

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

(Note: This is completely unspellchecked and unedited.)

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.

Managed
Care
plan
→ outcomes
how
to
beneficiaries
provide
care
accomplish
→ what
we
accomplish

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.

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 to increase these proportions to 90% across the board.

Through HHS, the Maternal and Child Health Bureau (MCHB) 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 (including housing), doing neighborhood outreach, and offering education and child birth 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 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.

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 1986 to 5.6 per 100,000 in 1993. List enormous amount of CDC stuff from Pap Smear Memo and CDC Cervical Cancer memo here.

DIABETES

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.

Administrative Response:

We need to get info on this from CDC and NIH.

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

260
1780
8

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)

Thursday or Friday

Race Meeting:

status

problem

Enrollment - current future

2000 goal

Indira Marikby

President

Board of service / research management

Cardiovascular / hypertension
immunization & all generations
AIDS

AIDS

I. Racial Discrepancies

- African-Americans accounted for 25% of yearly reported AIDS cases in 1985; this figure increased to 40% in 1995. Hispanics accounted for 15% of yearly reported cases in 1985; this figure increased to 19% in 1995. In contrast, whites accounted for 60% of yearly reported cases in 1985, a figure which decreased to 40% of yearly reported cases in 1995.
- AIDS affects minority children disproportionately and accounts for a large percentage of deaths in minority communities. 58% of reported cases of children with AIDS are non-Hispanic blacks, 23% are Hispanics. In 1994, 1 out of every 3 deaths among African-American men ages 25 to 44 was a result of HIV, and 1 in every 5 deaths among African-American females ages 25 to 44 was related.

Clinton Administration Initiatives

- **CDC Research.** Conducted studies on connection between STDs and HIV, outreach and treatment programs abroad, risks for sexually active young women, HIV transmission from mother to child, shared drug needles and risks to young African-American men. Developed outreach programs in workplaces nationwide, and worked to help state, local and community agencies develop educational programs. In addition, CDC created a National Center for HIV, STD and TB prevention and has developed an extensive international research program.
- **NIH Research.** Some research efforts specifically targeted to minorities
- **HOPWA program** -- helps provide Housing for People with AIDS.
- Perinatal transmission efforts -- helping stop transmission in
- **Significantly increased ADAP program** -- helping low-income Americans get access to treatment.
- **Medicaid coverage of protease inhibitors.**

Sickle cell ?
 Chronic substance abuse
 Other minority (non-black) state.

3-1-95
 P. [unclear]
 Y.
 2/16

Eliminating Disparities in Health

In support of the President's Initiative on Race, the Department of Health and Human Services has identified six areas in which racial and ethnic minorities experience serious disparities in access to health services and in health status. The leadership and resources of the Department will be committed to achieving significant reductions in these disparities by the Year 2000, with the ultimate goal of eliminating these disparities. Through this effort, we will contribute to meeting three of the five central goals of the President's Initiative on Race:

- educate the nation about the facts surrounding the issue of race
- promote a constructive dialogue to confront and work through the difficult and controversial issues surrounding race
- find, develop and implement solutions in critical areas such as health care for individuals, communities, corporations and government at all levels.

A national focus on health disparities is needed given the compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities between populations in the United States. Indeed, despite significant progress in the overall health of the nation, as documented in *Health, United States*, the annual report card on the health status of the American people, there are continuing disparities in the burden of death and illness experienced by Blacks, Hispanics, American Indians and Alaska Natives and Asians and Pacific Islanders as compared to the U.S. population as a whole. The demographic changes that will unfold over the next several decades heighten the importance of addressing the issue of disparities in health status: Groups that currently experience poorer health status will increase as a proportion of the total population. Therefore, the future health of the American people will be substantially influenced by our success in improving the health of racial and ethnic minorities.

It is particularly important that the Department and the nation focus on the issue of disparities in access to services and health status as major changes unfold in the systems through which care is financed and delivered. Indeed, one of the Department's strategic goals for the next six years is to improve the quality of health care, with particular attention given to the problem of disparities in access to quality services. However, it is important to note that improvements in prevention and clinical services can only partially address the difficult, complex and often controversial issues surrounding racial and ethnic disparities in health status. Education, income and other socioeconomic factors play a large role in influencing health outcomes. The Department's programs to improve the economic security of low-income families and communities will be important contributors to improving the health status of low-income populations--populations that are disproportionately composed of racial and ethnic minorities. We look forward to collaborations with other federal departments, states and the private sector to address the broader determinants of health.

The Department has selected six health problem areas to address as part of the President's Initiative on Race: infant mortality, breast and cervical cancer, heart disease and stroke, diabetes, AIDS case rates, and child and adult immunizations. These focus areas are drawn from the health objectives for the nation, *Healthy People 2000*. The targets to reduce these disparities have been established in collaboration with the major national organizations that are active in addressing health concerns for the affected populations. The six focus areas will receive priority attention because achieving these goals will make an important contribution to improving the health of racial and ethnic minorities. In the process we will also learn how to more effectively target strategies and resources to address other problem areas. This exercise will contribute materially to our longer term objective of substantially eliminating disparities in health status by the year 2010.

To achieve the goals of the President's Initiative on Race will require a reexamination and re-energizing of existing efforts within the Department. The Department must redouble its efforts to assure that the needs of its customers are identified and addressed, and that Departmental efforts are communicated as effectively as possible. The Department must broaden and strengthen its partnerships with state and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations--those who have the greatest access to and knowledge of the community. Finally, the Department must ensure that adequate monitoring efforts are carried out, and that local and national data necessary for determining priorities, and designing programs are available.

The Department has set forth an action plan for the next twelve months aimed at achieving progress towards the six goals. In addition, the Secretary and the Assistant Secretary for Health will conduct strategic assessments for each of the six goals over the next year to assess whether the Department and the nation are doing the right things to assure that the goals are met, and to begin a broad national dialogue to identify the most effective actions to achieve progress in these six areas, and by extension the other areas of disparity that must be addressed in the long term.

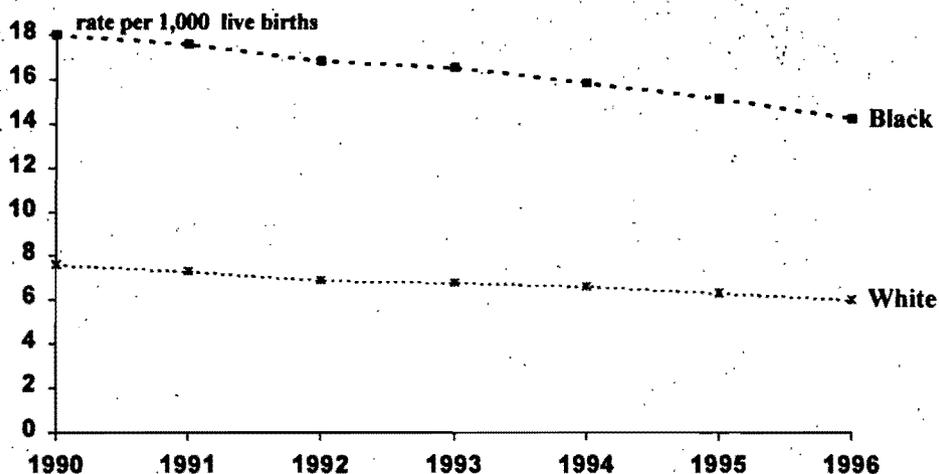


GOAL 1

**Eliminate disparities in infant mortality rates,
including death from Sudden Infant Death Syndrome (SIDS)**

There are substantial racial and ethnic disparities in infant morbidity and mortality rates in the United States. Our goal is to continue progress in reducing overall morbidity and mortality rates, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the greatest disparity in infant mortality, which is among blacks whose rate is nearly 2 ½ times as great as whites, by at least 20% from their 1996 rate by the Year 2000. We will also work to reduce infant mortality rates among American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians whose rates are also above the national average. These are our goals under *Healthy People*--the nation's health objectives.

Infant Mortality Rates for the United States by Race, 1990-1996.



Infant Mortality Rate Baselines:

Total: 7.2 per 1,000 live births (1996 preliminary data)

Black: 14.2 per 1,000 live births (1996 preliminary data)

