

NIH INVESTMENT IN RESEARCH AND RESEARCH TRAINING  
PROGRAMS RELATED TO MINORITIES

File

Minority

Health

The NIH investment in research and research training programs related to the minority populations in the U.S. is about \$1.5 billion. Of this, about \$115 million supports research training in the preparation of minorities for careers in biomedical research. Examples are: 1) the Minority Access to Research Careers Program for undergraduate student training in research and minority and predoctoral faculty fellowships; 2) the Bridges to the Future Program for students to make the transition from two-year to four-year colleges and from Master's degree granting to doctoral degree granting programs; 3) support for minority high school, college, graduate and postdoctoral students by supplemental funds to regular research grants; and 4) a program within NIH for loan repayment scholarship funds for undergraduate, graduate and medical students, as well as postdoctoral trainees studying AIDS.

Support for research activities performed by minority investigators and their students totals about \$136 million. Under the Minority Biomedical Research Program, research is performed by faculty and students at academic institutions having a significant number of minority students [Historically Black Colleges and Universities (HBCUs); Hispanic Serving Institutions (HSIs) having an enrollment of at least 25% Hispanic students; and institutions in inner cities and some other geographic areas in which a large number of minority students are enrolled].

Support for Research Centers at Minority Institutions is about \$32 million and includes special funds for construction at these institutions. The total funds provided to HBCUs will be about \$86 million and to HSIs about \$69 million in FY1998.

Funds for research related to diseases or conditions that inordinately affect the minority populations of this country are provided by the Institutes and Centers and total over \$2 billion. These funds are particularly directed to studies of breast, prostate and lung cancer, cardiovascular disease, hypertension, diabetes, stroke, sickle cell disease, sudden infant death syndrome and infant mortality.

The Office of Research on Minority Health serves as a focus of coordination of the activities of all the NIH Institutes and Centers and is described in the attached Fact Sheet. The Office is responsible for the Minority Health Initiative, which provides about \$70 million a year for projects supported by the Institutes and Centers. These include perinatal studies and interventions to improve infant mortality rates, the effects of alcohol on the fetus, adolescent alcohol use, lead poisoning in children, research on HIV infection in adolescents, studies of asthma in minority children, auditory and visual impairments in minority children, and many others.

The NIH is committed to ensuring that all Americans have equal access to good health and that all scientists have the opportunities to compete fairly for research funds.

April 1998

**FACT SHEET ON BLACK AND HISPANIC WORKERS**

**\*BULLETS**

**\*TABLES**

**\*CHARTS**

**U.S. DEPARTMENT OF LABOR  
BUREAU OF LABOR STATISTICS  
APRIL 1996**

## OVERVIEW

Blacks and Hispanics continue to lag considerably behind whites according to nearly every measure of labor market success. Blacks comprise this country's largest minority group -- 23 million persons of working age (16 years and over) in 1995, of whom 14.8 million were in the labor force. Despite recent labor market improvements, blacks continue to hold proportionately fewer jobs than whites and have much higher rates of unemployment. This problem is compounded by the fact that, once unemployed, blacks tend to remain jobless longer than whites. Among those who are employed, blacks are more likely than whites to be working part time involuntarily and to hold lower-skilled, lower-paying jobs. Blacks also comprise a disproportionate number of discouraged workers -- persons outside the labor force who want a job but aren't looking for work because they believe their job search would be in vain.

Hispanic workers -- persons who identify themselves as Mexican, Puerto Rican, Cuban, Central or South American, or of other Hispanic origin or descent -- comprise one of the Nation's fastest-growing minority groups, with a working-age population of 18.6 million and a labor force of 12.3 million in 1995. Over the past decade, their labor force has nearly doubled. While some indicators show that Hispanic workers tend to be somewhat more successful in the labor market than blacks, they still lag behind white workers in most labor market performance categories.

## UNEMPLOYMENT AND RELATED LABOR MARKET PROBLEMS

- \* Blacks are still more than twice as likely as whites to be unemployed, a situation that has persisted for several decades. In 1995, the unemployment rate for black workers was 10.4 percent, compared to 4.9 percent for whites. In the past, the unemployment rate for Hispanics hovered roughly midway between that for whites and blacks. Recently, however, the gap between the Hispanic and black jobless rates has narrowed; in 1995, the unemployment rate for Hispanics was 9.3 percent. (See table 1.)
  
- \* The higher unemployment rates for blacks and Hispanics occur across all major age-sex groups. In 1995, the rates for black adult men and adult women were 8.8 and 8.6 percent, respectively, compared to 7.7 and 8.9 percent for Hispanics and 4.3 for white adult men and adult women. Black teenagers, a group especially vulnerable to joblessness, had an unemployment rate of 35.7 percent in 1995, compared with 24.4 percent for Hispanic teens and 14.5 percent for white teenagers. (See table 1.)
  
- \* Not only are blacks more likely to be unemployed than whites, but they also spend more time looking for work. In 1995, the average duration of unemployment for blacks was 19.6 weeks, compared to 15.7 weeks for whites. The average duration of unemployment for Hispanics was 16.6 weeks.

- \* The historically higher jobless rates for minority workers are associated with many factors, not all of which are measurable. These include their somewhat younger age profile; lower levels of schooling; their tendency to be employed in occupations that are more subject to unemployment; their greater concentration in the central cities of our urban areas, where job opportunities may be more limited; and the likelihood that they are subject to a greater degree of discrimination in the workplace.
  
- \* Minorities are more likely than whites to be reported as discouraged workers<sup>2</sup>—persons who indicate that they want a job but are *not currently looking for work* (and hence are not classified as unemployed) because they believe their search would be in vain. The existence of a sizable number of people who do not participate in the job market because of their discouragement over job prospects is a serious labor market problem, since these people represent additional labor resources that are not being utilized.
  
- \* The majority of persons who work part time (less than 35 hours a week) do so by choice. However, some would prefer and are available for full-time work but must settle for part time employment because their workweek has been cut back or they could only find part-time jobs. In 1995, minority workers were more likely than whites to be working part time for these “economic reasons.”

## EMPLOYMENT

- \* Blacks and Hispanics hold proportionately fewer jobs than whites. In 1995, the percent of the black working-age population that was employed (the employment-population ratio) was less than that for whites. Black and Hispanic teenagers are particularly disadvantaged in this area. (See table 1.)
  
- \* Although there has been occupational upgrading among minorities over the past decade, they continued to be concentrated in less-skilled, lower-paying occupations. In 1995, black and Hispanic men were about half as likely as white men to be employed as managers or professionals and much more likely to be employed as operators, fabricators, and laborers. Black and Hispanic women were much more likely than white women to be employed in generally lower-paid service occupations. (See table 2.)
  
- \* The earnings levels of blacks and Hispanics are much lower than that of whites. In 1995, the median weekly earnings of black men and Hispanic men working at full-time jobs (\$411, and \$350, respectively) were well below the figure for white men (\$566). The earnings of minority women were also below that of their white counterparts. (See table 3.)

- \* For men, the earnings disparity between minority and white workers occurs across all major occupational groupings. For example, the 1995 median weekly earnings of white men working full time in the high-paying managerial and professional specialty category -- \$844 -- were well above the figures for Hispanic men (\$666) and black men (\$641). Among women, the earnings gap between minority workers and whites is, in general, smaller, and in some major occupational categories the earnings levels are quite close. For example, the median weekly earnings of black and Hispanic women working full time in technical, sales, and administrative support positions, at \$367 and \$343, respectively, were only slightly below the \$385 figure for white women. (See table 4.)
  
- \* In 1995, Hispanic workers were more likely than blacks or whites to have hourly earnings at or below the minimum wage -- \$4.25 an hour. (See table 5.)

## EDUCATION

- \* With regard to level of schooling, in 1995, 87 percent of black adult workers (25 years and over) and only 64 percent of Hispanic workers had completed at least a high school education, compared to 90 percent of white workers. Data for November 1989 show that among Hispanics who had not completed high school, two-thirds were foreign born. For both blacks and Hispanics, the proportion of workers who were college graduates was well below that of whites. (See table 6.)

- \* Among minorities as well as whites, there is a clear relationship between years of schooling completed and labor market success. For each group, the higher the level of educational attainment, the greater the likelihood of being employed, and correspondingly, the less likelihood of being unemployed. (See table 6.)
  
- \* Minorities earn less than whites regardless of educational level. Among persons who have not completed high school, Hispanics usually working full time earned \$265 per week in 1995 and blacks made \$277, below the median weekly earnings for whites with similar years of schooling (\$298). Among those who have obtained at least a bachelor's degree, blacks' and Hispanics' weekly earnings were each \$620, compared with \$739 for whites. (See table 7.)
  
- \* Among minority youth (16 to 24 years of age), 19 percent of black and 21 percent of Hispanic high school students were employed in October 1994, a much lower proportion than for white students--39 percent. (See table 8.)
  
- \* Unemployment rates were higher for minorities regardless of school enrollment. Of those enrolled in school, the largest differences in the unemployment rates were among those attending high school. Jobless rates for black and Hispanic students enrolled in high school, at 38.2 and 27.9 percent, respectively, were about twice that for their white counterparts (15.1 percent). Unemployment rates for black and Hispanic high school graduates (with no college education), at 22.9 and 14.5 percent, respectively, were much higher than that for their white counterparts (9.2 percent). (See table 8.)

## FAMILY

- \* In 1994, higher proportions of both black (60 percent) and Hispanic (65 percent) families had children under 18 years old, compared with white families (48 percent). These proportions have changed little over the past decade. (See table 9.)
- \* The majority of both white and Hispanic families with children are two-parent families. By contrast, two-parent black families comprise only 40 percent of all black families with children. (See table 9.)
- \* About 53 percent of the Hispanic and 66 percent of black single mothers (never-married, divorced, widowed, or separated) were labor force participants, smaller proportions than for white mothers. By contrast, there was relatively little difference in the proportions of single fathers who were in the labor force. (See table 9.)
- \* Black and Hispanic families generally earn much less than white families. In 1993, the median weekly earnings for black families were \$490, not much different from \$505 for Hispanic families, but well below the \$739 figure for white families. (See table 10.)

**Table 1. Employment status of major age-sex groups by race and Hispanic origin, 1985 and 1995 annual averages**

(Numbers in thousands)

Employment status, sex and age	Black		Hispanic origin		White	
	1985	1995	1985	1995	1985	1995
<b>TOTAL</b>						
Civilian noninstitutional population....	19,664	23,246	11,528	18,629	153,679	166,914
Civilian labor force.....	12,364	14,817	7,448	12,267	99,926	111,950
Percent of population.....	62.9	63.7	64.6	65.8	65.0	67.1
Employed.....	10,501	13,279	6,664	11,127	93,736	106,490
Percent of population.....	53.4	57.1	57.8	59.7	61.0	63.8
Unemployed.....	1,864	1,538	785	1,140	6,191	5,459
Unemployment rate.....	15.1	10.4	10.5	9.3	6.2	4.9
<b>Men, 20 years and over</b>						
Civilian noninstitutional population....	7,731	9,280	5,036	8,375	67,386	74,879
Civilian labor force.....	5,749	6,730	4,232	6,898	52,895	57,719
Percent of population.....	74.4	72.5	84.0	82.4	78.5	77.1
Employed.....	4,992	6,137	3,845	6,367	50,061	55,254
Percent of population.....	64.6	66.1	76.4	76.0	74.3	73.8
Unemployed.....	757	593	387	530	2,834	2,465
Unemployment rate.....	13.2	8.8	9.1	7.7	5.4	4.3
<b>Women, 20 years and over</b>						
Civilian noninstitutional population....	9,773	11,682	5,258	8,382	74,394	80,567
Civilian labor force.....	5,727	7,175	2,667	4,520	40,190	47,686
Percent of population.....	58.6	61.4	50.7	53.9	54.0	59.2
Employed.....	4,977	6,556	2,403	4,116	37,907	45,643
Percent of population.....	50.9	56.1	45.7	49.1	51.0	56.7
Unemployed.....	750	620	264	404	2,283	2,042
Unemployment rate.....	13.1	8.6	9.9	8.9	5.7	4.3
<b>Both sexes, 16 to 19 years</b>						
Civilian noninstitutional population....	2,160	2,284	1,234	1,872	11,900	11,468
Civilian labor force.....	889	911	549	850	6,841	6,545
Percent of population.....	41.2	39.9	44.5	45.4	57.5	57.1
Employed.....	532	586	416	645	5,768	5,593
Percent of population.....	24.6	25.7	33.7	34.5	48.5	48.8
Unemployed.....	357	325	134	205	1,074	952
Unemployment rate.....	40.2	35.7	24.3	24.4	15.7	14.5

**Table 2. Employed persons by occupation, sex, race, and Hispanic origin, 1995 annual averages**

Occupation	Men			Women		
	Black	Hispanic origin	White	Black	Hispanic origin	White
Total employed (thousands).....	6,422	6,725	58,146	6,857	4,403	48,344
Managerial and professional specialty.....	1,139	805	16,515	1,512	744	14,808
Executive, administrative, and managerial.....	589	451	8,947	644	370	6,452
Professional specialty.....	550	354	7,568	868	373	8,356
Technical, sales, and administrative support.....	1,135	1,024	11,615	2,673	1,695	20,569
Technicians and related support.....	148	128	1,663	230	112	1,698
Sales occupations.....	451	509	6,905	732	539	6,461
Administrative support, including clerical.....	537	387	3,047	1,711	1,045	12,410
Service occupations.....	1,142	1,067	5,240	1,739	1,128	7,968
Private household.....	7	7	28	130	196	610
Protective service.....	305	144	1,527	101	22	244
Service, except private household and protective.....	830	916	3,685	1,508	909	7,114
Precision production, craft, and repair.....	918	1,285	10,985	155	145	965
Mechanics and repairers.....	349	352	3,779	19	13	150
Construction trades.....	350	573	4,479	12	7	105
Other precision production, craft, and repair.....	220	360	2,727	124	125	710
Operators, fabricators, and laborers.....	1,949	1,973	11,147	763	604	3,349
Machine operators, assemblers, and inspectors.....	668	790	4,041	551	459	2,180
Transportation and material moving occupations.....	677	478	3,858	82	33	396
Handlers, equipment cleaners, helpers, and laborers...	604	704	3,248	130	112	774
Farming, forestry, and fishing.....	139	571	2,646	15	87	684

