.7% between 1987 and 1992.5 However, Hispanic women are still less likely to participate in breast and cervical cancer screening than women of other racial and ethnic groups.6

While it is encouraging that breast cancer mortality is declining and mammography use among Hispanics is increasing, we have concerns regarding the generalizability of these trends to high-risk Hispanic subpopulations. Hispanic health data are typically generated from general population samples such as the National Health Interview Survey, and through random-digit dialing methodology and mail-out surveys. These methods consistently miss those who are illiterate, those with language barriers, and those without telephones, thus overlooking a large segment of the most medically underserved individuals for inclusion in screening statistics.

We recently completed a series of studies in migrant health clinics in eastern Washington state to establish baseline breast and cervical cancer screening rates and determinants among Hispanic immigrants.7-10 Although these women, on average, had resided in the United States for more than 9 years, 85% reported Spanish as their language of preference, 30% had no telephone in their home, and the average educational attainment was 5.5 years. Only 61.3% of women 50 years of age or older had ever heard of a mammogram, and only 38.7% had undergone the procedure (32.4% in the prior 2 years). These rates are well below those obtained for the general Hispanic population. We hypothesize that our findings are a best-case scenario as to the true level of underscreening in Hispanic immigrants, because the women we interviewed were using the health care system.

It is predicted that Hispanics will be our largest minority group by the year 2000, with much of this growth resulting from immigration. While we applaud the overall trend of declining breast cancer mortality, we also recognize that the actual number of deaths for those most at risk of underscreening may be rising. Without a continued focus on our most vulnerable citizens, their mortality rates will continue to be disproportionately high.

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References

CDC at 50: Lessons to Be Learned

David Satcher1 presents a cogent argument for the indispensability of the social and behavioral sciences and primary prevention in his review of Centers for Disease Control and Prevention (CDC) activities over the past 50 years. A large portion of CDC’s efforts devoted to understanding risky behaviors and developing behavioral interventions has occurred in the recently reorganized National Center for HIV, STD, and TB Prevention, where approximately $15 million (2.4%) of the $632 million fiscal year 1996 allocation for HIV prevention was spent on social and behavioral research and demonstration projects.2 Currently, the Behavioral Intervention Research Branch oversees 22 cooperative agreements and four contracts to develop, implement, and evaluate social and behavioral interventions to stop the spread of HIV, the virus that causes AIDS.

The 22 projects listed by the Behavioral Intervention Research Branch as ongoing are being conducted in 15 major metropolitan areas of the United States (Table 1). The only behavioral research projects being conducted with Behavioral Intervention Research Branch support in the South are being carried out by the Department of Psychology at Georgia State University in Atlanta, the headquarters of CDC. Apparently, no behavioral research projects are being supported by CDC in 3 of the 6 cities reporting the greatest incidence of AIDS in 1996: Miami (99.4 per 100,000), West Palm Beach (85.4 per 100,000), and Ft. Lauderdale (83.6 per 100,000), Florida.4

Although the US Congress has expressed reservations about how CDC oversees its grants for HIV prevention,5 CDC has never evaluated the process by which it (1) awards grants and contracts to eligible applicants, (2) monitors cooperative agreements to guarantee quality performance, or (3) demonstrates the effectiveness of its cooperative agreement program in serving the health needs of our nation. Formal evaluations by independent evaluators
are necessary to assure the American people and their elected representatives that resources are being distributed fairly and equitably to the most capable investigators working in the areas of greatest need.

CDC should follow in the footsteps of the National Institutes of Health to thoroughly review its cooperative agreement and extramural research programs. We encourage Dr Satcher or his successor to call for an independent group of qualified evaluators to examine the grant review, administration, and effectiveness process. Such an independent review would be in keeping with CDC’s primary concerns about “the centrality of science,” “working ethics,” and the formation of “partnerships” with all Americans.  

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References


Validity of Adolescent Self-Reports of Cigarette Smoking

Wills and Cleary concluded from their research that “self-reports of cigarette smoking by Black and White adolescents were generally valid and that differences in false-negative and false-positive rates across ethnic groups did not seriously qualify results” that the ethnic differentials in cigarette smoking indicated by previous epidemiological research are real and not a consequence of reporting artifacts. Their study was an attempt to replicate our research concluding that Black-White differences in self-reports of cigarette smoking and tobacco use were due in part to measurement error. Wills and Cleary believe their findings differ from ours, whereas we believe they are strikingly similar. We also consider the conclusions they draw from their data, and the conclusions about their data they attribute to us, to be potentially misleading.

Their findings were consistent across grade in school, and we focus on their subjects as 10th graders because Wills and Cleary consider them most appropriate for this consideration. Using carbon monoxide in alveolar breath as the standard for determining cigarette smoking, they found sensitivity rates (proportions with positive CO who reported smoking) of 0.98 for Whites and .56 for Blacks. That 0.42 difference (0.98 – 0.56 = 0.42) is large, consistent with our findings and conclusions, and at variance with the conclusion Wills and Cleary drew from their data and from ours. That 44% of the Black 10th graders who were smokers, according to the CO standard chosen by Wills and Cleary, did not report their smoking ought to be taken seriously by researchers and policymakers who rely on self-reports of smoking by Blacks. Also consistent with our findings, Wills and Cleary found that specificity (proportion with negative CO who report themselves as nonsmokers) was lower for Whites (0.83) than for Blacks (0.98); this difference was more than trivial because most young people are nonsmokers.

The White-to-Black ratio of CO prevalence in our study was smaller than the White-to-Black ratio of self-report prevalence. Wills and Cleary found the same result in their data for 3 of the 4 comparisons they made but concluded there was no difference. They also replicated our analyses that adjusted Black self-reports for measurement error. The adjustments resulted in Black reports being more similar to White reports. These findings are consistent with our study findings and conclusion that invalid reporting appeared to account for part of the Black–White difference in self-reports.

As we did in our paper, Wills and Cleary addressed possible limitations of using CO as the standard to measure smoking. However, they did not mention that we also used cotinine in saliva to assess self-reports of tobacco use. The completely different biochemical method used to assess a second self-report measure produced very similar findings. They also incorrectly described the ages of our 12- to 14-year-old subjects and characterized our standard metropolitan statistical areas with populations of 200 000 to 500 000 as “smaller towns.”

A contribution of the Wills and Cleary study that should not be lost here, or in their paper, is that they included Hispanics as a