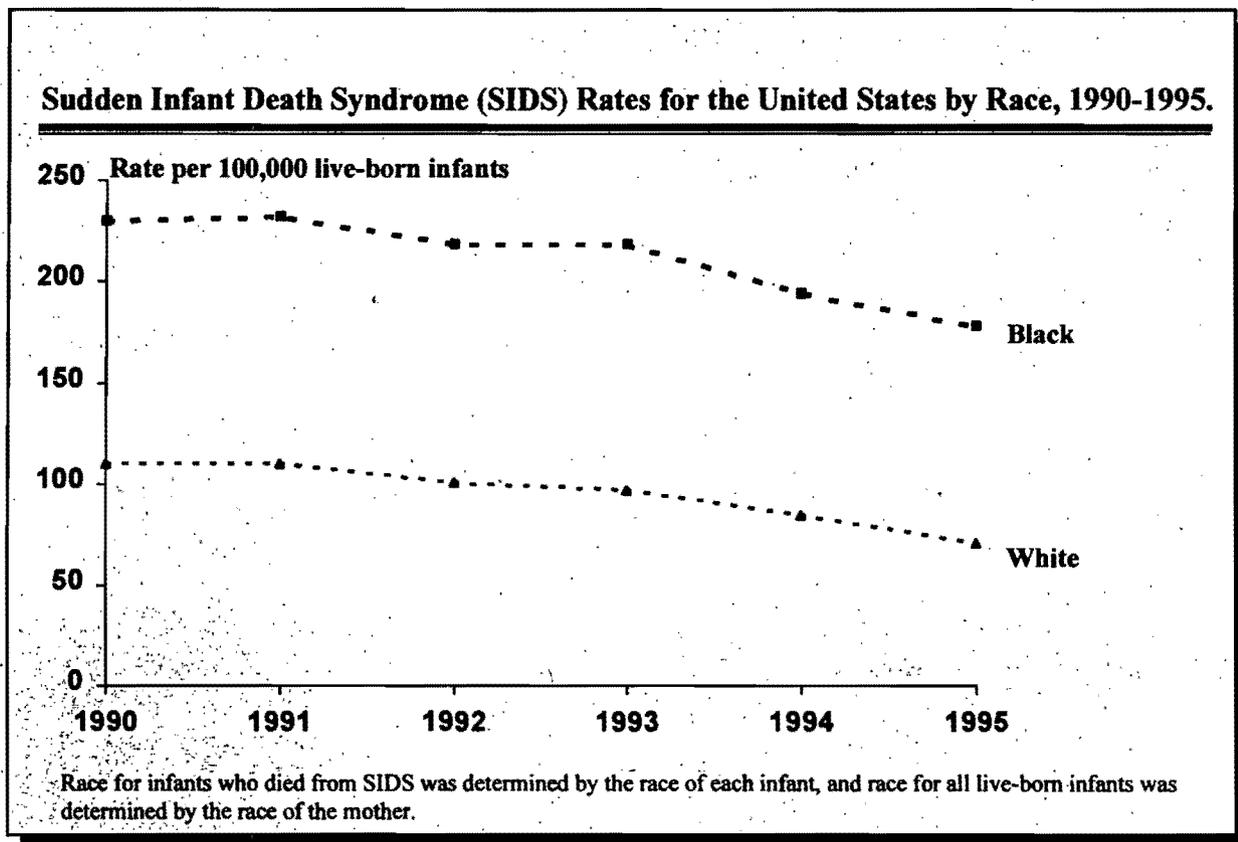
White: 6.0 per 1,000 live births (1996 preliminary data)

Data Source: National Vital Statistics System natality/mortality files, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population, and for white and black subgroups are available nine months after the close of the data year; final data are available 16 months after the close of the data year. Data for other subgroups come from linked data sources and are not available until 21 months after the close of the year (due to inconsistencies in

reporting ethnic origin, birth and death files for Hispanic and other minorities that must be linked before accurate statistics can be reported). Linked infant birth and death file data for 1995 will be available this fall for American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians.

Background: Although overall infant mortality rates have been declining, the decline in rates for a number of racial and ethnic groups significantly lags behind the national experience. A major factor in these varied rates is the substantial racial disparity in low birth weight and preterm birth. Much of the decline in overall rates can be traced to research advances, better understanding and treatment of respiratory distress syndrome as well as reductions in deaths due to Sudden Infant Death Syndrome (SIDS). Despite improvements in recent years, SIDS still accounts for approximately 10% of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS, with rates among blacks being two and one half times that of whites, and among some American Indian and Alaska Native populations being three to four times greater. Among blacks the SIDS rate has declined 18 percent between 1993 and 1995, the largest decline ever observed. However, the disparity *between* blacks and whites for SIDS remains large.



Sudden Infant Death Syndrome Rate Baselines:

- Total:** 74.2 per 100,000 live-born infants (1996 preliminary data)
- Black:** 178.6 per 100,000 live-born infants (1995)
- White:** 71.0 per 100,000 live-born infants (1995)

Data Source: National Vital Statistics System mortality data, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population are available nine months after the close of the data year; final data that include racial subgroups are available 16 months after the close of the data year.

Strategy for Achieving the Goal

- Provide enhanced prenatal services to low-income pregnant women by building community-based outreach and family-centered infrastructures in communities with high rates of infant mortality, morbidity, and poverty.
- Support a range of biological and behavioral research to better identify the specific factors contributing to the racial and ethnic disparities associated with infant death, preterm delivery, low birth weight, SIDS, and related adverse outcomes.
- Form linkages among public agencies and academic, professional, business and other private entities to address and promote coordinated research and health and social services.
- Promote the recruitment and training of minority researchers and the support of minority institutions that have immediate access and can contribute to the care of high-risk populations.

Action Steps for the Next 12 Months

- ◊ Increase to 100% the number of States with a plan that addresses infant mortality reduction and the associated racial/ethnic disparities. Emphasis will be placed on increasing the percentage of minority pregnant women receiving prenatal care in the first trimester.
- ◊ All 50 States will have active "Back to Sleep" or SIDS risk reduction campaigns
- ◊ Increase to 60 the number of high-risk communities addressing infant mortality reduction, and especially the elimination of disparities in infant mortality rates.

Examples of Programs that Support this Strategy

- **"Back-to-Sleep" Campaign:** Much of the recent decline in the incidence of SIDS is credited to this campaign which recommends that healthy babies be placed on their backs to sleep to help reduce the incidence of SIDS. The campaign will expand efforts to reach minority and ethnic populations. (NIH, HRSA, CDC)
- **Cultural Competence in SIDS Service Delivery Systems:** Complete a Task Force Report by Fall 1997 with recommendations for culturally competent strategies to improve public

health campaigns and bereavement services for under served racial and ethnic populations. (HRSA)

- **SIDS-Related Research:** Support research to 1) better understand the physiologic causes of SIDS and why SIDS infants die, 2) develop effective screening tests that can identify infants at risk for SIDS, 3) develop effective pharmacologic therapies for high risk infants; and 4) define specific patterns of risk in racial populations. (NIH)
- **Healthy Start Initiative:** Fund approximately 40 new high-risk communities to implement one or more of the community-based strategies to reduce infant mortality determined to best address the needs of the individual community. (HRSA)
- **State Mortality/Morbidity Review Support Programs:** Support up to five States in their efforts to promote, coordinate, and sustain mortality and morbidity review programs at state and community levels. This will allow States to expand their focus to morbidities and additional population groups. Emphasis will be placed on developing community and state partnerships that utilize the community-based review findings pertaining to service barriers and proposed systems changes to improve racial disparities and other problems associated with poor pregnancy or child health outcomes. (HRSA)
- **Perinatal Research:** Increase identification of risk factors and biological markers for adverse pregnancy outcomes, (e.g., LBW and preterm births), as well as SIDS, among minorities, with the expectation of developing appropriate and effective interventions and treatments for clinical conditions. (NIH, HRSA, CDC)

GOAL 2

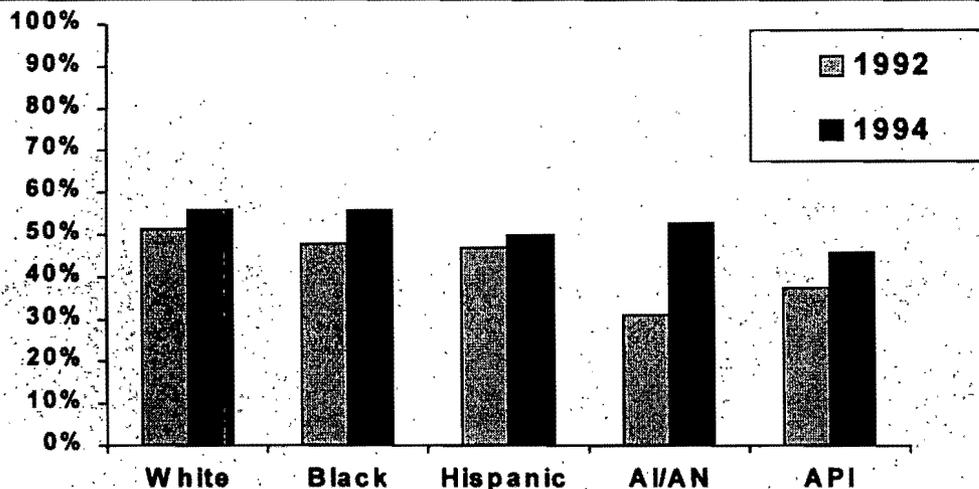
Eliminate disparities in breast and cervical cancer screening and management.

Cancer is the second leading cause of death for all women. Disparities in breast and cervical cancer incidence and death rates occur among various racial and ethnic groups. Screening to detect early disease is critical in the management of these two cancers. Even small changes in the percentage of women screened by mammography and Pap tests can have significant impact on the overall burden of suffering from these cancers. Our goal is to continue progress in getting more women screened for these two cancers at the appropriate age and time intervals, and to eventually eliminate disparities among all racial and ethnic groups in regards to screening and management.

Breast Cancer:

Our goal for the year 2000 for breast cancer screening is to increase to at least 60% those women of all racial or ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the preceding two years. This means we will have to increase the screening rate among white and black women by 7% from their 1994 level, American Indian and Alaska Natives by 13 %, Hispanic women by 20%, and Asian and Pacific Islanders by 30% in order to reach our goal under *Healthy People*--the nation's health objectives.

Proportion of Women Aged 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding Two Years, United States, 1992 and 1994.