**Table 2. Employed persons by occupation, sex, race, and Hispanic origin, 1995 annual averages**

Occupation	Men			Women		
	Black	Hispanic origin	White	Black	Hispanic origin	White
Total employed (thousands).....	6,241	6,530	57,452	6,595	4,258	47,738
Percent.....	100.0	100.0	100.0	100.0	100.0	100.0
Managerial and professional specialty.....	17.7	12.0	28.4	22.1	16.9	30.6
Executive, administrative, and managerial.....	9.2	6.7	15.4	9.4	8.4	13.3
Professional specialty.....	8.6	5.3	13.0	12.7	8.5	17.3
Technical, sales, and administrative support.....	17.7	15.2	20.0	39.0	38.5	42.5
Technicians and related support.....	2.3	1.9	2.9	3.4	2.5	3.5
Sales occupations.....	7.0	7.6	11.9	10.7	12.2	13.4
Administrative support, including clerical.....	8.4	5.8	5.2	25.0	23.7	25.7
Service occupations.....	17.8	15.9	9.0	25.4	25.6	16.5
Private household.....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	1.9	4.5	1.3
Protective service.....	4.7	2.1	2.6	1.5	.5	.5
Service, except private household and protective.....	12.9	13.6	6.3	22.0	20.6	14.7
Precision production, craft, and repair.....	14.3	19.1	18.9	2.3	3.3	2.0
Mechanics and repairers.....	5.4	5.2	6.5	.3	.3	.3
Construction trades.....	5.5	8.5	7.7	.2	.2	.2
Other precision production, craft, and repair.....	3.4	5.4	4.7	1.8	2.8	1.5
Operators, fabricators, and laborers.....	30.3	29.3	19.2	11.1	13.7	6.9
Machine operators, assemblers, and inspectors.....	10.4	11.7	6.9	8.0	10.4	4.5
Transportation and material moving occupations.....	10.5	7.1	6.6	1.2	.7	.8
Handlers, equipment cleaners, helpers, and laborers.....	9.4	10.5	5.6	1.9	2.5	1.6
Farming, forestry, and fishing.....	2.2	8.5	4.6	.2	2.0	1.4

<sup>1</sup>Data not shown where base is less than 50,000.

**Table 3. Median usual weekly earnings of full- or part-time wage and salary workers by race, sex, and Hispanic origin, 1985 and 1995 annual averages**

Full- or part-time status, race, sex, and Hispanic origin	Number of workers (in thousands)		Median weekly earnings	
	1985	1995	1985	1995
<b>Full-time workers</b>				
Black .....	8,393	10,596	\$277	\$383
Men .....	4,367	5,279	304	411
Women .....	4,026	5,317	252	355
Hispanic origin .....	5,285	8,719	269	329
Men .....	3,391	5,597	295	350
Women .....	1,893	3,122	229	305
White .....	66,481	74,874	355	494
Men .....	40,030	43,747	417	566
Women .....	26,452	31,127	281	415
<b>Part-time workers<sup>1</sup></b>				
Black .....	1,680	2,035	89	135
Men .....	600	718	87	133
Women .....	1,080	1,317	90	135
Hispanic origin .....	933	1,668	97	139
Men .....	366	616	96	144
Women .....	567	1,052	97	136
White .....	15,380	17,702	95	141
Men .....	4,650	5,312	88	128
Women .....	10,731	12,390	98	146

<sup>1</sup>Earnings data for part-time workers are not strictly comparable.

**Table 4. Median usual weekly earnings of full-time wage and salary workers by occupation, sex, race, and Hispanic origin, 1995 annual averages**

Occupation	Men			Women		
	Black	Hispanic origin	White	Black	Hispanic origin	White
Managerial and professional specialty.....	\$641	\$666	\$844	\$566	\$513	\$608
Executive, administrative, and managerial.....	607	636	854	563	498	570
Professional specialty.....	678	707	835	568	544	637
Technical, sales, and administrative support.....	421	432	579	367	343	385
Technicians and related support.....	602	550	644	462	441	479
Sales occupations.....	378	412	594	260	277	347
Administrative support, including clerical.....	410	412	503	383	358	384
Service occupations.....	307	284	377	263	230	264
Private household.....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )	216	182	186
Protective service.....	411	519	585	408	( <sup>1</sup> )	453
Service, except private household and protective.....	270	268	306	258	238	264
Precision production, craft, and repair.....	483	405	546	340	306	384
Mechanics and repairers.....	501	428	546	( <sup>1</sup> )	( <sup>1</sup> )	564
Construction trades.....	445	381	515	( <sup>1</sup> )	( <sup>1</sup> )	387
Other precision production, craft, and repair.....	486	415	586	316	303	360
Operators, fabricators, and laborers.....	368	313	425	288	244	302
Machine operators, assemblers, and inspectors.....	391	309	433	291	238	299
Transportation and material moving occupations.....	390	395	496	309	( <sup>1</sup> )	363
Handlers, equipment cleaners, helpers, and laborers.....	317	284	332	252	256	292
Farming, forestry, and fishing.....	268	266	298	( <sup>1</sup> )	221	247

<sup>1</sup>Data not shown where base is less than 50,000.

**Table 5. Employed wage and salary workers paid hourly rates with earnings at or below the prevailing Federal minimum wage by race, sex, and Hispanic origin, 1995 annual averages**

Sex, race, and Hispanic origin	Number of workers (in thousands)				Percent of all workers paid hourly rates		
	Total paid hourly rates	At or below \$4.25			At or below \$4.25		
		Total	At \$4.25	Below \$4.25	Total	At \$4.25	Below \$4.25
Black .....	8,957	498	314	184	5.6	3.5	2.1
Men .....	4,281	191	120	71	4.5	2.8	1.7
Women .....	4,676	308	194	114	6.6	4.1	2.4
Hispanic origin .....	7,624	566	363	203	7.4	4.8	2.7
Men .....	4,637	289	179	110	6.2	3.9	2.4
Women .....	2,987	277	184	93	9.3	6.2	3.1
White .....	56,475	2,995	1,549	1,446	5.3	2.7	2.6
Men .....	28,609	1,078	637	441	3.8	2.2	1.5
Women .....	27,866	1,916	911	1,005	6.9	3.3	3.6

**Table 6. Employment status of persons 25 years and over by educational attainment, race, and Hispanic origin, 1995 annual averages**

(Numbers in thousands)

Educational attainment, race, and Hispanic origin	Civilian noninsti- tutional population	Civilian labor force					
		Total	Percent of population	Employed		Unemployed	
				Total	Percent of population	Total	Percent of labor force
<b>Black</b>							
Total, 25 years and over.....	18,409	12,152	66.0	11,249	61.1	902	7.4
Less than a high school diploma.....	4,667	1,691	36.2	1,482	31.7	209	12.4
High school graduates, no college.....	6,477	4,513	69.7	4,142	64.0	371	8.2
Some college, no degree.....	3,470	2,722	78.4	2,517	72.5	205	7.5
Associate degree.....	1,200	1,006	83.8	960	80.0	46	4.6
College graduates.....	2,594	2,220	85.6	2,149	82.8	71	3.2
<b>Hispanic origin</b>							
Total, 25 years and over.....	14,229	9,599	67.5	8,873	62.4	725	7.6
Less than a high school diploma.....	6,469	3,574	55.3	3,204	49.5	370	10.4
High school graduates, no college.....	3,792	2,817	74.3	2,624	69.2	193	6.8
Some college, no degree.....	1,923	1,519	79.0	1,427	74.2	92	6.1
Associate degree.....	693	565	81.5	534	77.1	31	5.5
College graduates.....	1,352	1,124	83.1	1,084	80.2	40	3.5
<b>White</b>							
Total, 25 years and over.....	141,133	94,139	66.7	90,498	64.1	3,641	3.9
Less than a high school diploma.....	23,695	9,473	40.0	8,690	36.7	783	8.3
High school graduates, no college.....	47,954	31,071	64.8	29,776	62.1	1,295	4.2
Some college, no degree.....	25,004	17,933	71.7	17,265	69.0	667	3.7
Associate degree.....	10,442	8,224	78.8	7,970	76.3	253	3.1
College graduates.....	34,038	27,438	80.6	26,796	78.7	642	2.3

**Table 7. Median usual weekly earnings of full-time wage and salary workers by educational attainment, sex, race, and Hispanic origin, 1995 annual averages**

Educational attainment, race, and Hispanic origin	Both sexes	Men	Women
<b>Black</b>			
Total, 16 years and over.....	\$383	\$411	\$355
Less than a high school diploma.....	277	301	246
High school graduates, no college.....	336	377	305
Some college, no degree.....	381	412	358
Associate degree.....	438	494	405
College graduates.....	620	655	600
<b>Hispanic origin</b>			
Total, 16 years and over.....	329	350	305
Less than a high school diploma.....	265	282	225
High school graduates, no college.....	346	382	305
Some college, no degree.....	404	454	365
Associate degree.....	462	527	388
College graduates.....	620	663	574
<b>White</b>			
Total, 16 years and over.....	494	566	415
Less than a high school diploma.....	298	321	251
High school graduates, no college.....	420	493	349
Some college, no degree.....	466	550	390
Associate degree.....	528	607	456
College graduates.....	739	842	629

**Table 8. Employment status of persons 16 to 24 years old by school enrollment, educational attainment, race, and Hispanic origin, October 1994**

(Numbers in thousands)

Characteristic	Civilian noninstitutional population	Civilian labor force					
		Total	Percent of population	Employed		Unemployed	
				Total	Percent of population	Number	Percent of labor force
<b>Black</b>							
Total 16 to 24 years.....	4,868	2,707	55.6	2,058	42.3	649	24.0
Enrolled in school.....	2,427	933	38.5	690	28.4	243	26.0
High school.....	1,390	430	31.0	266	19.1	165	38.2
College.....	1,037	503	48.5	425	40.9	78	15.6
Full-time students.....	869	360	41.4	290	33.4	69	19.3
Part-time students.....	168	143	85.4	134	80.1	9	6.2
Not enrolled in school.....	2,441	1,773	72.7	1,367	56.0	406	22.9
Less than a high school diploma.....	618	338	54.6	224	36.2	114	33.7
High school graduates, no college...	1,154	856	74.2	660	57.2	196	22.9
Less than a bachelor's degree.....	548	469	85.6	378	69.0	91	19.4
College graduates.....	121	110	91.2	105	86.9	5	4.7
<b>Hispanic origin</b>							
Total 16 to 24 years.....	4,411	2,678	60.7	2,309	52.3	369	13.8
Enrolled in school.....	1,750	747	42.7	632	36.1	115	15.4
High school.....	1,080	318	29.4	229	21.2	89	27.9
College.....	671	429	64.0	403	60.1	26	6.1
Full-time students.....	436	234	53.8	219	50.2	16	6.7
Part-time students.....	235	195	82.9	184	78.4	10	5.3
Not enrolled in school.....	2,661	1,932	72.6	1,677	63.0	255	13.2
Less than a high school diploma.....	1,322	838	63.4	717	54.2	121	14.5
High school graduates, no college...	913	719	78.8	615	67.4	104	14.5
Less than a bachelor's degree.....	358	313	87.4	289	80.7	24	9.0
College graduates.....	68	62	( <sup>1</sup> )	57	( <sup>1</sup> )	5	( <sup>1</sup> )
<b>White</b>							
Total 16 to 24 years.....	25,918	17,687	68.2	16,027	61.8	1,660	9.4
Enrolled in school.....	13,488	7,357	54.5	6,682	49.5	674	9.2
High school.....	6,270	2,902	46.3	2,465	39.3	437	15.1
College.....	7,218	4,454	61.7	4,217	58.4	237	5.3
Full-time students.....	5,909	3,270	55.3	3,073	52.0	198	6.0
Part-time students.....	1,309	1,184	90.4	1,144	87.4	40	3.4
Not enrolled in school.....	12,431	10,330	83.1	9,345	75.2	985	9.5
Less than a high school diploma.....	2,835	1,840	64.9	1,504	53.0	337	18.3
High school graduates, no college...	5,422	4,621	85.2	4,195	77.4	425	9.2
Less than a bachelor's degree.....	2,816	2,584	91.8	2,424	86.1	158	6.1
College graduates.....	1,359	1,286	94.7	1,222	89.9	64	5.0

<sup>1</sup>Data not shown where base is less than 75,000.