Breast Cancer Screening Rate Baselines for women \geq 50 years of age:

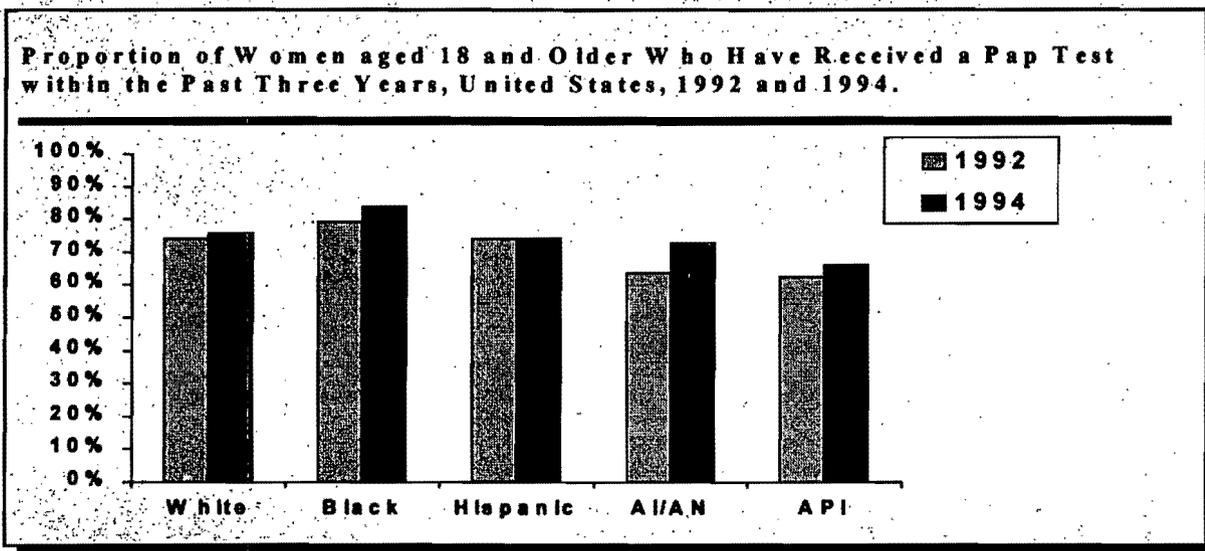
- Total: 56% (1994)**
- White: 56% (1994)**
- Black: 56% (1994)**
- Hispanic: 50% (1994)**
- American Indian/Alaska Native (AI/AN): 53% (1994)**
- Asian and Pacific Islanders (API): 46% (1994)**

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Cervical Cancer:

Our goal for the year 2000 for cervical cancer is to increase to at least 85% the proportion of all women aged 18 and older who have received a Pap test within the preceding three years. This is our goal under *Healthy People*--the nation's health objectives.



Cervical Cancer Screening Rate Baselines for women age \geq 18 years :

- Total: 77% (1994)**
- White: 76% (1994)**
- Black: 84% (1994)**
- Hispanic: 74% (1994)**
- American Indian/Alaska Native (AI/AN): 73% (1994)**
- Asian and Pacific Islanders (API): 66% (1994)**

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Discussion: Black women have a 30% greater risk of dying from breast cancer than white women, despite an overall lower risk of acquiring breast cancer in the first place. This higher death rate among blacks is most likely due to later diagnosis and treatment, hence the need for better cancer screening and management among minority populations. Furthermore, the breast cancer death rate *decreased* 10 percent for white women during 1980-1995, while it *increased* 18 percent for black women. These disparities hold true for cervical cancer as well, where the death rates are higher for black (5.2 per 100,000 in 1995) and Hispanic women (3.1 per 100,000) than for the total population (2.5 per 100,000).

Strategy for Achieving the Goal

- Increase public education campaigns to address the benefits of mammography, thereby increasing the proportions of women aged 50-70 who have had a screening mammogram in the prior two years.
- Provide access to optimal care for minority women.
- Establish the Healthy People goal as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 months

- ◇ Increase in the proportion of minority women 50 to 70 years of age who have had a mammogram and clinical breast exam in the past two years as measured by the 1998 National Health Interview Survey.
- ◇ Increase the proportion of minority women aged 18 and above who have had a Pap test in the prior three years as measured by the 1998 National Health Interview Survey.
- ◇ Expand access to screening and treatment to underserved women through the Breast and Cervical Cancer Early Detection Program.

Examples of Programs that Support this Strategy

- **CDC's National Breast and Cervical Cancer Early Detection Program** builds the public health infrastructure for breast and cervical cancer early detection in States through public and provider education, quality assurance, surveillance and partnership development. This program offers free or low-cost mammography and Pap tests to medically under served women, many of whom are minorities. Nearly 1 million screening tests have been performed since the program's inception.

- **The National Cancer Institute (NCI)** is funding twelve regional conferences in FY 1997 on the recruitment and retention of minorities in clinical trials.
- **The Minority Based Community Clinical Oncology Program** which is one of the programs responsible for the proportional representation of blacks and Hispanics in NCI sponsored treatment trials.
- **The National Black Leadership Initiative on Cancer and The National Hispanic Leadership Initiative on Cancer** are important public education programs working in concert with the NCI's Office of Cancer Communication.
- **The National Program of Cancer Registries (NPCR)**, which supports comprehensive, timely, accurate cancer registries in 42 States and the District of Columbia. The NPCR enables reporting of cancer data by age, ethnicity and geographic regions and provides critical feedback to States for tracking cancer trends, targeting and evaluating cancer control interventions, and health resource planning.
- **The Information Action Council of the National Action Plan on Breast Cancer** has developed a **Bridge to Underserved Populations initiative**. This initiative is exploring a variety of strategies for providing hard-to-reach populations with breast cancer information using the Internet. The IAC convened a series of regional meetings across the country to investigate and develop strategies for bridging the gap between the underserved women and the Information Superhighway. The meetings brought together community based organizations, private organizations, and women from underserved communities. The IAC plans to build partnerships with community based organizations in model pilot projects, that will ensure that underserved women have access to the wealth of information about breast cancer available on the Information Superhighway.
- **The Health Care Financing Administration Medicare Mammography Campaign**, which was launched in conjunction with First Lady Hillary Rodham Clinton and the U.S. Public Health Service's Office on Women's Health, encourages older women to use Medicare's mammography screening benefit.
- **Coverage of Mammography and Pap Smears Under Medicare and Medicaid** - Under H.R. 2015, enacted in August 1997, mammography coverage under Medicare will be expanded to include annual screening mammograms for women over 39, with the cost-sharing waived. Pelvic exams, clinical breast exams, and Pap smears will be covered under Medicare every three years, with annual Pap smears for women at risk of developing cervical cancer and those who have not had negative Pap smear in the past three years. Cost-sharing would also be waived. The Health Care Financing Administration has also sent letters to state Medicaid Directors urging them to provide coverage for annual screening mammograms for women aged 40 and older under Medicaid.
- **HCFA** will continue projects with medical peer review organizations to measure quality of medical practice and assure that all Americans receive the same high quality health care.

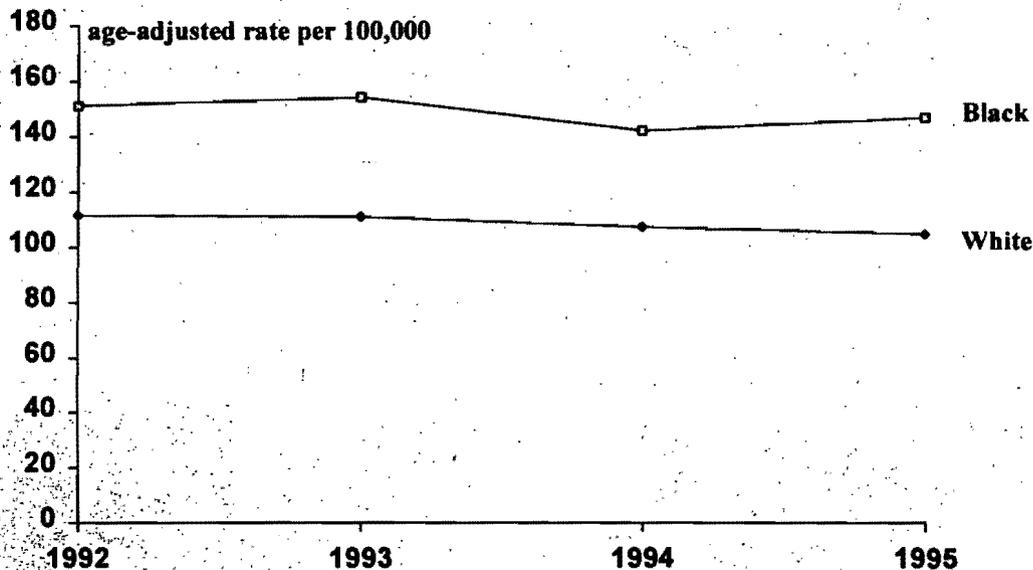
- **The Minority Women's Health Initiative** of the PHS Office on Women's Health (OWH) was developed in response to recommendations made during the PHS OWH Minority Women's Health Conference in January 1997. This initiative will target breast cancer in minority women as a top priority.
- **The Federal Coordinating Committee on Breast Cancer** will be awarding up to \$3 million in fiscal year 1997 to supplement existing programs as well as to support approved but unfunded projects that are targeted towards reducing breast cancer in underserved populations. These funds will be distributed to all agencies of the federal government that carry out breast cancer activities.

GOAL 3

Eliminate disparities in heart disease and stroke

Cardiovascular disease, particularly heart disease and stroke, kills nearly as many Americans as all other diseases combined and is also one of the major causes of disability in the United States. Our goal is to continue progress in reducing the overall death rates from heart disease and stroke, and to eventually eliminate disparities among all racial and ethnic groups. In order to have the greatest impact towards that end, we have set near term goals of reducing the heart disease and stroke mortality rates among blacks by 25% from their 1995 level by the year 2000; these are our goals under *Healthy People*--the nation's health objectives. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Rates of Coronary Heart Disease (CHD) Deaths, United States, 1992-1995.



Coronary Heart Disease Mortality Rate Baselines:

Total: 108 per 100,000 persons (age-adjusted) (1995)

White: 105 per 100,000 persons (age-adjusted) (1995)

Black: 147 per 100,000 persons (age-adjusted) (1995)

American Indian/Alaska Natives: 76 per 100,000 persons (age-adjusted) (1995)

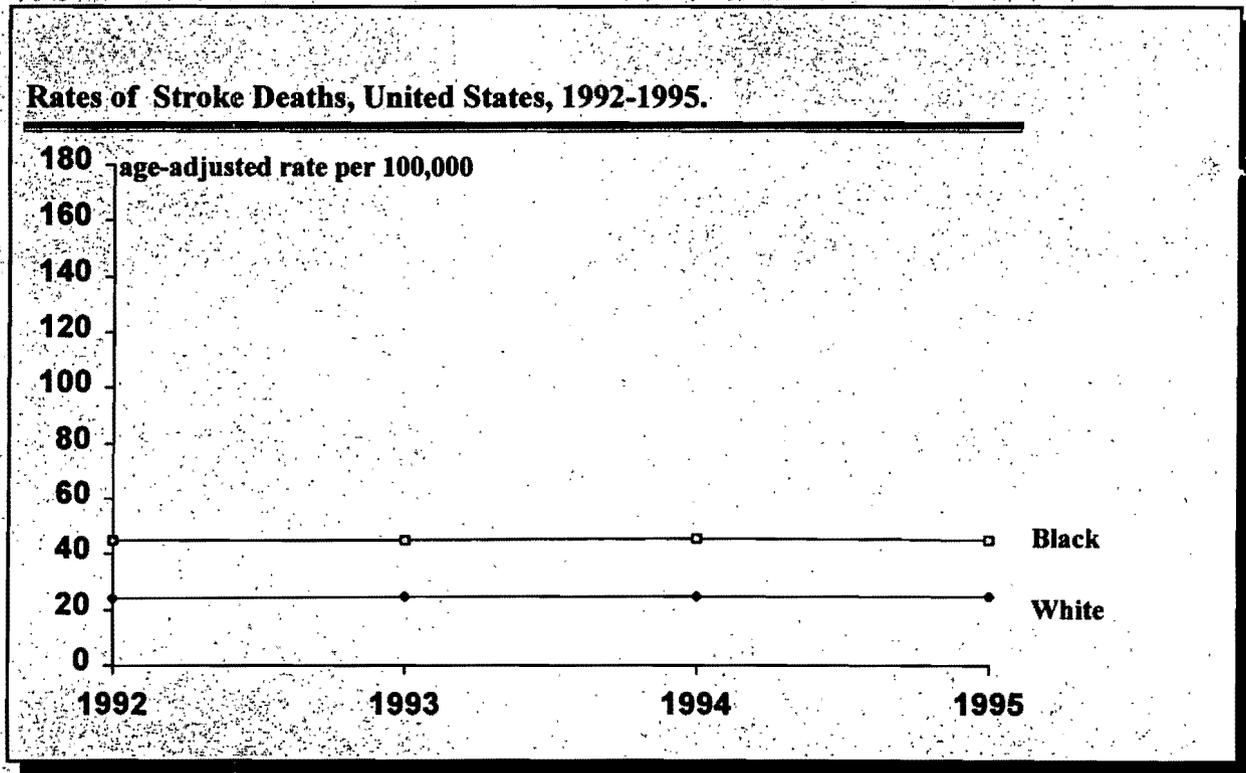
Asian/Pacific Islanders: 63 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Mortality data are collected on minority subgroups; however, denominator data for total Hispanic population requires special data runs from Census to estimate the population sizes as of July 1 of the data year. These data are available approximately 28-30 months following the July 1 date. (1995 data will be available in fall 1997.)

Mortality data are collected on Asian/Pacific Islander subpopulations. However, the latest denominator data available from Census for these subpopulations is 1990.



Stroke Mortality Rate Baselines:

Total: 26.7 per 100,000 persons (age-adjusted) (1995)

White: 24.7 per 100,000 persons (age-adjusted) (1995)

Black: 45.0 per 100,000 persons (age-adjusted) (1995)

American Indian/Alaska Natives: 21.6 per 100,000 persons (age-adjusted) (1995)

Asian/Pacific Islanders: 25.8 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Discussion: The age-adjusted death rate for coronary heart disease for the total population declined by 20% from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Within similarly insured populations such as Medicare recipients, there are significant disparities between blacks and whites in the use of certain diagnostic procedures for heart disease that cannot be explained by differences in the severity of symptoms. Racial and ethnic minorities also have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to be undergoing treatment to control their high blood pressure. Furthermore, the rates for regular screening for cholesterol, another risk factor for heart disease, show disparities for certain racial and ethnic minorities--only 50% of American Indians/Alaska Natives, 44% of Asian Americans, and 38% of Hispanics have had their cholesterol checked within the past two years.

Strategy for Achieving the Goal

- Foster efforts by public and private health-related organizations to disseminate and implement current knowledge about prevention and treatment of cardiovascular disease
- Further explore issues of cardiovascular risk factors to define more clearly those populations that are at increased risk for cardiovascular disease.
- Conduct research to identify genetic determinants of elevated risk.
- Establish the Healthy People goals as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 Months

- ◊ Evaluate results of the Latino Community Cardiovascular Disease Prevention and Outreach Initiative and use findings for planning a national strategy.
- ◊ Implement selected program outreach strategies as reflected in the NHLBI Ad Hoc Committee on Minority Populations 5-Year Strategic Plan developed in FY 97.
- ◊ Initiate a new Asian/Pacific Islander American Cardiovascular Disease Prevention Initiative.
- ◊ Initiate a new coronary heart disease professional medical education Website for health professionals who provide care to black patients.
- ◊ Disseminate widely the training materials on cultural competence so that health care providers have information that is relevant to greater patient compliance and better outcomes.

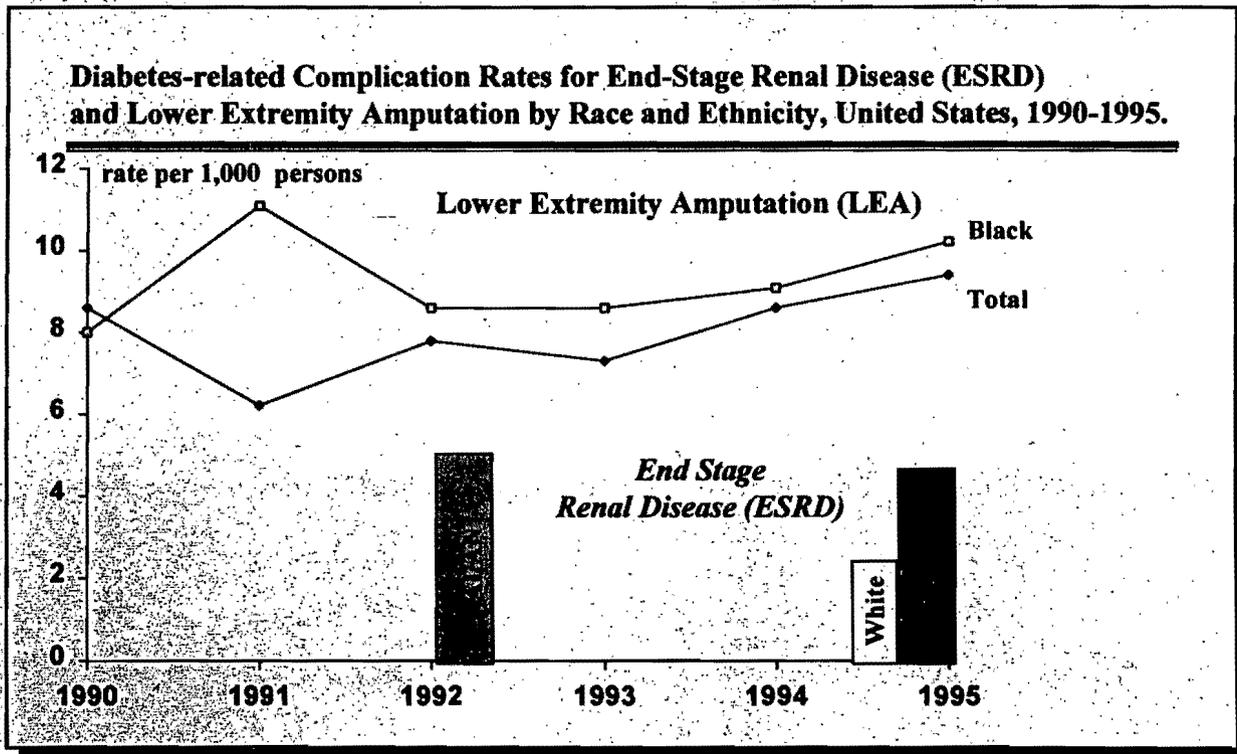
Examples of Programs that Support this Strategy

- **The African American Community Cardiovascular Disease Prevention and Outreach Initiative**, established by the **National Heart, Lung, and Blood Institute (NHLBI)** in 1992. As a part of this initiative, the NHLBI works with the **National Medical Association, Association of Black Cardiologists, National Black Nurses' Association**, and historically black medical colleges and universities' medical schools to develop and implement community-based cardiovascular disease prevention and education projects for inner-city blacks.
- **The Latino Community Cardiovascular Disease Prevention and Outreach Initiative**, established in 1995 by the **NHLBI**. This initiative is composed of local projects that involve community members in health promotion and disease prevention programs; develop culturally appropriate and language-specific materials; involve existing community organizations and services; use select influential media; and incorporate positive community lifestyles, values, and beliefs. Plans are underway to transition these local projects to a national effort.
- **Building Healthy Hearts for American Indians and Alaska Natives** was established in 1996 by the **NHLBI**. It seeks to increase awareness and knowledge of risk factors for cardiovascular diseases, which account for nearly a quarter of all American Indians and Alaska Native deaths. The initiative develops heart health promotion strategies that address needs and incorporate culture, tradition, lifestyles and values of Native Peoples.
- **The Smoking Cessation Strategies for Minorities Initiative** has been conducted by the **NHLBI** since 1989 to stimulate development of culturally specific smoking cessation and relapse prevention programs for under served minorities. The program developed data on smoking prevalence, acceptability of programs, and incentives that are effective in recruiting and retaining individuals in smoking cessation programs.
- **Improving Hypertensive Care for Inner City Minorities** is a research program initiated by the **NHLBI** in 1993 to develop and then evaluate the feasibility, acceptability, and effectiveness of various methods of maintaining therapy and control of hypertension in inner city minority groups.
- **The Centers for Disease Control and Prevention's** Division of Nutrition and Physical Activity oversees **WISEWOMAN**, which targets Hispanic women who are 50 years of age or older, do not qualify for Medicaid, and do not have medical insurance. This project, conducted in three states, aims to determine whether a comprehensive program to screen women for cardiovascular disease is feasible and effective, and whether a physical intervention activity is beneficial.