**Table 9. Selected characteristics of families by race and Hispanic origin, March 1984 and 1994**

(Numbers in thousands)

Characteristic	Black		Hispanic origin		White	
	1984	1994	1984	1994	1984	1994
Total families.....	6,779	8,116	3,837	6,075	54,263	58,428
With children under 18 <sup>1</sup> .....	3,985	4,901	2,551	3,916	26,525	28,163
Percent of all families.....	58.8	60.4	66.5	64.5	48.9	48.2
Married-couple families.....	1,873	1,950	1,866	2,628	21,743	21,876
Percent of all families with children.....	47.0	39.8	73.1	67.1	82.0	77.7
Father in labor force, only <sup>2</sup> .....	471	394	872	1,064	8,674	6,294
Both parents in labor force <sup>2</sup> .....	1,278	1,347	893	1,351	12,199	14,524
Maintained by women <sup>3</sup> .....	1,976	2,705	621	1,102	4,108	5,213
Mother in labor force.....	1,223	1,781	298	582	2,969	3,649
Maintained by men.....	136	247	65	187	675	1,074
Father in labor force.....	102	211	52	164	616	962
With no children under 18.....	2,794	3,215	1,286	2,159	27,738	30,265
Married-couple families.....	1,586	1,801	900	1,425	23,765	25,587
Percent of all families with no children.....	56.8	56.0	70.0	66.0	85.7	84.5
Husband in labor force, only <sup>2</sup> .....	295	266	273	347	5,598	4,252
Husband and wife in labor force <sup>2</sup> .....	691	763	353	612	9,562	11,558
Maintained by women <sup>3</sup> .....	979	1,196	269	496	2,976	3,383
Householder in labor force.....	463	665	148	296	1,462	1,833
Maintained by men <sup>3</sup> .....	230	212	117	235	996	1,289
Householder in labor force.....	147	135	95	195	689	865

<sup>1</sup>Children are own children and include sons, daughters, and adopted or step-children. Excluded are nieces, nephews, grandchildren, and other related or unrelated children.

<sup>2</sup>Includes men in the Armed Forces living with their families on or off post.

<sup>3</sup>Refers to families maintained by never married, widowed, divorced, or separated persons.

**Table 10. Median weekly wage and salary earnings of families by presence of children, names of earners, race, and Hispanic origin, 1993 annual averages**

(Numbers in thousands)

Presence of children and number of earners	Black		Hispanic origin		White	
	Number	Median weekly earnings	Number	Median weekly earnings	Number	Median weekly earnings
Families with wage and salary earnings <sup>1</sup> .....	5,268	\$490	3,879	\$505	37,458	\$739
<b>WITH CHILDREN UNDER 18</b>						
Total.....	3,050	464	2,518	483	20,277	734
Married-couple families.....	1,551	688	1,916	552	16,386	822
One earner.....	460	372	834	339	5,771	549
Father.....	328	379	697	361	4,935	598
Two or more earners.....	1,091	820	1,083	717	10,615	957
Father and mother.....	1,024	836	887	744	9,842	974
Families maintained by women <sup>2</sup> .....	1,329	304	461	309	3,019	355
One earner.....	1,169	283	367	269	2,487	317
Mother.....	1,106	287	329	287	2,372	324
Two or more earners.....	160	552	95	483	532	569
Mother and other relative in family.....	150	553	83	481	509	578
Families maintained by men <sup>2</sup> .....	171	377	141	368	872	506
One earner.....	154	349	115	313	749	478
Father.....	151	553	113	315	731	483
Two or more earners.....	17	( <sup>3</sup> )	26	( <sup>3</sup> )	124	759
Father and other relative in family.....	16	( <sup>3</sup> )	25	( <sup>3</sup> )	122	761
<b>WITH NO CHILDREN UNDER 18</b>						
Total.....	2,218	524	1,360	545	17,181	745
Married-couple families.....	1,147	647	884	607	13,901	806
One earner.....	449	321	344	323	5,019	424
Husband.....	211	383	215	381	2,820	538
Two or more earners.....	698	892	540	799	8,882	1,018
Husband and wife.....	567	949	393	850	7,730	1,047
Families maintained by women <sup>2</sup> .....	839	426	288	451	2,336	513
One earner.....	484	277	139	269	1,145	336
Householder.....	289	305	66	280	506	358
Two or more earners.....	355	637	148	649	1,191	716
Householder and other relative in family.....	302	655	115	619	1,047	718
Families maintained by men <sup>2</sup> .....	232	464	189	484	943	598
One earner.....	118	277	66	302	449	445
Householder.....	55	352	41	( <sup>3</sup> )	266	512
Two or more earners.....	114	703	123	610	494	774
Householder and other relative in family.....	103	709	112	619	458	777

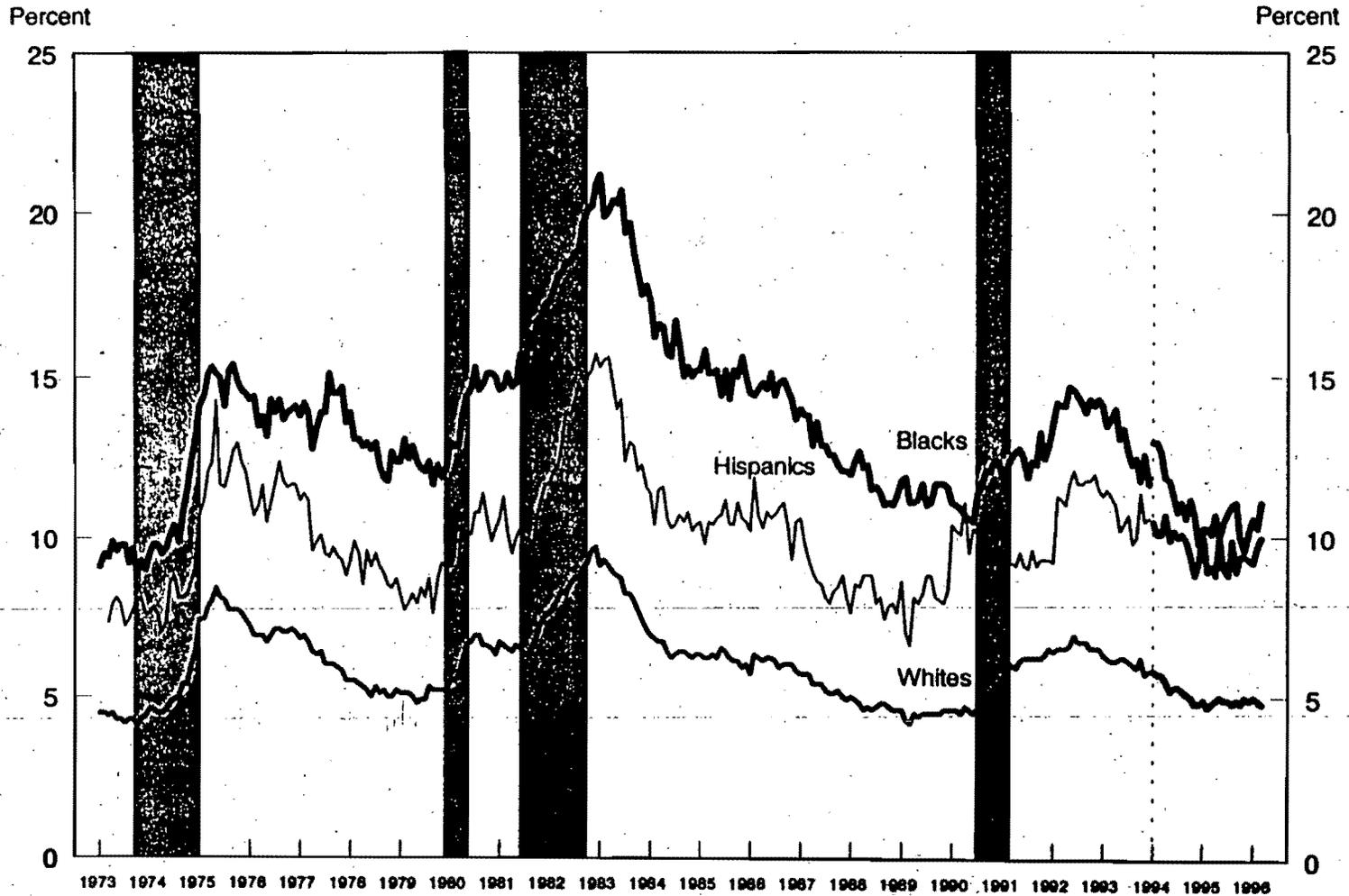
<sup>1</sup>Data exclude families in which the husband, wife, or person maintaining the family is either self-employed or in Armed Forces.

<sup>2</sup>Families maintained by never married, widowed, divorced, or separated persons.

<sup>3</sup>Median not shown where base is less than 50,000.

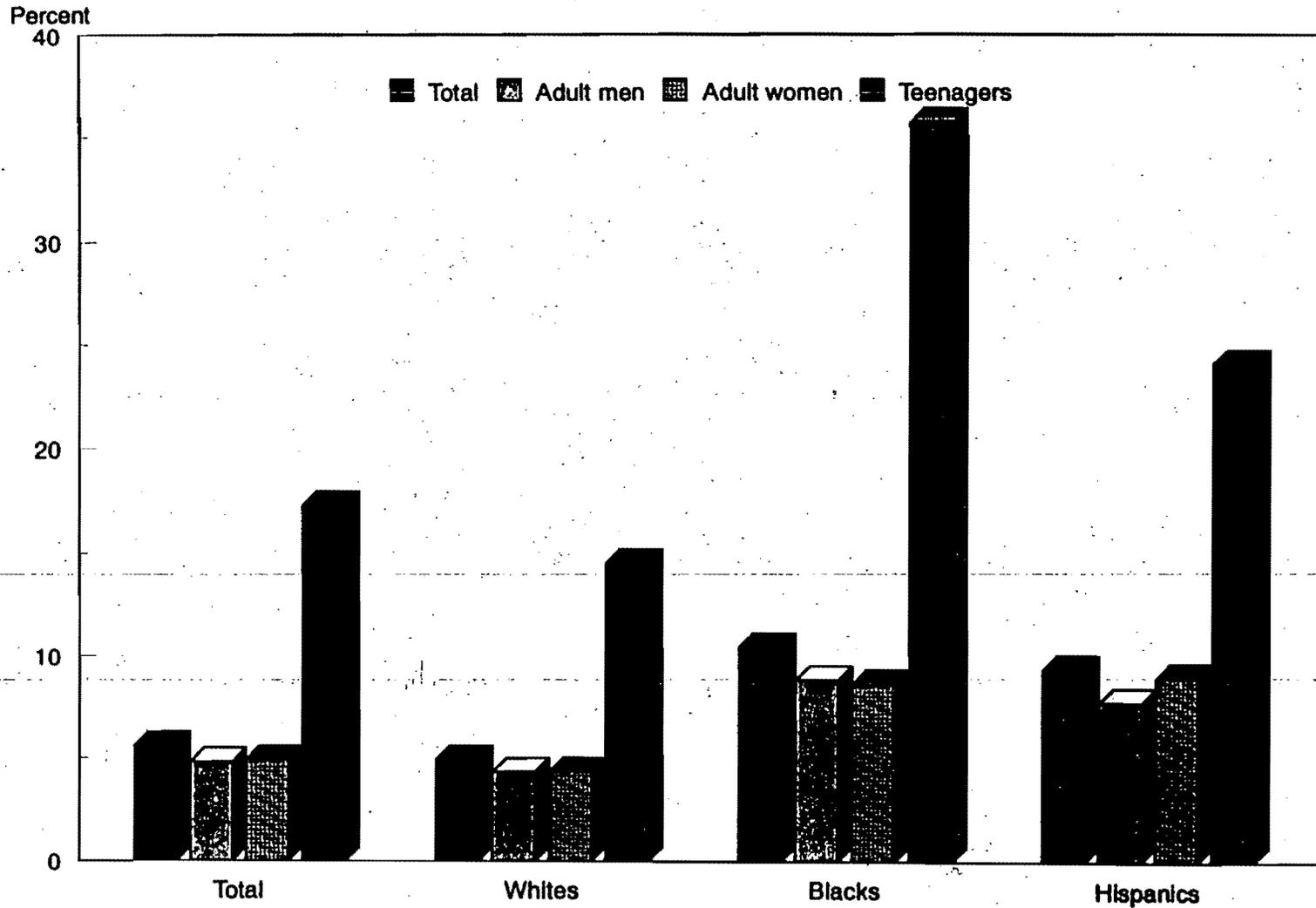
NOTE: Children are own children and include sons, daughters, and adopted or step-children. Excluded are nieces, nephews, grandchildren, and other related or unrelated children.

**Chart 1. Unemployment rates for whites, blacks, and persons of Hispanic origin, seasonally adjusted, 1973-96**



NOTE: Shaded areas represent recessions. Beginning in 1994, household data reflect the introduction of a major redesign of the Current Population Survey questionnaire and collection methodology and are not directly comparable with data for prior years. Beginning in 1990, these data incorporate 1990 Census-based population controls, adjusted for the estimated undercount.

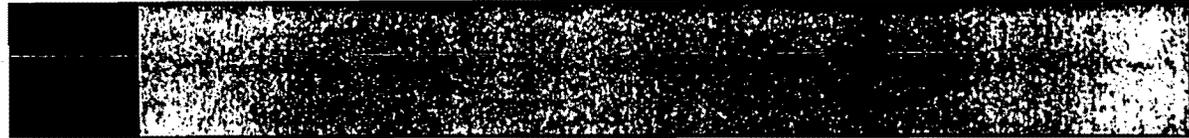
**Chart 2. Unemployment rates for major age-sex groups by race and Hispanic origin, 1995 annual averages**



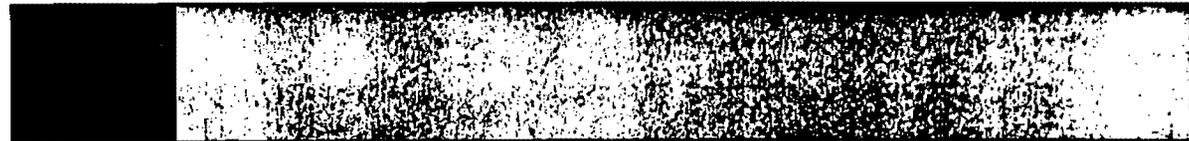
### Chart 3. Selected labor force characteristics of black workers, 1995 annual averages

Blacks comprise:

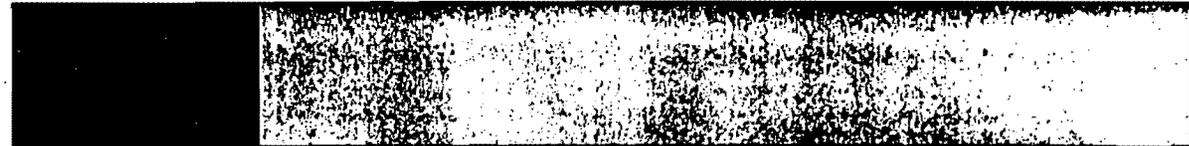
11 percent of the labor force



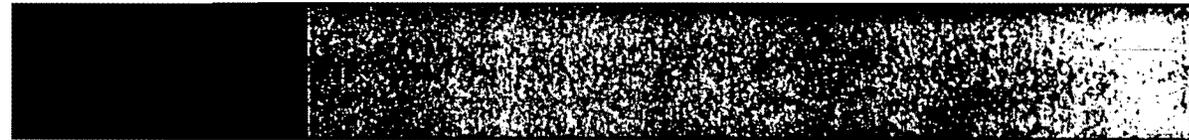
14 percent of those working part time for economic reasons



21 percent of the unemployed



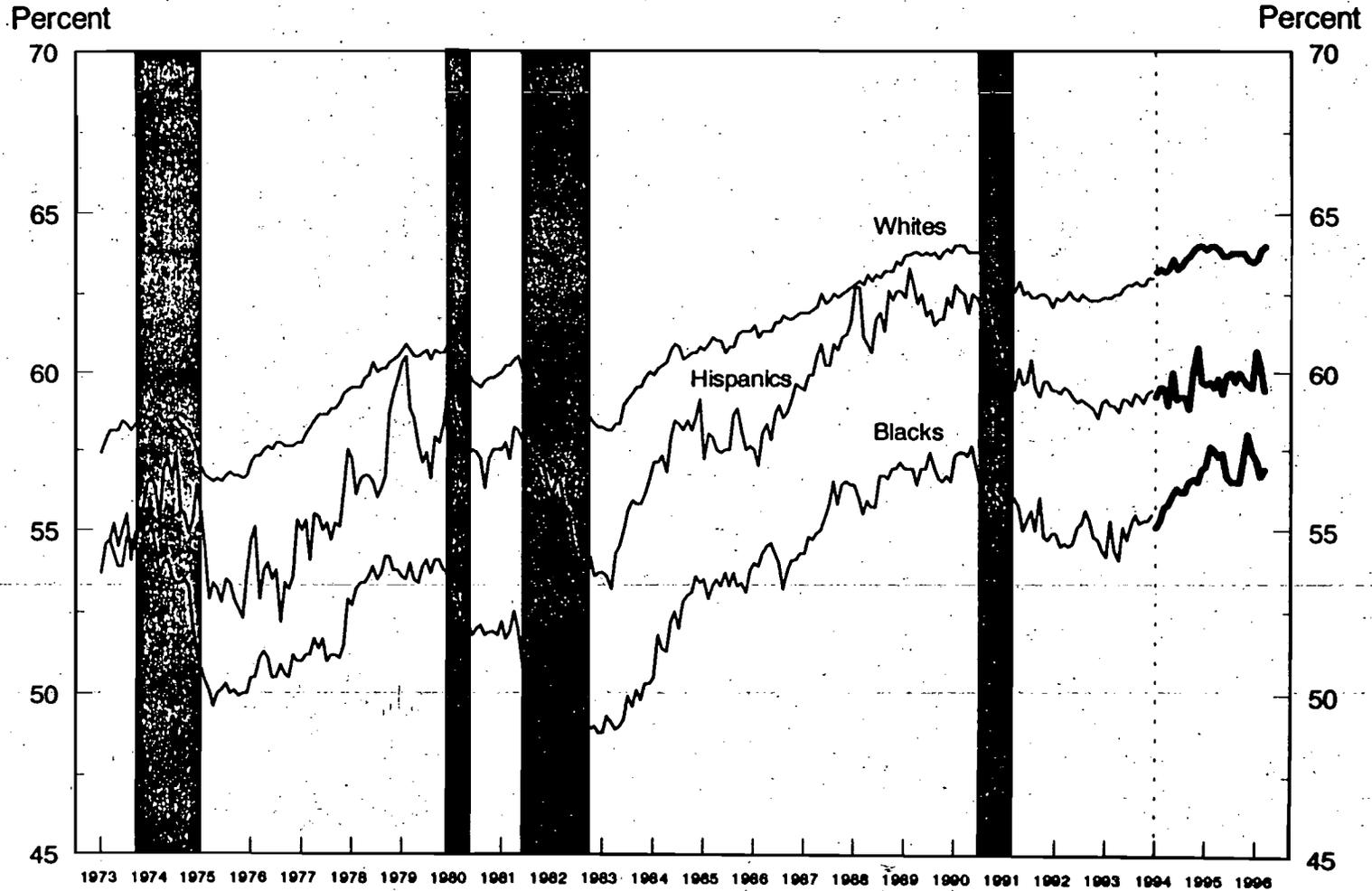
25 percent of the long-term unemployed



31 percent of discouraged workers



**Chart 4. Civillian employment-population ratios for whites, blacks, and persons of Hispanic origin, seasonally adjusted, 1973-96**



NOTE: Shaded areas represent recessions. Beginning in 1994, household data reflect the introduction of a major redesign of the Current Population Survey questionnaire and collection methodology and are not directly comparable with data for prior years. Beginning in 1990, these data incorporate 1990 Census-based population controls, adjusted for the estimated undercount.



*A nationwide service of the U.S. Department of Health and Human Services  
Public Health Service ■ Office of Minority Health ■ 1-800-444-6472*

OFFICE OF MINORITY HEALTH RESOURCE CENTER

## **BILINGUAL/BICULTURAL SERVICE DEMONSTRATION GRANTS**

### **THE PROGRAM**

#### **Program Description**

The Bilingual/Bicultural Service Demonstration Grant Program is administered and funded by the Office of Minority Health (OMH) of the U.S. Department of Health and Human Services (DHHS). The OMH was created in December 1985 to address the historical disparity between the health status of whites and that of racial and ethnic minorities. Its mission is to improve the health of racial and ethnic populations through the development of effective health policies and programs.

The Bilingual/Bicultural Service Demonstration Grant Program was developed in 1993 to reduce social, cultural and linguistic barriers between providers and clients with limited-English-proficiency, and to improve their access to good health care. The projects described in this fact sheet are funded for the three-year project period 9/30/95 through 9/29/98. The grants are administered by community-based organizations linked with health care facilities. These projects seek to improve the ability of health care providers and other health care professionals to deliver linguistically and culturally competent health services to populations that speak limited English.

Each of the projects offers activities unique to the needs of the target community. In addition to developing cultural competency training programs for physicians, nurses, and other professionals, the projects work to increase the use of case managers and outreach workers from the racial and ethnic communities they serve. They provide counseling, mentoring, and support group programs for clients who speak limited English, and enhance translation and interpreting services for minority populations. For additional information, please contact the Division of Program Operations, Office of Minority Health at (301) 594-0769.

## AMERICAN SAMOA

---

### American Samoa Government

Department of Health  
LBJ Tropical Medical Center  
Pago Pago, AS 96799

PHONE: 011 (684) 633-2243  
FAX: 011 (684) 633-5379

Title:  
Health Education Curriculum  
Improvement and Service Extension Project

Project Director:  
Joseph Tufa, D.S.M., M.P.H.

Grant No.:  
D56MP95091

Target Population:  
Asian/Pacific Islander

Age Group:  
All age groups

American Samoa, a United States territory located in the Pacific region, consists of five islands. It is a territory of minority populations, with the majority (approximately 97%) living on the main island of Tattily.

Health care services are provided by two main government agencies: LBJ Tropical Medical Center and the American Samoa Department of Health. The LBJ Tropical Medical Center is the island's only hospital and provides inpatient and outpatient care. The Department of Health is responsible for providing home care and preventive health care services, including health education programs.

The Department of Health is expanding its health education services to previously unserved or underserved communities. *The Health Education Curriculum Improvement and Service Extension Project* targets women from the islands' three main ethnic groups--Samoans, Tongans, and Filipinos--who have limited-English-speaking proficiency.

Health education materials are under development in the following subject areas: prenatal care, immunization, oral health care, and skin diseases/problems. Once designed, the materials will be translated into the appropriate languages. Some of these materials are videos in the Samoan language with Polynesian cast members. The videos will also be translated to the Tongan and Filipino languages. Culturally and linguistically appropriate training programs are also being prepared for health educators chosen by the Tongan and Filipino communities.

## CALIFORNIA

---

### Asian Aids Project

785 Market Street, Suite 420  
San Francisco, CA 94103  
PHONE: (415) 227-0946  
FAX: (415) 227-8945

Title:  
HIV Case Management-Education to  
High Risk Asians and Pacific Islanders

Project Director:  
John Manzon-Santos

Grant No.:  
D56MP95078

Target Population:  
Asian/Pacific Islander

Age Group:  
Adults

Formed in 1987, the Asian Aids Project (AAP) was the first HIV/AIDS program in the United States to target the Asian Pacific Islander (API) community. In 1989, the AAP conducted a baseline survey of HIV/AIDS knowledge, attitudes, beliefs and behavior among Chinese and Japanese communities in San Francisco.

*The HIV Case Management-Education to High Risk Asians and Pacific Islanders Project* targets the following high risk groups for HIV infection: women working in massage parlors, transgender/transsexuals, and men who have sex with men. These groups currently have limited or inadequate access to HIV health services.

Over the three-year period of this project, AAP is: 1) increasing the utilization of health and human services through its case management-education model; 2) increasing the target group's future accessibility to health and human services through health education; and 3) expanding the cultural competency and linguistic capacity of health care professionals and para-professionals working with these groups. The project is providing in-service training and instituting referral protocols between and among health care organizations for the target groups.

## CALIFORNIA

---

### Asian Americans for Community Involvement, Inc.

2400 Moorpark Avenue, Suite #300  
San Jose, CA 95128  
PHONE: (408) 975-2730  
FAX: (408) 975-2745

Title:  
Asian Seniors Health Promotion Project

Project Director:  
Carlina Yeung, M.S.W.

Grant No.:  
D56MP95083

Target Population:  
Asian/Pacific Islander

Age Group:  
55 years and older

*The Asian Seniors Health Promotion Project (ASHPP)*, conducted by Asian Americans for Community Involvement, Inc., serves as a point-of-entry program for seniors who have been unable to use or are distrustful of local health care services. The goal of the ASHPP is to bring seniors and the health care system in closer alignment. Problems that the project addresses include language and cultural barriers between the Asian seniors and the service providers, lack of knowledge about disease and disease management, and lack of trust and understanding of Western medical practices, including the complexity of the system itself.

The project offers six main activities: intercultural communication effectiveness workshops for health care providers, bicultural and bilingual volunteer training, health screenings, lectures, In-Home Promotion and Support Services, and an Information and Assistance Phone Support System.

The ASHPP recruits and trains bilingual and bicultural volunteers (Cambodian, Chinese, Laotian, and Vietnamese) to assist the Asian seniors. The project conducts health screenings to help the seniors learn about health problems and recognize their need for medical attention. Through the Information and Assistance Phone Support System, the project connects homebound seniors with health care services and case management services, including translation and transportation.

## CALIFORNIA

---

### Special Services for Groups

605 W. Olympic Blvd., Suite 600

Los Angeles, CA 90015

PHONE: (213) 553-1818

FAX: (213) 553-1812

Title:

**Pacific Asian Language Services Project (PALS)**

Project Director:

Heng L. Foong

Grant No.:

D56MP95068

Target Population:

Asian/Pacific Islander

Age Group:

All age groups

*The Pacific Asian Language Services Project (PALS)* is conducted by Special Services for Groups, a multi-service "umbrella" agency that provides an array of human services to ethnic minority communities and groups. This project is based on a PALS model previously developed in 1991 through the Special Services for Groups to address language issues that become problematic in the treatment of HIV/AIDS.

This PALS project has implemented a mobile, interpretation service staffed by bilingual/bicultural interpreters. The goal is to increase health care access for low-income, monolingual, limited-English-speaking residents of Los Angeles County, with special emphasis on areas with a high concentration of Asian Pacific Islanders (APIs).

PALS has assembled a team of trained interpreters, some of whom will be further trained in mental health assessments and crisis intervention. The language consultants who have mental health and crisis intervention skills help with the Psychiatric Emergency Teams at mainstream mental health clinics. Seminars are conducted to enhance the skills of the consultants in such areas as interpreter techniques, resources, medical updates, HIV/AIDS, tuberculosis, mental health, and women's health.

Promotion of the PALS project is two-tiered: outreach and education to the medical care providers is carried out through mass mailings, and consumers are targeted through the ethnic media. The project's promotion campaign uses bus stop advertisements, bill boards, and television public service announcements.

## CALIFORNIA

---

### The Cambodian Family

1111 E. Wakeham Ave., Suite E

Santa Ana, CA 92705

PHONE: (714) 571-1966

FAX: (714) 571-1974

Title:

**Health Care Access for Cambodians**

Project Director:

Rifka Hirsch

Grant No.:

D56MP95066

Target Population:

Asian/Pacific Islander

Age Group:

All age groups

The mission of The Cambodian Family is to help refugees develop knowledge, skills, and self-esteem to become self-reliant, contributing members of society. The Cambodian Family has been in existence since 1982 and its services include providing translation services for hospitals, doctors, and clinics, as well as offering health education programs for Cambodian families.