GOAL 4

Eliminate disparities in diabetes-related complications.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting 16 million Americans, with disparities among racial and ethnic groups in the rate of diabetes-related complications. Our goal is to continue progress in reducing the overall rate of diabetic complications among all persons with diabetes, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the rate of end stage renal disease from diabetes among blacks and American Indians/Alaska Natives with diabetes by 65% from their 1995 levels by the year 2000. In addition, by the year 2000, we will reduce lower extremity amputation rates from diabetes among blacks by 40% from their 1995 levels. These are our goals under *Healthy People*--the nation's health objectives. Rates of diabetes complications among Hispanics are also high; however, existing data do not permit us to monitor diabetes complications among this group. We will develop strategies to reduce diabetes-related complications among Hispanics, and to improve data collection.



Lower Extremity Amputation Rate Baselines:
Total: 9.4 per 1,000 persons with diabetes (1995)
Black: 10.2 per 1,000 person with diabetes (1995)

Data Source: Numerator: National Hospital Discharge Survey, CDC, NCHS
Denominator: National Health Interview Survey, CDC, NCHS

Periodicity of data source: Data are currently available on an annual basis, 22 months after close of the data year.

End Stage Renal Disease Baselines:

Total: 3.0 per 1,000 persons with diabetes (1992-1995)

White: 2.4 per 1,000 persons with diabetes (1992-1995)

Black: 5.2 per 1,000 person with diabetes (1992-1995)

American Indian/Alaska Native: 5.4 per 1,000 person with diabetes (1992)

Data Source: Bureau of Data Management and Strategy, HCFA Program Statistics, PHS, IHS

Periodicity of Data Source: Data are available on an annual basis; data can be made available 12 months after the close of the data year.

Discussion: While remaining the same or decreasing for whites, prevalence and mortality rates for diabetes among American Indians/Alaska Natives and blacks have been increasing; the prevalence rate of diabetes among American Indian/Alaska Natives is more than twice that for the total populations (73 per 1,000 in 1994 compared to 30 per 1,000). Diabetes rates are also high for Puerto Ricans, Mexican-Americans, Cuban-Americans, Native Hawaiians and certain subgroups of Asian Americans. Rates for diabetes-related complications such as end-stage renal disease and amputations are also higher among blacks and American Indians as compared to the total population. Even with similarly insured populations such as Medicare recipients, blacks are more likely than whites to be hospitalized for amputations, septicemia and debridement--signs of poor diabetic control. Complication rates as outcome measures may not be sensitive indicators of progress regarding this initiative on eliminating racial disparities. We will continue to monitor behavioral practices and health care access issues as indicators of success in achieving a reduction in disparities. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of glucose, clinic visits, diabetic foot care, dilated eye exams. These measures can be tracked by modifications of some currently available sources that will provide annual data.

Strategy for Achieving the Goal

- Expand research efforts through the NIH that are inclusive of racial and ethnic minorities.
- Establish comprehensive community-directed and community-based efforts to reduce the incidence of Type II diabetes and its complications among American Indians and Alaska Natives
- Enhance educational efforts for public and provider groups.
- Continue strong partnerships with national and local private sector interests.

Action Steps for the Next 12 Months

- Develop a major national outreach and consensus intervention initiative to reduce diabetes-associated disease and death, especially in racial and ethnic minorities.
- Establish cooperative agreements which focus on comprehensive community-directed and community-based efforts to reduce the incidence of type II diabetes, reduce its complications, and lower mortality among minority populations.
- Implement the Indian Health Service Diabetes Initiative.

Examples of Programs that Support this Strategy

- **National Diabetes Education Program:** Involves both public and private partners to design ways to improve treatment and outcomes for people with diabetes, to promote early diagnosis, and ultimately to prevent the onset of the disease.
- **The Diabetes Prevention Program Clinical Trial:** Designed 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.
- **Diabetes Prevention Studies in Minority Populations:** The NIDDK continues to encourage increased research efforts on the disproportionate impact of diabetes in minority populations, including blacks, Hispanics, Asian and Pacific Islanders, Alaska Natives, and Native Americans and Hawaiians.
- **National Diabetes Data Group (NDDG):** The NDDG continues its collaboration with the National Center for Health Statistics in the diabetes component of the Third National Health and Nutrition Examination Survey. The NDDG also is continuing analyses of the diabetes component in the 1989 National Health Interview Survey of the NCHS. In addition, the NDDG recently published *Diabetes in America, 1995*. This important publication is a compilation of epidemiologic and public health data on diabetes, including data about the incidence, prevalence, and impact of diabetes and its complications on minorities.
- **The HRSA Lower Extremity Amputation Prevention (LEAP) program** will expand its partnerships with diabetes associations, pharmaceutical corporations, and community groups. Emphasis is on underserved populations, teaching patients to properly test and care for their feet to eliminate causes of amputation.
- The Indian Health Service has established 19 model diabetes centers to address the prevention and treatment of Type II diabetes. In 1998, the IHS will begin a 5 year effort to substantively increase its treatment and prevention capacity with funds (\$30 million per year) provided by the Budget Reconciliation Act.

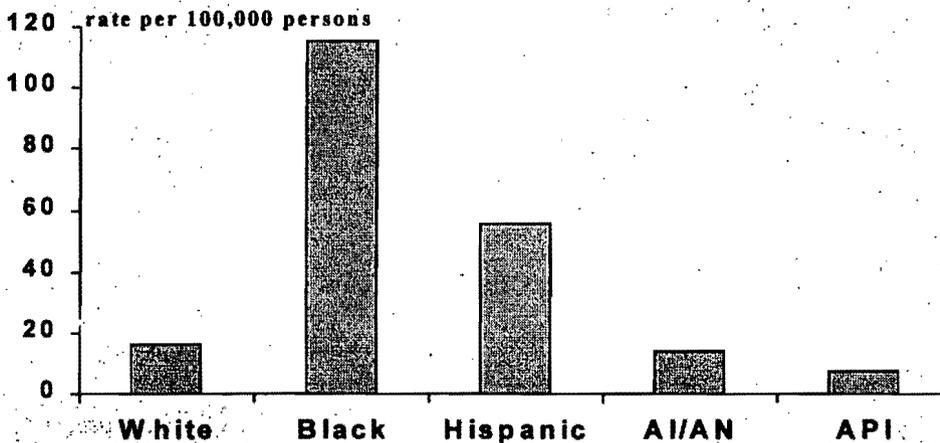


GOAL 5

Reduce disparities in AIDS case rates among racial/ethnic populations through increased knowledge of HIV serostatus and improved access to early medical treatment.

HIV infection/AIDS has been a leading cause of death for all persons 25-44 years of age for several years regardless of race or ethnicity. Although racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, they account for more than 50 percent of all AIDS cases. Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and assuring access to appropriate health services for all, and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act will assure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75% of low income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

AIDS Case Rates in Persons \geq 13 years of age by Race/Ethnicity, United States, 1996



Adult (\geq 13 years) AIDS Case Rate Baselines:

Total: 31.4 per 100,000 1996
White: 16.2 per 100,000 1996
Black: 115.3 per 100,000 1996
Hispanic: 55.8 per 100,000 1996
American Indian/Alaska Native (AI/AN) 14.1 per 100,000
Asian and Pacific Islanders (API) 7.5 per 100,000

Data Source: Adult/Adolescent AIDS Reporting System, CDC

Periodicity of data source: Annual. Data are available three months after the close of the data year.

Pediatric (<13 years) AIDS Case Rate Baselines:

Total: 1.3 per 100,000 1996
White: 0.3 per 100,000 1996
Black: 5.7 per 100,000 1996
Hispanic: 1.7 per 100,000 1996
American Indian/Alaska Native (AI/AN) 0.6 per 100,000
Asian and Pacific Islanders (API) 0.0 per 100,000

Data Source: Pediatric AIDS Case Reporting System, CDC

Periodicity of Data Source: Annual. Data are available three months after the close of the data year.

Discussion: Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities. AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 3/4 were among minority populations (50% African American and 24% Hispanic). During 1995-96, AIDS death rates declined 19% for the total U.S. population, while declining only 10% for blacks and 16% for Hispanics. Contributing factors for these mortality disparities include late identification of disease, lack of health insurance to pay for drug therapies, differential access to HIV primary care, and inconsistency in the level of HIV education and experience among physicians treating historically disenfranchised groups. The cost of efficacious treatment, between \$10,000-\$12,000 per patient per year, is a major hurdle in the effort to assure equitable access to available drug therapies.

Strategy for Achieving the Goal

- Increase the percentage of minority populations that know their HIV serostatus and receive early access to primary care to prevent or delay progression of AIDS.
- Increase the number of racial/ethnic individuals, especially those with high risk factors, who receive counseling and treatment services in public settings.
- Increase access to counseling and testing and therapies that will prevent vertical transmission of HIV between mother and child, with a special emphasis on women of color and their children.