*The Health Care Access for Cambodians Program* seeks to build the skills of both providers and clients to bridge the gap between Western medicine practices and the traditional, spirit-oriented health practices of the new Cambodian arrivals. The primary target area is the neighborhood with the densest population of Cambodians in Orange County, an area referred to as the Minnie Street area. The program provides cultural and linguistic interpretation for health care providers, health screenings in the Cambodian community, health promotion among Cambodians, and cultural competence training systems. Seminars for health care providers include presentations on the Cambodian culture, health beliefs and health accessing behaviors, as well as working translators and non-literate clients. Project staff design, test and use culturally and linguistically appropriate health promotional materials.

## CALIFORNIA

---

### Union of Pan Asian Communities

1031 25th Street  
San Diego, CA 92102  
PHONE: (619) 232-6454  
FAX: (619) 235-9002

Title:  
**Southeast Asian Health Care Access Project**

Project Director:  
Irene Linayao-Putman

Grant No.:  
D56MP95057

Target Population:  
Asian/Pacific Islander

Age Group:  
Adults

The Union of Pan Asian Communities (UPAC) has a 21-year history of providing services, both independently and in partnership with other health/human service providers, to San Diego's diverse Asian and Pacific Islander population. Among its many efforts, the organization addresses mental health, child abuse and domestic violence issues; as well as the cultural adjustment and language assistance needs of Southeast Asians.

The major goals of the *Southeast Asian Health Care Access Project* are to: 1) reduce barriers and improve access to cancer relevant health care among limited-English-proficient Vietnamese, Chinese-Vietnamese, Laotian, and Cambodians in San Diego County; and 2) improve the cultural competency level of local health care providers.

The project is involved in developing culturally and linguistically appropriate cancer screening and educational materials, and small group educational presentations; producing and disseminating a health services resource directory; conducting on-site visits to cancer-relevant health care facilities; and providing interpretation services and cultural competency training for health care providers.

The project has health education materials in several Chinese languages, including Cantonese, Mandarin, Chau Chieu, Toisan and Taiwanese. Materials are being adapted and translated into four Southeast Asian languages (Vietnamese, Chinese, Lao and Cambodian). UPAC is also preparing a bilingual health care resource directory in Chinese/English, Vietnamese/English, Cambodian/English and Laotian languages.

Training programs on cancer are conducted for patients, as well as providers. Topics include health information on hepatitis B and cancers of the liver, lung, cervix, and breast. Prevention strategies take into account knowledge, attitudes, beliefs, and values of targeted ethnic groups toward cancer in general, and more specifically toward preventive health care practices, early cancer detection procedures, and various cancer treatment options. Project staff participate in an ongoing review program of cancer terminology to ensure accurate translations.

## CALIFORNIA

---

### Vista Community Clinic

956 Vale Terrace, Suite 201

Vista, CA 92084

PHONE: (619) 631-5040

FAX: (619) 631-5010

Title:

Medical Interpretation and Cultural  
Competency Training Project for  
Community Clinic Support Personnel

Project Director:

Fernando Sanudo

Grant No.:

D56MP95012

Target Population:

Hispanic

Age Group:

All age groups

Vista Community Clinic has offered health care and health education since 1972 for those residents who have been unable to access care due to economic, social, or cultural barriers. Its Health Promotion Center is known for its innovative and culturally sensitive health promotion and disease prevention programs.

*The Medical Interpretation and Cultural Competency Training Project for Community Clinic Support Personnel (MICC)* is developing a medical interpretation and cultural competence training program for community clinic support personnel in San Diego County. Topics address such issues as professional and ethical conduct, intercultural issues, technical vocabulary in both languages, pre-interpreting skills and consecutive interpreting. The support personnel are also trained to elicit accurate information from the limited-English-speaking patients.

A medical interpretation and cultural competence training manual for use in the *Train a Trainer* program has been pilot tested in several community clinics in San Diego, Orange County and Imperial Valley. Upon completion of the course, trainers are certified in the MICC program. The program has linked with local colleges where medical assistant programs are conducted in an effort to institutionalize the *Train the Trainer* program for medical interpretation and translation. In the last year of this project, the MICC program will be modified for use with district hospital support personnel. This will enhance the interpretation and cultural competency skills of support personnel who can also provide interpretation for medical personnel in hospitals, emergency room, and urgent care facilities.

## DISTRICT OF COLUMBIA

---

### La Clinica del Pueblo

1470 Irving Street, N.W.  
Washington, D.C. 20010  
PHONE: (202) 462-4788  
FAX: (202) 667-3706

Title:  
**Bilingual/Bicultural Interpreter Services Project**

Project Director:  
Juan Romagoza, M.D.

Grant Number:  
D56MP95100

Target Population:  
Hispanic/Latino

Age Group:  
All Ages

La Clinica del Pueblo, founded in 1983, is the only free bilingual/bicultural medical clinic for Hispanics and Latinos in the Washington, D.C. area. It serves more than 7,000 clients per year. The clinic offers a predominantly Central American population access to primary health care and subspecialty medicine. Health areas include adult primary care, diabetes, mental health, AIDS, neurology, rheumatology, occupational medicine, reproductive health, adolescent medicine, pediatrics, and dermatology.

The goals of the *Bilingual/Bicultural Interpreter Services Project* are to: 1) establish on- and off-site culturally appropriate interpreter services; 2) provide on-site education to health care providers; 3) conduct cultural sensitivity workshops; and 4) develop a culturally appropriate English-Spanish dictionary comprised of 300 words that are unique to predominantly Central American countries, including slang phrases and key medical words. Through the activities of this project, La Clinica del Pueblo is addressing the barriers to health care encountered by its target population, such as the inability to pay for health insurance, linguistic isolation, lack of cultural sensitivity in the medical profession, and fear of government institutions.

## DISTRICT OF COLUMBIA

---

### Mary's Center for Maternal and Child Care, Inc.

2333 Ontario Road, NW  
Washington, D.C. 20009  
PHONE: (202) 483-8196  
FAX: (202) 797-2628

Title:  
**Proyecto Conexion**

Project Director:  
Maria S. Gomez, R.N.

Grant Number:  
D56MP95002

Target Population:  
Hispanic/Latino

Age Group:  
Prenatal through Adult

Mary's Center for Maternal and Child Care, Inc. (Mary's Center), established in 1988, is a non-profit, minority community-based agency. It focuses on increasing access to health care for limited-English-proficient (LEP) Hispanic and Latina women and children through the provision of low-cost, comprehensive services.

The goal of *Proyecto Conexion* is to decrease barriers and increase access to culturally and linguistically appropriate health care for the target population. Project activities are divided into three primary components.

*Entitlement Assistance* provides guidance in applying for services including Medicaid, food stamps, emergency assistance, and Social Security.

*The Home Visiting Team*, in partnership with Providence Hospital, provides education, counseling, HIV/AIDS testing/counseling, advocacy, immunizations, and case management services for pregnant women and babies from the prenatal stage to one year of age.

*Pediatric Case Management* provides assistance and education to ensure proper child development.

## ILLINOIS

---

### City of Chicago

Office of Hispanic Affairs  
Chicago Department of Health  
DePaul Center, Second Floor, Room 2144  
333 S. State Street  
Chicago, Illinois 60604  
PHONE: (312) 747-8820  
FAX: (312) 747-9694

Title:  
Chicago Department of Health Bilingual/  
Bicultural Service Demonstration Project

Project Director:  
Esther Sciammarella

Grant Number:  
D56MP95036

Target Population:  
Hispanic and Latino

Age Group:  
Adults

The Chicago Department of Health (CDOH), Office of Hispanic Affairs, addresses the physical and mental health of Hispanic and Latino residents through the CDOH Health Clinics. The clinics provide effective and accessible health services that emphasize health promotion and disease prevention.

The goal of the *CDOH Bilingual/Bicultural Service Demonstration Project* is to improve the effectiveness of health care delivery to limited-English-proficient Hispanics. This project focuses on five of the seven CDOH clinics used by the target population. Intensive language and cultural sensitivity training is provided to health care professionals, including doctors and nurses, and paraprofessionals from the Sexually Transmitted Disease, Tuberculosis, and Immunization units. This training increases their knowledge of the values, beliefs and culture of the Hispanic community, and improves the level of communication between provider and patient.

## KANSAS

---

### Wichita-Sedgwick County

Department of Community Health  
1900 East Ninth  
Wichita, Kansas 67214  
PHONE: (316) 268-8342  
FAX: (316) 268-8397

Title:  
Bilingual/Bicultural Service Demonstration  
Project

Project Director:  
Margaret Baker

Grant Number:  
D56MP95087

Target Populations:  
Hispanic and Asian

Age Group:  
All Ages

The Wichita-Sedgwick County Department of Community Health (WSCDCH) is responsible for protecting the citizens of Wichita-Sedgwick County from excessive morbidity by preventing the spread of disease, encouraging a healthy life style, and providing a safe environment. The WSCDCH's Personal Health Division provides clients with both primary and preventive health services.

The Bilingual/Bicultural Service Demonstration Project focuses on a comprehensive approach to improving the ability of health care providers and other professionals to deliver linguistically and culturally competent health service to limited-English-speaking Hispanics and Asians. Two WSCDCH Health Stations have been established within the Asian and Hispanic communities to improve the delivery of all health services, with an emphasis on cancer prevention for Hispanics, and health assessments and referrals for Asians.

The activities of this project also emphasize: early enrollment of patients in the Maternal and Infant Program; routine clinical breast examinations, mammograms and Pap tests; and compliance with direct-observed therapy by Asian clients. Other activities include the translation of health education materials, the purchase of health education materials that are language and reading level appropriate, and promotion of bilingual/bicultural services.

## MICHIGAN

---

### Midwest Migrant Health Information Office, Inc.

502 W. Elm Avenue  
Monroe, Michigan 48162  
PHONE: (313) 243-0711  
FAX: (313) 243-0435

Title:  
Colonia Health Worker Program

Project Director:  
June Grube-Robinson, M.P.H.

Grant Number:  
D57MP95041

Target Population:  
Hispanic and Latino

Age Group:  
All Ages

The Midwest Migrant Health Information Office, Inc. (MMHIO), is a nationwide lay health promotion agency that strives to provide full access to health services and improve health conditions for migrant farm workers and their families. Although headquartered in Michigan, MMHIO maintains a facility in the Rio Grande Valley, Texas, that works closely with health care providers, community service agencies and farm workers.

The *Colonia Health Worker Program* targets poor Hispanic residents of the colonias of the Rio Grande Valley. It has trained twelve migrant farmworkers to be effective peer health educators and serve as a crucial link between colonia residents and the health care system. The training emphasizes culturally sensitive information on HIV/AIDS. The trained peer health educators participate in home visits and distribute HIV/AIDS health information to the residents of the colonias, and provide health-related referrals to Valley agencies. The peer health educators also provide information on the conditions and lifestyles of colonia residents to health professionals enabling them to provide more culturally and linguistically appropriate health care.

## NEW YORK

---

### African Services Committee, Inc.

28 East 35th Street  
New York, New York 10016  
PHONE: (212) 683-5021  
FAX: (212) 779-2862

Title:  
Bilingual/Bicultural Access to HIV/STD/TB  
Medical Services for African Refugees and  
Immigrants

Project Director:  
Kim Nichols

Grant Number:  
D57MP95076

Target Population:  
African Immigrants and Refugees

Age Group:  
Prenatal, Infants, and Adults

The African Services Committee, Inc., a 13-year old community-based organization, provides services to African immigrants and refugees who require access to medical services within the five boroughs of New York City. These services include multilingual outreach, HIV pre- and post-test counseling, and HIV resource referral. In 1993 and 1994, the organization expanded its services to provide testing, treatment and follow up for Sexually Transmitted Diseases (STD) and Tuberculosis (TB).

The *Bilingual/Bicultural Access to HIV/STD/TB Medical Services for African Refugees and Immigrants* project provides culturally competent interpretations and translations, HIV/STD/TB prevention education, medical counseling, and referral and follow-up services to prevent and reduce the risk of infection for this population. Project services include:

- 1) an escort to pre-test screenings, as well as interpretation and counseling for clients;
- 2) referrals to primary medical care and follow up for positive diagnoses, including prophylaxis for opportunistic infections, direct observed therapy and STD treatment;
- 3) short-notice and emergency interpretations and translations at hospitals; and
- 4) bilingual attitude, belief and behavioral risk assessments.

## NEW YORK

---

### St. Joseph's Hospital

158-40 79th Avenue  
Flushing, New York 11366  
PHONE: (718) 558-6211  
FAX: (718) 558-6209

Title:  
Culturally Sensitive Primary Care Services  
to the Korean Community of  
Queens, New York

Project Director:  
Andrea Dell Ensley-Williams, M.H.A.

Grant Number:  
D56MP95038

Target Population:  
Korean

Age Group:  
All Ages

St. Joseph's Hospital, a 200-bed community hospital, is located in the Queens Borough of New York City, an area with a diverse mix of ethnic and racial groups. According to the 1990 Census, 64 percent of the 70,598 Koreans living in New York City are concentrated in St. Joseph's primary and secondary service areas.

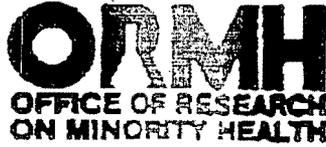
The project's overall goal is to improve access to primary care services by the limited-English-proficient Korean community. Hindered by language barriers, this population experiences some difficulty in understanding the health care system.

To achieve the goals and objectives of this project, St. Joseph's Hospital has established linkages with a community-based organization, Korean Community Services (KCS) and the American Cancer Society.

Through these partnerships, the project offers community-based health education and screening programs, low-cost/no cost mammography and cervical screenings, age-appropriate health maintenance services and counseling, interpreter support, translation of patient information and education materials, outreach services, and cultural awareness and basic language training for the hospital staff.

# FAX COVER SHEET

## OFFICE OF RESEARCH ON MINORITY HEALTH



National Institutes of Health  
 Building 31, Room 2B63  
 Bethesda, MD 20892  
 Phone: (301) 496-3637  
 Fax: (301) 496-4035

DATE: 7/25/97

TO: Sarah Bianchi

FROM: Lovita Watson

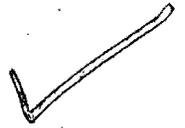
FAX NUMBER: 202-456-5557

Number of Pages (Including Cover Sheet) 37.22

MESSAGE:

more to follow

# AIDS



\* In the 12 months ending June 1995 the AIDS case rate was 19 percent greater for American Indian women than White women.

\* The AIDS case rate was 21 percent lower for American Indian men than non-Hispanic white men.

# Substance Abuse

\* In 1989-91 cirrhosis was the second leading cause of death for American Indian adults, with a rate that was more than four times that for White adults.

# Infant Mortality ✓

\* Infant mortality among Native

Americans is nearly one-third higher

than for all Americans.

# Homicide

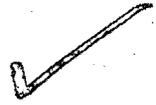
\* The homicide rate is 60 percent higher for Native Americans than for the total population. Alcohol is a significant factor in those deaths.

# Suicide

\* In 1989-91, suicide was the second leading cause of death among American Indian youth 15 - 24 years of age (26.3), with a rate that was nearly twice that for White youth (13.8).

\* Suicide rates for Hispanic, Black and Asian youth were 28 to 40 percent less than that for White youth.

# Diabetes



\* The prevalence of diabetes in Native Americans is so great that in many tribes more than 20 percent of the members have the disease.

# Cancer



\* In American Indians, overall rates for prevalence of cancer are lower than the general population.

\* Rates for lung cancer are twice as high among Oklahoma American Indians than the general population.

# AIDS

\* The AIDS prevalence rate for

Asians and Pacific Islanders is below

that of Caucasians

# Alcohol Abuse

- \* Asian populations appear to have lower rates of alcoholism than other ethnic groups

# Diabetes

\* Native Hawaiians have twice the

death rate from diabetes as Caucasians

in Hawaii.

# Cardiovascular Disease

\* Cardiovascular disease (CVD)

rates among first-generation Asian

American and Pacific Islander (AAPI)

immigrants are generally intermediate

between that of the country of origin

and of the U.S.

# Cardiovascular Disease and Stroke

\* The age-adjusted mortality rate of heart disease for Hawaiians is

273 per 100,000 persons

compared with

190 per 100,000 persons

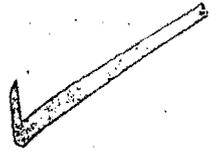
for the total U.S. population.

Mokuau, N. 1996. Health and Well-Being for Pacific Islanders  
Status, Barriers and Resolutions: Proceedings of the First  
National Summit of Asian America and Pacific Islander Health  
Organizational Leaders. *Journal of Health* 4(No 1-3): 55-67

# Cancer

- \* The age-adjusted mortality rate for cancer among Hawaiians is 184 per 100,000 persons compared with 133 per 100,000 persons for the total U.S. population

# AIDS



\* In 1989-91, AIDS in Hispanic adults 25 - 44 years of age, was the second leading cause of death, with a rate that was 35 percent higher than that for White adults.

# Infant Mortality

\* In 1989, the infant mortality rate (the number of deaths per 1000 live births) for Latinos in the U. S. (8.5) was comparable to that for Whites (7.9) but considerably lower than that for African-Americans (18.5).

# Homicide

\* In 1989-91 the homicide rate for

young Hispanic males was about 3.5

times the rate for White males.

# Diabetes



\* Mexican Americans with diabetes have six times the rate of end-stage renal disease requiring dialysis and three times the rate of retinopathy as their counterparts who are not Hispanics.

# Cardiovascular Disease



\* Latinos of the three major subgroups-- Mexicans, Puerto Ricans and Cubans, in the U.S. had lower death rates from heart disease and stroke than Whites or African Americans

# Stomach Cancer



\* Latinos generally experience rates of stomach cancer that are two to three times higher than those among Whites

# Prostate Cancer



\* Prostate cancer poses the highest risk of any cancer for Latino men.

Incidence rates among Latinos, which had been less than or equal to those among Whites, have increased over the past decade.

FAX COVER SHEET

OFFICE OF RESEARCH ON MINORITY HEALTH



National Institutes of Health  
Building 31, Room 2B63  
Bethesda, MD 20892  
Phone: (301) 496-3637  
Fax: (301) 496-4035

for fax.  
Phone #

DATE: 7/25/97

TO: Sarah Bianchi

FROM: Lovita Watson

FAX NUMBER: 202-456-5557

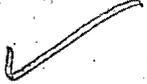
Number of Pages (Including Cover Sheet) ~~32-33~~ 11

MESSAGE: more to follow

# Cancer

\*The National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Report found incidence rates for cancers of the esophagus, pancreas, prostate and stomach to be higher among Latinos than among both Whites and African Americans.

# AIDS



\* The rate of AIDS among  
African Americans  
is more than triple that of  
Whites

# Substance Abuse

\* Blacks of all ages experienced twice

as many cocaine related emergency

room episodes as did Whites in 1992.

# Infant Mortality



**1992**

**Blacks** 16.8 deaths per  
1,000 births

**Whites** 6.9 deaths per  
1,000 births

# Homicide

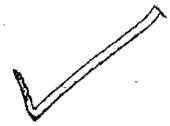
\* Homicide is the most

common cause of death for

Black men between the

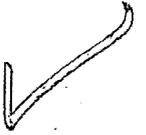
ages of 15 and 34

# Diabetes



- \* Diabetes is three times more common among Blacks than Whites

# Cardiovascular Disease and Stroke



\* The age-adjusted death rate from stroke is almost twice as high for Blacks as it is for Whites

\* Stroke is the third most common cause of death for Black women

\* Black women have the highest prevalence rates of hypertension in the U.S. with almost 50% having the disease by age 50

# Pancreatic Cancer



\* Cancer of the pancreas has a 70%  
higher incidence among Blacks than  
among Whites

# Prostate Cancer



\* The actual rate of prostate cancer among Blacks is 32% higher than in whites

# Breast Cancer

\* In 1993 Black women were 28 percent more likely to die from breast cancer than white women.

## STATISTICS ON THE DISPARITIES IN HEALTH CARE FOR MINORITIES

- **More likely to have AIDS.** Fifty-eight percent of children reported with AIDS are non-Hispanic blacks. Twenty-three percent are Hispanics. Twenty-nine percent of all AIDS cases in the United States are African-Americans and 16 percent are Hispanic-Americans.
- **Less likely to receive cervical cancer screening.** Older black women are much less likely to receive cervical cancer screening than white women: more than 40 percent of black women over 65 have never even had a Pap smear. Evidence shows that women are not tested are three to ten times more likely to get full blown cervical cancer.
- **Less likely to have health care insurance.** Thirty-three percent of Hispanic-Americans and 22 percent of African-Americans do not have health insurance, compared to 14.5 percent of whites.
- **A smaller percentage of doctors.** African-Americans and Hispanic-Americans make up 12 percent and 9 percent of the population yet they make up only 3.2 percent and 4.4 percent of the nation's physicians.
- **More likely to seek emergency room treatment and less likely to have regular physician appointments.** The visit rate for African-Americans was higher than for whites in emergency and outpatient departments, but the visit rate for whites was higher than for African-Americans in physician offices.
- **Less likely to receive prenatal care.** African-American mothers are less likely to receive prenatal care than were white women at every educational level. (what are we doing with access to prenatal care)
- **More likely to suffer from heart disease.** Between 1980 and 1993, the rate of heart disease was about 67 percent higher among black women than among white women.
- **Higher mortality rates associated with diabetes.** Black women had an 134 percent death rate associated with diabetes than white women.
- **Higher death rates for infants.** The death rate for infants is more than twice that of whites. (SIDS campaign)
- **More likely to have hypertension.** The age-adjusted prevalence of hypertension was higher for non-Hispanic black women (31 percent) than for non-Hispanic white women (21 percent) or Mexican-American women (22 percent). Hypertension is a leading cause of strokes and heart disease.

## PRENATAL CARE

### Racial Discrepancies:

Women with no prenatal care are often metropolitan residents, unmarried women, foreign-born women, women with less than nine years of education, and women with less than one year between births. Risks for no prenatal care is also higher for women who are teenagers, unmarried, black, or of other racial/ethnic groups, have less than 12 years of education, were born outside of the US and have given birth to more than two children.

Among black women, the adjusted risk of no care more than doubled from 1980 to 1989. Figures from 1992 indicate that African American women are nearly 4 times more likely to receive no prenatal care (4.2% receive none) than white women (only 1.2% receive no prenatal care). About one-third of African-American, Hispanic and Native American women receive no prenatal care or don't obtain care until the final trimester of pregnancy while the national average of all women failing to get prenatal care in their first trimester is only 20%.

Annual percentages of no prenatal care were highest for women younger than 15 years (5.5-6.5%) and for black women (2.7-4.7%). In 1995, only 70.3% of black mothers and 70.4% of Hispanic women received prenatal care beginning in the first trimester compared with 83.5% of white mothers.

Compared with women who initiated care in the third trimester, those who received no care were more likely to be older, black and unmarried.

Among women who began prenatal care late (in the third trimester), had no care or whose care status is unknown, 12.2% are black, 5.7% are white and 11.5% are Hispanic.

In 1993, 80.3% of white mothers, 63.7% of black mothers, 61.9% of American Indian mothers, and 64.6% of Hispanic mothers began prenatal care for live births in their first trimester.

Babies born to women who receive no prenatal care are three times more likely to be born with low birthweight and five times more likely to die than those whose mothers receive care in their first trimester. Yet 20 percent of pregnant women don't seek health care in their first trimester.

However, even when babies to receive care in the first trimester, 5.6% of white babies are low birthweight compared to 12.3% of black babies born in 1993.

Infant mortality among Native Americans is nearly one-third higher than for all Americans.

In 1992, there were 16.8 deaths per 1,000 births for black women and 6.9 deaths per 1,000 births for white women.

The death rate for black infants is more than twice that of whites.

### Administrative Action:

CDC administers the Pregnancy Risk Assessment Monitoring Systems (PRAMS) which provides technical assistance to state Maternal and Child Health Directors to evaluate barriers to prenatal care. PRAMS is a population-based surveillance system of maternal behaviors and experiences before and during a woman's pregnancy and during her child's early infancy. PRAMS surveys 35% of all US births for the purpose of reducing infant mortality and low birth weight. States often use PRAMS data to create and evaluate programs and policies designed to improve prenatal care. For example, PRAMS data from West Virginia which indicated that

Medicaid eligible women didn't obtain prenatal care because they lacked transportation was used to change West Virginia's Medicaid policy to supply transport vouchers for women attending prenatal care clinics.

CDC also supports three community based intervention research projects examining approaches to improving prenatal care outreach and the quality of services. In Chicago, community health centers worked with the Prevention Research Center of the University of Illinois to study the effect of a woman's relations with others upon her attainment of prenatal care. In Los Angeles, CDC has a partnership with Charles Drew University and a community coalition to compile a thorough ethnography of pregnancy and health among African American women. In Harlem, CDC is working with the New York Urban League and academicians from Columbia University and the City University of New York to study the anthropology of pregnancy in women living in central Harlem. A community advisory board comprised of representatives from several community based agencies will work with CDC and the academics to design health and social interventions to promote better care for pregnant women.

The results have been impressive: For 1994, 80% of mothers began care in the first trimester of pregnancy compared with 79% for 1993 and 78% for 1992. The proportion of mothers beginning prenatal care in the first trimester rose in 1995 to 81.2% compared with 80.2% in 1994. The proportion of white women receiving care jumped from 82.8% to 83.5% from 1994 to 1995; the proportions of black women receiving care jumped from 68.3% in 1994 to 70.3% in 1995; and the proportions of Hispanic women receiving care jumped from 68.9% in 1994 to 70.4% in 1995. From 1992 to 1993, proportions of black women receiving care jumped from 63.9% to 66.0%, Hispanic women jumped from 62.1% to 63.4%; and American Indian/Alaska Native women jumped from 62.1% to 63.4%. CDC's goal is increase these proportions to 90% across the board.

Through HHS, the Maternal and Child Health Bureau (MCBH) administers four major programs which, in FY 1997, had a total budget of \$825 million: the Maternal and Child Health Services Block Grant (FY 97 \$681 million), the Healthy Start Initiative (FY 97 \$96 million), the Emergency Medical Services for Children Program (FY 97 budget \$12.5 million), Grants for HIV Coordinated Services and Access to Research for Women, Infants, Children and Youth (FY 97 budget \$36 million).

The Healthy Start initiative relies on community-based collaborative efforts to provide thorough health and social support services in order to make services more accessible, develop thorough services, make available a variety of self-help programs, supply case management services for follow ups, employ outreach workers (often from the neighborhood) and provide many other services. Healthy Start communities include cities in MD, AL, MA, IL, OH, MI, IN, LA, NY, CA, PA, SC, Washington DC and Northern Plains Indian communities. Through Healthy Start, clinics, schools, churches, media, neighborhood organizations, and committed individuals work together to help protect the health of mothers and babies through such efforts as providing health and social services (housing), doing neighborhood outreach, and offering education and childbirth and infant care.

The Community and Migrant Health Centers provide numerous services to reduce negative birth outcomes. Strangely enough, from 1992 to 1995 while funding stayed at a steady 35 million dollars and number of programs stayed at 291, the number of clients served dropped from 187,757 in FY 1992 to 112,163 in FY 1995. Statistics on HHS' comprehensive perinatal care program indicate that a total of 1,127,654 female users take advantage of the programs

## DIABETES

David  
Nathan  
Bureau  
of Nat.  
Affairs  
225-2941

Ellen  
from HCFA  
610-5512

### Racial Discrepancies:

The prevalence of diabetes in Native Americans is so great that in many tribes, more than 20 percent of the members have the disease. Diabetes is three times more common among blacks than whites. Black women had an 134% death rate associated with diabetes than white women.