Action Steps for the Next 12 Months

- Continue to work with directly funded community based organizations to target individuals at high risk for HIV infection within racial/ethnic communities to increase counseling, referral services, and access to testing.
- Continue to work with state, city, and territorial health departments to support the HIV Prevention Community Planning process. Through this process, community planning groups work with health departments to develop a comprehensive prevention plan that reflects prioritized needs and is directly responsive to high risk racial/ethnic communities.
- Develop an initiative which creates an epidemiological profile of racial/ethnic communities throughout the country, examines current available programs serving these communities, identifies unmet needs, and develops strategies to address these needs.
- Increase access to prevention and supportive services, and efficacious medications, to assure that individuals from specific racial and ethnic groups receive services in proportion to their representation in the overall epidemic.
- Assure that the composition of the HIV prevention community planning groups reflect the epidemiologic profile of the jurisdiction and increase those groups with linkages to correction and drug treatment facilities.
- Implement the Office of Drug Pricing rebate program for the AIDS Drug Assistance Programs to increase the buying power of Federal, State, and local funds allotted to these programs.

Examples of Programs that Support this Strategy

- The CDC HIV Counseling and Testing Data System began operating in 1985 to increase the availability of HIV counseling and testing services for persons who wanted to know their HIV status. Health departments in 65 States, cities, and territories collect information on the characteristics of persons seeking these services. In 1995, nearly 10,000 sites performed nearly 2.4 million HIV tests and reported results to CDC.
- CDC provides financial and technical assistance to **community-based organizations** working to prevent HIV infection, both directly and indirectly through health departments. This program primarily targets high-risk individuals within racial and ethnic communities. CDC also provides funds to National and Regional Minority organizations to identify the prevention needs of community-based organizations that work with racial and ethnic minorities.

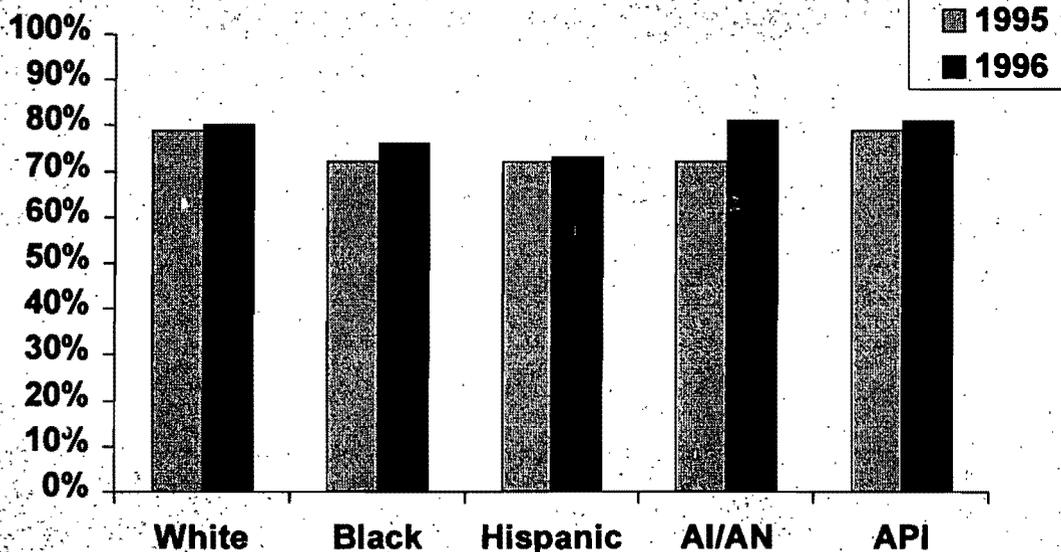
- **The Young African-American Men's Study** is a CDC, 2-year formative study to prevent HIV/AIDS in young black men. Data are being collected in Chicago and Atlanta through interviews, observations and group discussions with community leaders, health care providers, and young men who have sex with men.
- **HRSA's AIDS Education and Training Center (AETC)** have a legislative mandate to provide training for minority providers and providers who treat minority populations in appropriate HIV therapeutics.
- The majority of HRSA's **Special Projects of National Significance (SPNS) Program** grants develop new models of HIV care for individuals from minority racial and ethnic populations. The SPNS Program currently is funding support service grants to increase access to HIV/AIDS care and related services for Hispanic populations living on the U.S./Mexico border, urban blacks dually diagnosed with HIV and substance abuse, Native Americans and Alaska Natives who were not accessing HIV services, and Asian and Pacific Islanders in New York City.
- **HRSA's Title III Early Intervention Services Program** provides grant support for outpatient HIV early intervention and primary care services for low-income, medically underserved individuals, primarily people of color in existing primary care systems. The objective of these programs is to maximize access to comprehensive and continuing clinical and supportive care for populations that have been disproportionately affected by the AIDS epidemic. Currently, approximately two-thirds of the clients who receive primary care services at Title III programs are members of racial and ethnic minority groups.
- HRSA continues to publish "**HIV Care Access Issues**" -- a technical assistance series of reports that identify barriers and strategies to overcome barriers to HIV care among specific population groups, e.g., black, Hispanics, Native Americans, and Asian Americans.
- **HRSA's AIDS Drug Assistance Programs (ADAP)** serve individuals from racial/ethnic minorities in approximate proportion to their cumulative representation in the epidemic to date.
- HCFA estimates that in excess of 50% of people with AIDS, and over 90% of children with AIDS are served through **Medicaid**.

GOAL 6

Eliminate disparities in child and adult immunization rates

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. Although immunization rates have been lower in minority populations compared to the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. Our goal is to sustain current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives.

Childhood Immunization Rates* by Race and Ethnicity, United States, 1995-1996



*Immunization rates reflect those children ages 19-35 months of age who have received 4 doses of DTP (diphtheria, tetanus, pertussis), 3 Polio, and 1 MMR (measles, mumps, rubella).

Childhood Immunization Rate Baselines:

Total: 78 % (1996)

White: 80% (1996)

Black: 76% (1996)

Hispanic: 73 % (1996)

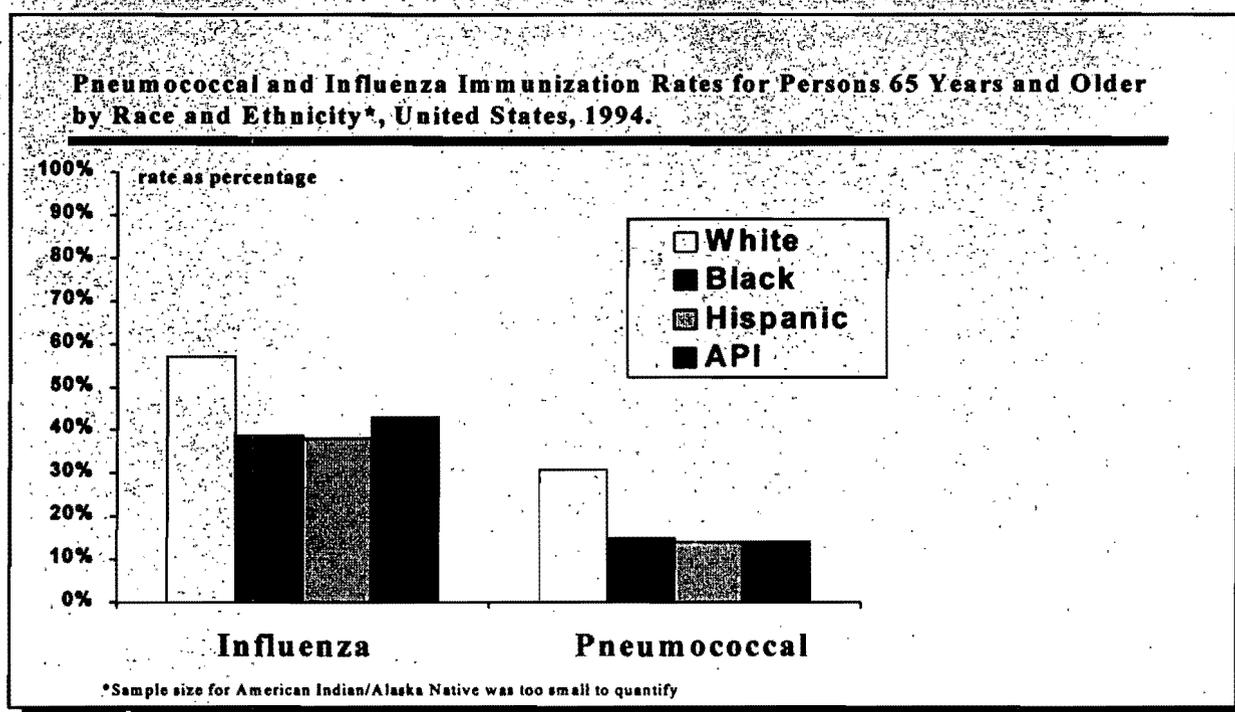
American Indian/Alaska Native (AI/AN): 81% (1996)

Asian/Pacific Islanders (API): 81% (1996)

Data Source: National Immunization Survey, CDC, NCHS

Periodicity of Data Source: Data are reported semi-annually, eight months after the close of the respective data period.

Adult immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. There is a disproportionate burden of these vaccine-preventable diseases in minority and under served populations. Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives. In order to reach this goal, by the year 2000 we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asian and Pacific Islanders and to *quadruple* the 1994 pneumococcal immunization rates among these groups.



Immunization Rate Baselines for Adults 65 years and older:

Influenza:

- Total: 55% (1994)**
- White: 57% (1994)**
- Black: 39% (1994)**
- Hispanic: 38% (1994)**
- Asian/Pacific Islander: 43% (1994)**

Pneumococcal:

- Total: 30% (1994)**
- White: 31% (1994)**
- Black: 15% (1994)**
- Hispanic: 14% (1994)**
- Asian/Pacific Islander: 14% (1994)**

Data Source: National Health Interview Survey (NHIS), CDC, NCHS

Periodicity of Data Source: Data will be available annually, approximately six months after the close of the data year. Data have previously been collected as part of supplements, but are currently in the adult core questionnaire. Data collected as part of the core using the new computer assisted personal interview procedure should be available approximately six months following the close of the data year. This system is currently being implemented.