African Americans are 1.5 times more likely to have diabetes. Nearly 6% of African American men and nearly 8% of African American women have diabetes. African Americans also experience higher rates of at least three of the serious complications of diabetes: blindness, amputation and end stage renal disease (kidney failure).

Diabetes has reached epidemic proportions among Native Americans. Complications from diabetes are major causes of death and health problems in most Native American populations.

Approximately one in every 10 Hispanic adults has diabetes. Population studies among Hispanic women with diabetes show significantly higher death and complication rates during pregnancy. Cuban Americans are one and a half times more likely than the general populations to have diabetes. Both Mexican Americans and Puerto Rican Americans are twice as likely as the general population to have diabetes.

### Administrative Response:

Funding for diabetes research programs within the Public Health Service is estimated to be nearly \$340 million in FY 1997. The major portion of this funding is through the National Institutes of Health (\$316 million), with the NIDDK contributing the most support (\$209 million) to diabetes research. The majority of this funding is used to support basic diabetes research.

An important NIDDK multicenter clinical trial, completed in 1993, made the groundbreaking discovery that maintaining blood glucose levels as close to normal as possible throughout the day can prevent and delay the onset of diabetic complications. Based on this study, the NIDDK in 1994 began a new, comprehensive initiative targeted at preventing diabetes and its complications. This multi-faceted initiative, called the Diabetes prevention and Treatment Initiative, encompasses opportunities in basic and applied research, clinical studies and trials, national multicenter trials, and a national education program.

Current topics of study being funded include the mechanism of insulin action, risk factors for diabetes, immunologic aspects of diabetes, the regulation of glucose metabolism, the cell biology of the insulin producing beta cells of the pancreas, the regulation of insulin synthesis and secretion from the beta cell, the interplay of genetic and environmental factors that results in diabetes, genetic analyses of all aspects of diabetes, and the role of advanced glycosylation end-products and other factors in the development of health complications from diabetes.

In September of 1997, the NIH and NIDDK will cosponsor a scientific conference entitled, "Diabetes Mellitus: Challenges and Opportunities," led by invited, internationally-recognized experts in diabetes research.

In the past few years, investigators have been able to establish immune, metabolic, and genetic screening tests to identify individuals at high risk for developing type 1 diabetes. Researchers also have shown that low-dose insulin therapy may prevent or delay the onset of the

clinical manifestation of type 1 diabetes.

The Institute is also conducting a clinical trial to determine whether type 2 diabetes can be prevented or delayed in at-risk populations. Because type 2 diabetes disproportionately affects minority populations, approximately 50 percent of those enrolled in the DPP will be from those populations.

The institute is also intensifying its genetic research for both type 1 and type 2 diabetes, as well as on the topics of the relationship between obesity and diabetes, diabetes management, diabetes and coronary artery disease, diabetes and cardiovascular disease.

The NIDDK has also implemented a special series of prevention studies in minority populations. THE NIDDK encourages increased research efforts on the disproportionate impact of diabetes in minority populations, including African Americans, Hispanic Americans, Asian and Pacific Islanders, Alaska Natives, and Native Americans and Hawaiians.

The NIDDK has also initiated a National Diabetes Outreach Program and a media campaign, "Do Your Level Best: Start Controlling Blood Sugar Today." This campaign encourages physicians and people with diabetes to adopt a treatment approach that greatly reduces the complications of diabetes. Also, the HIDDK, the Centers for Disease Control and Prevention, and private sector diabetes organizations are collaborating to design a National Diabetes Education Program (NDEP). The program will incorporate research results, specifically those of the DCCT, in public messages about diabetes care.

Lastly, NIDDK is continuing its long-term effort to encourage research in the area of kidney disease of diabetes mellitus which is the single most frequent cause of end-stage renal disease.

## HEART DISEASE

### Racial Discrepancies:

The age-adjusted death rate from strokes is almost twice as high for blacks as it is for whites. Stroke is the third most common cause of death for Black women. Black women have the highest prevalence rates of hypertension in the U.S. with almost 50% having the disease by age 50.

In a study of Hypertension among persons 20 years of age and over, findings indicated that between 1988 and 1994, 24.3% of white males and 19.3% of white females *had* hypertension, compared to 34.9% of black males and 33.8% of black females.

Between 1980 and 1993, the rate of heart disease was about 67% higher among black women than among white women.

The age-adjusted prevalence of hypertension was higher for non-Hispanic black women (31%) than for non-Hispanic white women (21%) or Mexican-American women (22%). Hypertension is a leading cause of strokes and heart disease.

### Administrative Response:

In FY 1996, the National Heart, Lung, and Blood Institute (NHLBI) supported a total of \$796,815 in CVD research, including \$132,329 in research on hypertension. Within the total of \$796,815,000 spent on CVD research, \$95,184,000 was relevant to CVD in minorities. Of the \$95,184,000 in minority CVD research, \$37,723,000 focused on hypertension.

Other programs supported by the Institute in FY 1995 include the Epidemiological and Clinical Minority Studies, Honolulu Heart Program, Bogalusa Heart Study, Specialized Centers of Research in Hypertension, Community-Based Risk Reduction demonstration Research, Cardiovascular Risk Factor Studies and Prevention in Children and many others. Studies have explored incidence of and mortality from heart disease in minorities, early histories of heart disease in children, the development and pathophysiology of hypertension, education and evaluation strategies to promote heart disease risk reduction and many other important topics. (Tons and tons of other programs if you want me to take up space here)

## RACE AND HEALTH

Sarah -- Here are my very, very, very rough notes (parts of this are completely incoherent, other parts are extremely repetitive -- I think I even repeat the same statistics several times within a section). I was just transcribing every piece of information I have, I'll edit this down A LOT. Some of the stats are also kind of contradictory (different studies gave us different stats) -- we can use whichever ones seem best. See what you like and what you don't, and let me know

Sarah

### AIDS

#### Racial Differences:

AIDS cases are increasing most rapidly among women and minorities. Young minority gay and bisexual men remain at high risk for infection. HIV-related death has the greatest impact on young and middle-aged adults, especially racial and ethnic minorities. HIV is the leading cause of death for Americans between 25 and 44 years old. In 1994, 1 out of every 3 deaths among African-American men ages 25 to 44 was as result of HIV. 1 in every 5 deaths among African-American females ages 25 to 44 was HIV related.

African Americans and Hispanics are disproportionately affected by AIDS. In 1995, the incidence of AIDS among African Americans was 92.6 per 100,000; the rate among Hispanics was 46.2 per 100,000; the rate for whites was 15.4 per 100,000; the rate for American Indian and Alaska Native was 12.3 per 100,000; the rate for Asian Pacific Islanders was 6.2 per 100,000.

58% of children reported with AIDS are non-Hispanic blacks, 23% are Hispanics, 29% of all AIDS cases in the United States are African-Americans and 16% are Hispanic-Americans.

The proportion of AIDS cases among African Americans and Hispanics is increasing. In 1995, for the first time, the proportion of African American people with AIDS was equal to the proportion of white people with AIDS (40%). African Americans and Hispanics combined represented the majority of cases among men (54%) and women (76%).

Among 16 to 21 year old youth entering the Job Corps, a training program for socially and economically disadvantaged youth, prevalence of HIV infection was .41% in African Americans, .14% in Hispanics and .08% among whites.

African Americans account for 25% of yearly reported AIDS cases in 1985; they accounted for 40% of yearly reported cases in 1995. The proportion of newly reported cases among Hispanics increased from 15% in 1985 to 19% in 1995. In contrast, the proportion of cases among whites has decreased from 60% in 1985 to 40% in 1995.

Between 1989 and 1994 the rate of new AIDS diagnosed among African American men who sleep with men increased by 49% in New York City, 48% in Los Angeles, and 53% in San Francisco.

Among men who sleep with men in 6 urban counties, 8-13% of blacks, 5-9% of Hispanics and 4-6% of whites were infected by HIV.

In the 12 months ending June 1995, the AIDS case rate was 19% greater for American

Indian women than White women.

[The rate of AIDS among African Americans is more than triple that of Whites.]

#### Administrative Action:

CDC has developed (1992) the Business Responds to AIDS (BRTA) workplace program which is a public-private partnership of the public health sector, business, labor and the CDC designed to prevent the spread of HIV. The CDC uses this program to help large and small business all over the country create policies and implement programs for employees. The program is comprised of five core elements: development of an HIV/AIDS policy, training of supervisors in the policy, HIV/AIDS education for employees, HIV/AIDS education for employees' families, and encouragement of employee volunteerism, community service and corporate philanthropy. 41% of large firms have adopted at least two of these five elements.

CDC has also completed a groundbreaking study completed in rural Tanzania which indicated an approximate 42% reduction in new HIV infections when STDs were aggressively treated. STD's increase the risk of HIV infection by causing genital ulcers which provide an entry route for HIV and by causing inflammation of the genital tract which also increases the chance of infection. Treating these STDs decreases the routes by which the AIDS infection can enter the body. Notes Helene Gayle, M.D., M.P.H, Director of CDC's National Center for HIV, STD, and TB Prevention, "We have certainly known about the interrelationships between HIV infection and other STDs for some time...but this is the first time we're seeing direct evidence of the impact of STD treatment on the rate at which people become infected with HIV."

CDC also completed a study exploring a successful STD outreach and treatment program in Bolivia. Over a three year period, the subjects being screened for STD's increased by more than 300% and the prevalence of STDs declined by more than 50%.

CDC also recently released the findings of another study which indicated that sexually active young women may be at increased risk for HIV infection by having sex with older men. Young women whose first sexual experience was with an older man were less likely to use condoms and were possibly at higher risk for HIV than young women whose first sexual experience was with someone of the same age. Both the communication difficulties caused by age gaps and the increased likelihood of greater sex and drug use experiences among the older men contribute to the higher risk of contracting HIV. Another study showed that young people can be classified in more categories than just "sexually active" and "sexually inactive." The study grouped teenagers into several other categories such as "anticipators" (those planning to begin intercourse in the next year), "steadies" (those who have had sex with only one partner) and "multiples" (those who've had sex with many people).

These studies have allowed the CDC to design more effective outreach and education programs. CDC has worked for many years to assist state and local health and education agencies and community-based organizations in designing effective HIV-prevention messages and programs for young people.

The Centers for Disease Control and Prevention has conducted other studies finding that perinatal HIV transmission can be reduced by treating the mother and child with the drug zidovudine (ZDV). Notes R.J. Simonds, M.D., a CDC researcher, "Before 1994, when our ZDV treatment guidelines were published, 21% of the children in our study were infected. Since the guidelines, it's dropped to 10%." Even when the mothers are severely ill with AIDS, ZDV can

still help stop transmission.

To further reduce transmissions from mother to child, greater prenatal care outreach programs are needed. Such programs are especially vital as they can teach women how to reduce the chances of transmission to their children by such actions as refraining from breast feeding (a known route of perinatal transmission). Prenatal care has been found to be cost effective. Notes Paul Farnham Ph.D, "Without intervention, a 25% mother-to-infant transmission rate would result in approximately 1,750 HIV-infected infants annually in the U.S., and lifetime medical costs of \$282 million...we estimated the cost of intervention at \$67.6 million, preventing 656 infant HIV infections with a savings of \$105.6 million in medical care costs, and a net cost-savings of \$38.1 million. These results strongly support routine counseling, voluntary testing and ZDV use."

CDC has also conducted studies on the transmission of AIDS through shared drug needles. CDC has provided communities across America with vital information on how to curtail the spread of AIDS through sterilization efforts and behavioral recommendations. Communities take advantage of the biomedical and behavioral science provided to help design, develop, deliver and evaluate HIV programming for intravenous drug users. CDC conducts and funds surveillance, epidemiology and behavior research to help create local HIV prevention programming. CDC does everything from large scale tracking studies to specific risk behavior studies to evaluations of intervention and prevention programs. CDC also distributes research results to scientific and academic communities, federal state and local health organizations. CDC has completed extensive studies on adolescents and women, and has sponsored projects such as small-group interventions, and has conducted surveys of various populations. CDC is also working with five communities to design targeted interventions to reach high risk youth in the local area, helping areas to market effective HIV prevention programs. CDC puts a big emphasis on prevention at the community level.

Most important and relevant to race, the CDC conducted The Young African-American Men's Study which attempts to understand the social, cultural and psychological influences on young African-American's risky sexual behavior, sex with other men and seeks to evaluate community-based HIV intervention. Findings suggest that low self-esteem and risky sexual behavior are often connected, homosexuals are very stigmatized in the black community, the church is extremely important in interventions designed for black communities, and there are lots of HIV/AIDS myths among young black men who sleep with men.

CDC has also created a National Center for HIV, STD and TB Prevention as STDs increase chances of getting HIV and TB is a tremendous threat to those with HIV.

CDC also has an extensive international research program aimed at developing techniques which can be used to fight AIDS within the United States as well. International studies have included such topics as perinatal HIV transmission, intravenous drug transmission, genetic analysis, risk analyses and others.

CDC has also conducted studies and surveys focusing on women and HIV including such topics as the female condom, the effectiveness of hierarchical prevention messages for women of color (e.g. grading various prevention choices from most to least effective), communication between partners, nonoxynol-9 and spermicide preferences. CDC has also done research on the effectiveness of female condoms.

From 1990 to 1995, percentages of high school students having intercourse remained steady, but overall condom use was up from 46% in 1990 to 53% in 1995 with female and

African-American students indicating the greatest increases in condom use.