Discussion: Though coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of under-immunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas within traditionally underserved populations, they have the potential to spawn outbreaks of vaccine-preventable diseases. Each year, an estimated 45,000 adults die of influenza, pneumococcal infections and liver cancer due to chronic hepatitis B infection despite the availability of safe and effective vaccines to prevent these conditions and their complications. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the Healthy People Year 2000 targets.

Strategy for Achieving the Goal

Childhood

- The **Childhood Immunization Initiative (CII)** was launched to reduce most diseases preventable by childhood vaccination to zero and to establish a sustainable system to ensure that all 2-year olds receive required vaccines by the year 2000 and beyond. The CII is a comprehensive effort designed to marshal efforts of the public and private sectors, health care professionals and volunteer organizations.

Adult

- Increasing provider awareness of the need for timely immunizations in adults.
- Assuring effective vaccine delivery mechanisms for adults.
- Intensifying vaccine-preventable disease program evaluations, surveillance activities, and investigation of reported outbreaks or unusual occurrences of disease.
- Encouraging outreach to all seniors through Medicare beneficiary education efforts, with special efforts to target minorities.

Action Steps for the Next 12 Months

- ◊ Develop and promote use of software to assess vaccination practices and track vaccinations levels.

- ◇ Increase emphasis on immunizations by supporting collaborative activities to enhance influenza and pneumococcal vaccination levels among Medicare beneficiaries.
- ◇ Develop and test assessment tools for documenting adult immunization levels and practices in Community/Migrant Health Center sites.
- ◇ Continue to support the Department-wide Asian and Pacific Islander Americans (APIA) Action Agenda to ensure that susceptible APIA children and adolescents receive a hepatitis B vaccine series.
- ◇ As directed by the President, hold a national conference for the establishment of State and community immunization registries.

Examples of Programs that Support this Strategy

Childhood

CDC is working with its partners to:

- Develop and implement State and community immunization registries as a cornerstone to increase and sustain vaccination coverage rates to prevent outbreaks of disease.
- Target a range of interventions to address pockets of need in each State or major city.
- Continue implementing proven interventions, such as WIC/Immunization linkages and assessment of coverage levels in provider settings.

Adult

- The DHHS Action Plan for Adult Immunization identifies key steps for each agency to implement to increase adult immunization levels, including efforts targeted at populations with an increased burden of vaccine-preventable diseases.
- The National Coalition for Adult Immunization (NCAI), with about 100 members, cooperates in nationwide informational and educational programs to promote adult immunization activities.
- HCFA's Horizon's Pilot Project targets black Medicare beneficiaries in eight southern States by working with Historically Black Colleges and Universities and HCFA's Quality Improvement Organizations to improve influenza vaccination levels.
- CDC is collaborating with HRSA to conduct a quality improvement project in a limited number of Community/Migrant Health Center (C/MHC) sites targeting adults.

File Race & Health

Eliminating Disparities in Health

In support of the President's Initiative on Race, the Department of Health and Human Services has identified six areas in which racial and ethnic minorities experience serious disparities in access to health services and in health status. The leadership and resources of the Department will be committed to achieving significant reductions in these disparities by the Year 2000, with the ultimate goal of eliminating these disparities. Through this effort, we will contribute to meeting three of the five central goals of the President's Initiative on Race:

- educate the nation about the facts surrounding the issue of race
- promote a constructive dialogue to confront and work through the difficult and controversial issues surrounding race
- find, develop and implement solutions in critical areas such as health care for individuals, communities, corporations and government at all levels.

A national focus on health disparities is needed given the compelling evidence that race and ethnicity correlate with persistent, and often increasing, health disparities between populations in the United States. Indeed, despite significant progress in the overall health of the nation, as documented in *Health, United States*, the annual report card on the health status of the American people, there are continuing disparities in the burden of death and illness experienced by Blacks, Hispanics, American Indians and Alaska Natives and Asians and Pacific Islanders as compared to the U.S. population as a whole. The demographic changes that will unfold over the next several decades heighten the importance of addressing the issue of disparities in health status: Groups that currently experience poorer health status will increase as a proportion of the total population. Therefore, the future health of the American people will be substantially influenced by our success in improving the health of racial and ethnic minorities.

It is particularly important that the Department and the nation focus on the issue of disparities in access to services and health status as major changes unfold in the systems through which care is financed and delivered. Indeed, one of the Department's strategic goals for the next six years is to improve the quality of health care, with particular attention given to the problem of disparities in access to quality services. However, it is important to note that improvements in prevention and clinical services can only partially address the difficult, complex and often controversial issues surrounding racial and ethnic disparities in health status. Education, income and other socioeconomic factors play a large role in influencing health outcomes. The Department's programs to improve the economic security of low-income families and communities will be important contributors to improving the health status of low-income populations—populations that are disproportionately composed of racial and ethnic minorities. We look forward to collaborations with other federal departments, states and the private sector to address the broader determinants of health.

The Department has selected six health problem areas to address as part of the President's Initiative on Race: infant mortality, breast and cervical cancer, heart disease and stroke, diabetes, AIDS case rates, and child and adult immunizations. These focus areas are drawn from the health objectives for the nation, *Healthy People 2000*. The targets to reduce these disparities have been established in collaboration with the major national organizations that are active in addressing health concerns for the affected populations. The six focus areas will receive priority attention because achieving these goals will make an important contribution to improving the health of racial and ethnic minorities. In the process we will also learn how to more effectively target strategies and resources to address other problem areas. This exercise will contribute materially to our longer term objective of substantially eliminating disparities in health status by the year 2010.

To achieve the goals of the President's Initiative on Race will require a reexamination and re-energizing of existing efforts within the Department. The Department must redouble its efforts to assure that the needs of its customers are identified and addressed, and that Departmental efforts are communicated as effectively as possible. The Department must broaden and strengthen its partnerships with state and local governments, with national and regional minority health and other minority-focused organizations, and with minority community-based organizations--those who have the greatest access to and knowledge of the community. Finally, the Department must ensure that adequate monitoring efforts are carried out, and that local and national data necessary for determining priorities, and designing programs are available.

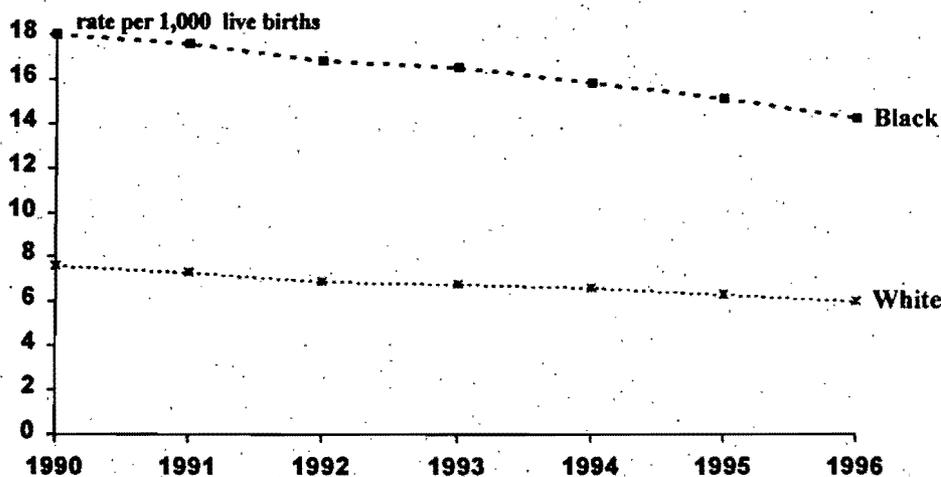
The Department has set forth an action plan for the next twelve months aimed at achieving progress towards the six goals. In addition, the Secretary and the Assistant Secretary for Health will conduct strategic assessments for each of the six goals over the next year to assess whether the Department and the nation are doing the right things to assure that the goals are met, and to begin a broad national dialogue to identify the most effective actions to achieve progress in these six areas, and by extension the other areas of disparity that must be addressed in the long term.

GOAL 1

Eliminate disparities in infant mortality rates, including death from Sudden Infant Death Syndrome (SIDS)

There are substantial racial and ethnic disparities in infant morbidity and mortality rates in the United States. Our goal is to continue progress in reducing overall morbidity and mortality rates, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the greatest disparity in infant mortality, which is among blacks whose rate is nearly 2 ½ times as great as whites, by at least 20% from their 1996 rate by the Year 2000. We will also work to reduce infant mortality rates among American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians whose rates are also above the national average. These are our goals under *Healthy People*--the nation's health objectives.

Infant Mortality Rates for the United States by Race, 1990-1996.