#### NIH STUFF TOO:

The discovery of a new class of anti-HIV drugs was partially based on fundamental research supported by NIH. NIH has provided doctors and their patients with the most up-to-date advice on how to use new combinations of drugs, including when to begin therapy; when and how to switch therapies; how to monitor the course of the disease; which drugs to use in combinations. It was NIH-supported research that showed that zidovudine can greatly reduce the risk of transmission of HIV infection from a pregnant woman to her child. A panel recently updated and released for public comment the guidelines for the use of AZT in pregnant women which is of particular importance for minority citizens since the great majority of women with AIDS and the great majority of HIV-infected infants are minorities.

Further, in terms of the clinical trials supported by NIH, both major clinical trials networks, the adult AIDS Clinical Trials Group (ACTG) and the Community Program for Clinical Research on AIDS (CPCRA), supported by NIH have participant pools comprised of more than 40% African Americans and Hispanics. Further, the Adult ACTG has units in three minority institutions and CPCRA is based on the ideal of establishing units in community setting where patients who are infected seek their primary care. Additional programs have also been organized so as to obtain information of importance regarding HIV infection on members of minority groups including the Women's Interagency HIV Study and the Women and Infant Transmission Study in which minorities represent over 82% of the participants.

Other NIH programs and policies are designed to recruit individuals from underrepresented racial and ethnic groups in research careers. Programs include providing training and research opportunities to individuals ranging from high schoolers to independent investigators. The Research Supplements for Underrepresented Minorities program helps fund the salaries of individuals from underrepresented groups who wish to participate in ongoing research. Also, such programs as the AIDS Loan Repayment Program, the loan repayment program for individuals from disadvantaged backgrounds, the Howard Hughes Medical Institute (HHMI) training program for early recruitment into clinical research careers, and the Minority Clinical Associate Physician (MCAP) Program at the NIH National Center for Research Resources.

Looking toward the future, in between 1996 and the budget the President submitted for 1998, AIDS vaccine funding will have increased by more than 33%. Dr. David Baltimore, a Nobel laureate and President-designate of Cal Tech, has been recruited to provide leadership for restructuring and reinvigoration of the AIDS vaccine research program. Lastly, the President has announced the creation of the Vaccine REsearch Center on the NIH campus to mobilize considerable scientific resources towards the development of an AIDS vaccine.

#### ASTHMA

Race discrepancies:

In 1994, a total of 56.2 white people per 1000 and 56.4 black people per 100 had asthma. Asthma among the population in general was much higher in 1994 than it was in 1984. Death rates for African American individuals are substantially higher than those for white individuals.

Age-adjusted death rates for asthma are three times higher in black males than white males; almost three times higher in black females than white females; and slightly higher for females in general than males. In fact, age specific death rates are much higher in blacks than in whites in nearly every age group. The black-white gap in asthma mortality is widening, with rates much higher in blacks than whites.

#### Administrative Response:

The DLD (department of lung disease? division of lung disease?) supports a collaborative multicenter study in human pedigrees from various racial/ethnic groups to identify the major genes responsible for asthma in order to develop new treatments and understand causal interactions between genes and environmental factors that are relevant to asthma. It also supports research programs to develop and evaluate effective strategies for improving asthma care among Latino and black children.

Other asthma research projects include a five year multicenter clinical trial to examine the long-term effects of three different asthma medications on 1,000 children and a study to develop and evaluate innovated approaches to ensure optimal disease management and prevention in the elementary school setting. The DLD is also working with the National Institute of Child Health and Human Development (NICHD) to determine the effects of asthma and its treatment on pregnancy and the effects of pregnancy on asthma.

The DLD also supports an asthma clinical research network of interactive asthma clinical research groups who quickly evaluate new treatment methods and ensure that they are quickly disseminated to practitioners and health care professionals. The Division has prepared a report on the diagnosis and management of asthma in the elderly and is updating several important reports on asthma treatment. The DLD is participating in the organization of "Global Initiative for Asthma" which increases awareness of asthma, promotes the study of the connection between asthma and the environment and reduces asthma morbidity and mortality throughout the world.

## SICKLE CELL DISEASE

Racial Discrepancies: Black people get it. White people don't.

#### Administrative Response:

In 1996, eight applications for grants were awarded in areas such as computer-generated antisickling compounds, removal of pathological iron from sickle red blood cells, methods for gene transfer, and transgenic models of sickle cell disease.

The Division has also worked to disseminate research findings to the medical community through workshops, conferences and consensus development conferences. Topics covered include plasma transfusion, platelet transfusion therapy, diagnosis of deep-vein thrombosis, impact of routine HIV antibody testing of blood and plasma donors on public health, infectious disease testing for blood transfusions, stem cell therapy, and immune function in sickle cell disease.

The division manages an integrated and coordinated program of grants, contracts, training and career development awards and academic awards.

provided. Tons of other stuff available too -- volumes.

## GENERAL CANCER INFO.

Rates for lung cancer, colon cancer and rectal cancer are higher among African-American women than among women of any racial or ethnic group other than Alaska Natives. African-American men have a higher rate of cancer incidence overall than any other racial or ethnic group in the US. Additionally, African-American men have higher rates of prostate, lung and oral cavity than other racial or ethnic groups.

Rates for lung cancer are twice as high among Oklahoma American Indians than the general population. Latinos generally have two to three times the rate of stomach cancer that whites have. Latinos also have higher incidence rates for cancers of the esophagus, pancreas, prostate and stomach.

Cancer of the pancreas has a 70% higher incidence among blacks than among whites. The actual rate of prostate cancer among blacks is 32% higher than in whites.

## BREAST CANCER

### Racial Discrepancies:

In 1994, breast cancer mortality rates were over 30 per 100,000 for black women compared to approximately 25 per 100,000 for white women. 5 year survival rates were also disturbing: 85% of white women had a relative 5 year survival rate compared to only 70% of black women. Only 54.9% of African-American women over 50 report having had a clinical breast exam and a mammogram within the past two years.

In 1993, black women were 28% more likely to die from breast cancer than white women.

### Administrative Action:

The enactment of this law occurred at the same time the Department of Health and Human Service ordered CDC to create a National Strategic Plan for breast and cervical cancer screening. The plan that emerged from this effort had five parts: the integration and coordination of screening services, public education, professional education and practice, quality assurance, and surveillance and evaluation.

To achieve these goals, CDC developed the National Breast and Cervical Cancer Early Detection Program (NBCCDEP). Through this program, CDC reimburses states for clinical breast exams, screening mammograms, pelvic exams, Pap tests and some diagnostic procedures. State health agencies contract with various provider agencies including the YWCA, family planning organizations, community organizations, county health departments, and private physicians.

COMPONENTS OF THE NBCCDEP (partnerships and coalition development, public education and outreach, quality assurance, surveillance, professional education, screening and follow-up services)

Screening and Education/Outreach Programs: Through cooperation between public, private, commercial, state, local and federal groups, CDC helps to maintain many outreach and awareness programs.

Professional Education Programs: It also established professional education programs for program managers, health care professionals, health educators, administrative staff and outreach workers. The programs have focused on detection and diagnostic procedures, guidelines for screening, communication skills, data collection and reporting requirements and strengthening clinical skills. Training and education activities have been provided to radiologists, radiologic technologists, and cytotechnologists. Additional staff have been hired in some states to monitor the compliance of mammography facilities and cytopathology laboratories with state and federal quality assurance standards and requirements.

Quality Assurance: The CDC programs have created screening guidelines and helped the FDA to conduct quality assurance training programs. Programs have focused on improving specimen collection by the primary care practitioner and interpretation by the laboratory.

Also, to ensure high-quality screening tests, all mammography facilities are required to meet standards of the American College of Radiology and all cytology laboratories are required to meet CLIA 88 standards. Medical advisory committees have also been organized in states to provide technical guidance, assist with training activities, review and develop clinical protocols, and develop guidelines and systems to ensure that the breast cancer screening process is carried out.

Surveillance Programs: When the NBCCEDP was created in 1991, the CDC created a program to monitor screening, diagnostic and treatment activities. States collect and report to CDC information on screening location, demographic characteristics, screening results, diagnostic procedures and outcomes and initial treatment. Reminder systems have also been implemented to encourage women to return for rescreening.

Treatment: The legislation which authorized CDC to enact NBCCDEP does not allow CDC to use funds for treatment. However, many women manage to obtain treatment with state and local government support, donated medical services and community programs. There are a fair number of state-funded cancer clinics and even legislative mandates to use cigarette tax revenues for diagnostic or treatment services.

#### Monetary Allocations for NBCCEDP:

In FY 1993, \$72 billion was appropriated, in FY 1994, \$78 billion was appropriated, and in 1997, \$140 million was appropriated for CDC to expand its screening, follow up, education, quality-control and outreach programs. Fifty states, five territories, the District of Columbia and 13 American Indian/Alaska Native organizations currently participate in the program.

## CERVICAL CANCER

Racial Discrepancies:

7.7 per 100,000 white women are diagnosed with invasive cervical cancer whereas 12.2 per 100,000 black women are. 2.5 per 100,000 white women die of cervical cancer whereas 6.3 per 100,000 black women do. The gap widens when statistics for older women are analyzed. 14.7 per 100,000 of white women 65 and over are diagnosed with invasive cervical cancer whereas 34.4 per 100,000 black women 65 or over are. Only 8.0 per 100,000 white women die of invasive cervical cancer while 23.3 per 100,000 black women die of invasive cervical cancer.

As of 1993, the mortality rate for African-American women was more than two times greater than the rate among white women. White women are significantly more likely than black women to have their cancers diagnosed at an early, precancerous state: 54% of cervical cancers among white women are diagnosed at a localized stage while only 39% of cancers among African American women are.

From 1986-1992, the relative 5 year survival rate from cervical cancer was 71% for white women and only 56% for black women.

#### Administrative Response:

Mortality rates from cervical cancer for black women decreased from 6.3 per 100,000 in 1993 to 5.6 per 100,000 in 1993.

The enactment of this law occurred at the same time the Department of Health and Human Service ordered CDC to create a National Strategic Plan for breast and cervical cancer screening. The plan that emerged from this effort had five parts: the integration and coordination of screening services, public education, professional education and practice, quality assurance, and surveillance and evaluation.

To achieve these goals, CDC developed the National Breast and Cervical Cancer Early Detection Program (NBCCDEP). Through this program, CDC reimburses states for clinical breast exams, screening mammograms, pelvic exams, Pap tests and some diagnostic procedures. State health agencies contract with various provider agencies including the YWCA, family planning organizations, community organizations, county health departments, and private physicians.

#### COMPONENTS OF THE NBCCDEP

##### Screening and Education/Outreach Programs

- 1) Culturally appropriate outreach strategies and education materials for Alaska Native women managed by Alaska Natives close to the community.
- 2) A collaborative program between the California Department of Health's Breast and Cervical Cancer Early Detection Program and the YWCA of Glendale, the Mission City Clinic, University of California Los Angeles and many community organizations to improve and expand screening services and outreach efforts.
- 3) The Nebraska Breast and Cervical Cancer Early Detection Program which implemented culturally sensitive outreach programs aimed at Vietnamese women who have high rates of cancer. Through this program, letters in Vietnamese were mailed to all Vietnamese women over the age of 18 in Hastings Nebraska inviting them to the YWCA to learn about screening services.
- 4) The Texas Department of Health uses funds to pay the YWCA to recruit women through churches, clinics, senior centers and YWCA programs to gain treatment services.

- 5) The Maryland state health department placed funded outreach workers at each county health department throughout the state -- workers come from the community and are mainly older minority women.
- 6) In Massachusetts, the program provides printed educational materials in languages other than English including Haitian-Creole, French and Spanish.
- 7) The New York state health department created Breast Health Partnerships which brings together community agencies to increase screening: various agencies take care of different components of the program (e.g. coordination, reimbursement, data management).
- 8) National Collaborations with the American Cancer Society, Avon Products Inc., YWCA, National Alliance of Breast Cancer Organizations, National Cancer Institute, National Center for Farmworker Health, Inc. and other organizations to sponsor education and outreach efforts.

Through September 1996, 690,560 Pap tests were provided by NBCCDEP. 21,257 cases of cervical intraepithelial neoplasia (CIN, the precursor to cervical cancer) and 258 cases of invasive cervical cancer were discovered. As of January 31, 1995, 48% of Pap tests were provided to minority women.

**Professional Education Programs:** It also established professional education programs for program managers, health care professionals, health educators, administrative staff and outreach workers. The programs have focused on detection and diagnostic procedures, guidelines for screening, communication skills, data collection and reporting requirements and strengthening clinical skills.

**Quality Assurance:** The CDC programs have created screening guidelines and helped the FDA to conduct quality assurance training programs. Programs have focused on improving specimen collection by the primary care practitioner and interpretation by the laboratory.

**Surveillance Programs:** When the NBCCDEP was created in 1991, the CDC created a program to monitor screening, diagnostic and treatment activities. States collect and report to CDC information on screening location, demographic characteristics, screening results, diagnostic procedures and outcomes and initial treatment. Reminder systems have also been implemented to encourage women to return for rescreening.

**Treatment:** The legislation which authorized CDC to enact NBCCDEP does not allow CDC to use funds for treatment. However, many women manage to obtain treatment with state and local government support, donated medical services and community programs. There are a fair number of state-funded cancer clinics and even legislative mandates to use cigarette tax revenues for diagnostic or treatment services.

**Monetary Allocations for NBCCDEP:**

In FY 1993, \$72 billion was appropriated, in FY 1994, \$78 billion was appropriated, and in 1997, \$140 million was appropriated for CDC to expand its screening, follow up, education, quality-control and outreach programs. Fifty states, five territories, the District of Columbia and 13 American Indian/Alaska Native organizations currently participate in the program.