Infant Mortality Rate Baselines:

Total: 7.2 per 1,000 live births (1996 preliminary data)

Black: 14.2 per 1,000 live births (1996 preliminary data)

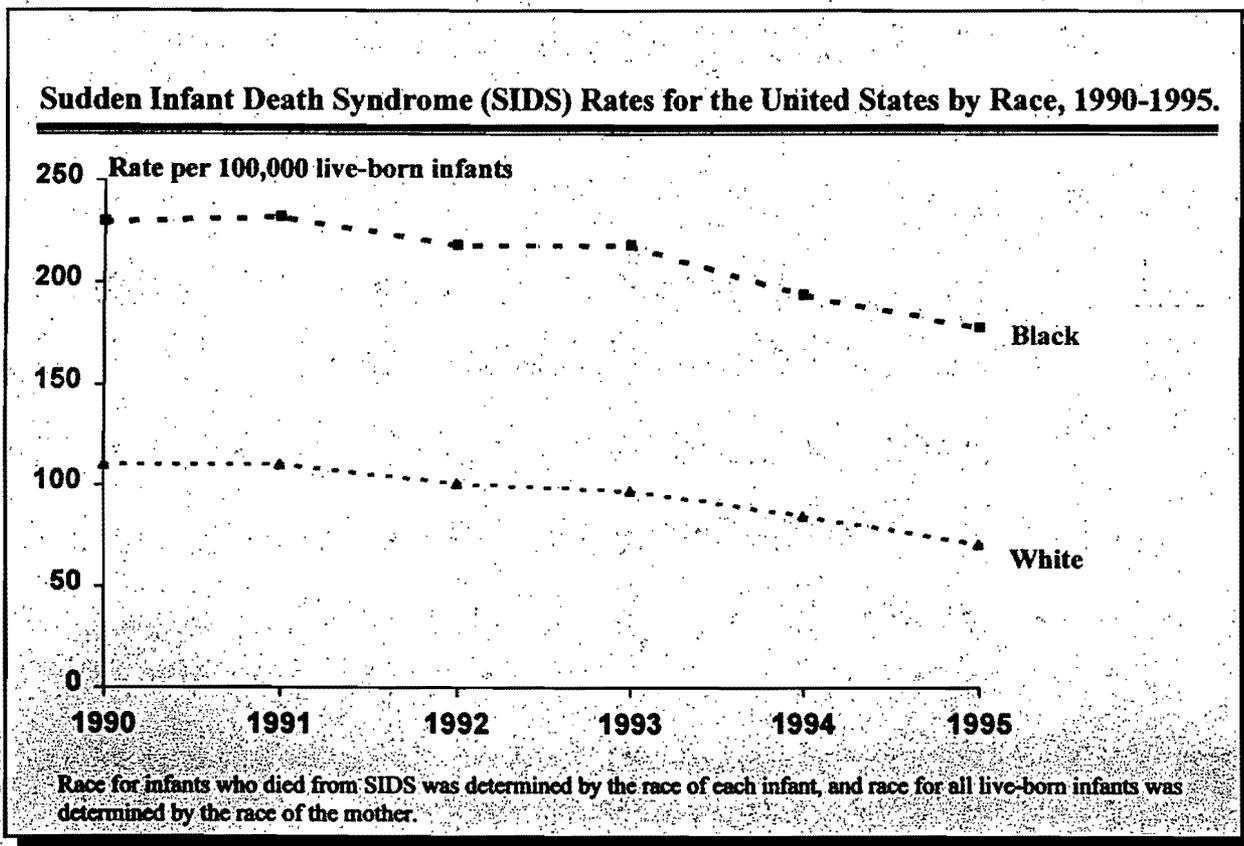
White: 6.0 per 1,000 live births (1996 preliminary data)

Data Source: National Vital Statistics System natality/mortality files, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population, and for white and black subgroups are available nine months after the close of the data year; final data are available 16 months after the close of the data year. Data for other subgroups come from linked data sources and are not available until 21 months after the close of the year (due to inconsistencies in

reporting ethnic origin, birth and death files for Hispanic and other minorities that must be linked before accurate statistics can be reported). Linked infant birth and death file data for 1995 will be available this fall for American Indians and Alaska Natives, Puerto Ricans, and Native Hawaiians.

Background: Although overall infant mortality rates have been declining, the decline in rates for a number of racial and ethnic groups significantly lags behind the national experience. A major factor in these varied rates is the substantial racial disparity in low birth weight and preterm birth. Much of the decline in overall rates can be traced to research advances, better understanding and treatment of respiratory distress syndrome as well as reductions in deaths due to Sudden Infant Death Syndrome (SIDS). Despite improvements in recent years, SIDS still accounts for approximately 10% of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS, with rates among blacks being two and one half times that of whites, and among some American Indian and Alaska Native populations being three to four times greater. Among blacks the SIDS rate has declined 18 percent between 1993 and 1995, the largest decline ever observed. However, the disparity *between* blacks and whites for SIDS remains large.



Sudden Infant Death Syndrome Rate Baselines:

Total: 74.2 per 100,000 live-born infants (1996 preliminary data)

Black: 178.6 per 100,000 live-born infants (1995)

White: 71.0 per 100,000 live-born infants (1995)

Data Source: National Vital Statistics System mortality data, CDC, NCHS

Periodicity of data source: Annual. Preliminary data for the total population are available nine months after the close of the data year; final data that include racial subgroups are available 16 months after the close of the data year.

Strategy for Achieving the Goal

- Provide enhanced prenatal services to low-income pregnant women by building community-based outreach and family-centered infrastructures in communities with high rates of infant mortality, morbidity, and poverty.
- Support a range of biological and behavioral research to better identify the specific factors contributing to the racial and ethnic disparities associated with infant death, preterm delivery, low birth weight, SIDS, and related adverse outcomes.
- Form linkages among public agencies and academic, professional, business and other private entities to address and promote coordinated research and health and social services.
- Promote the recruitment and training of minority researchers and the support of minority institutions that have immediate access and can contribute to the care of high-risk populations.

Action Steps for the Next 12 Months

- ⇒ Increase to 100% the number of States with a plan that addresses infant mortality reduction and the associated racial/ethnic disparities. Emphasis will be placed on increasing the percentage of minority pregnant women receiving prenatal care in the first trimester.
- ⇒ All 50 States will have active "Back to Sleep" or SIDS risk reduction campaigns
- ⇒ Increase to 60 the number of high-risk communities addressing infant mortality reduction, and especially the elimination of disparities in infant mortality rates.

Examples of Programs that Support this Strategy

- **"Back-to-Sleep" Campaign:** Much of the recent decline in the incidence of SIDS is credited to this campaign which recommends that healthy babies be placed on their backs to sleep to help reduce the incidence of SIDS. The campaign will expand efforts to reach minority and ethnic populations. (NIH, HRSA, CDC)
- **Cultural Competence in SIDS Service Delivery Systems:** Complete a Task Force Report by Fall 1997 with recommendations for culturally competent strategies to improve public

health campaigns and bereavement services for under served racial and ethnic populations. (HRSA)

- **SIDS-Related Research:** Support research to 1) better understand the physiologic causes of SIDS and why SIDS infants die, 2) develop effective screening tests that can identify infants at risk for SIDS, 3) develop effective pharmacologic therapies for high risk infants; and 4) define specific patterns of risk in racial populations. (NIH)
- **Healthy Start Initiative:** Fund approximately 40 new high-risk communities to implement one or more of the community-based strategies to reduce infant mortality determined to best address the needs of the individual community. (HRSA)
- **State Mortality/Morbidity Review Support Programs:** Support up to five States in their efforts to promote, coordinate, and sustain mortality and morbidity review programs at state and community levels. This will allow States to expand their focus to morbidities and additional population groups. Emphasis will be placed on developing community and state partnerships that utilize the community-based review findings pertaining to service barriers and proposed systems changes to improve racial disparities and other problems associated with poor pregnancy or child health outcomes. (HRSA)
- **Perinatal Research:** Increase identification of risk factors and biological markers for adverse pregnancy outcomes, (e.g., LBW and preterm births), as well as SIDS, among minorities, with the expectation of developing appropriate and effective interventions and treatments for clinical conditions. (NIH, HRSA, CDC)

GOAL 2

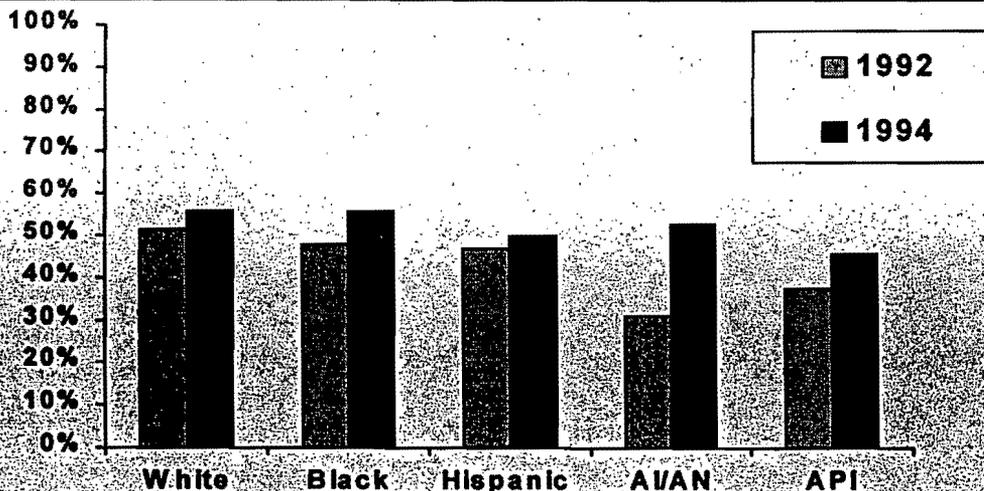
Eliminate disparities in breast and cervical cancer screening and management.

Cancer is the second leading cause of death for all women. Disparities in breast and cervical cancer incidence and death rates occur among various racial and ethnic groups. Screening to detect early disease is critical in the management of these two cancers. Even small changes in the percentage of women screened by mammography and Pap tests can have significant impact on the overall burden of suffering from these cancers. Our goal is to continue progress in getting more women screened for these two cancers at the appropriate age and time intervals, and to eventually eliminate disparities among all racial and ethnic groups in regards to screening and management.

Breast Cancer:

Our goal for the year 2000 for breast cancer screening is to increase to at least 60% those women of all racial or ethnic groups aged 50 and older who have received a clinical breast exam and a mammogram within the preceding two years. This means we will have to increase the screening rate among white and black women by 7% from their 1994 level, American Indian and Alaska Natives by 13 %, Hispanic women by 20%, and Asian and Pacific Islanders by 30% in order to reach our goal under *Healthy People*--the nation's health objectives.

Proportion of Women Aged 50 and Older Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding Two Years, United States, 1992 and 1994.



Breast Cancer Screening Rate Baselines for women \geq 50 years of age:

Total: 56 % (1994)

White: 56% (1994)

Black: 56% (1994)

Hispanic: 50 % (1994)

American Indian/Alaska Native (AI/AN): 53% (1994)

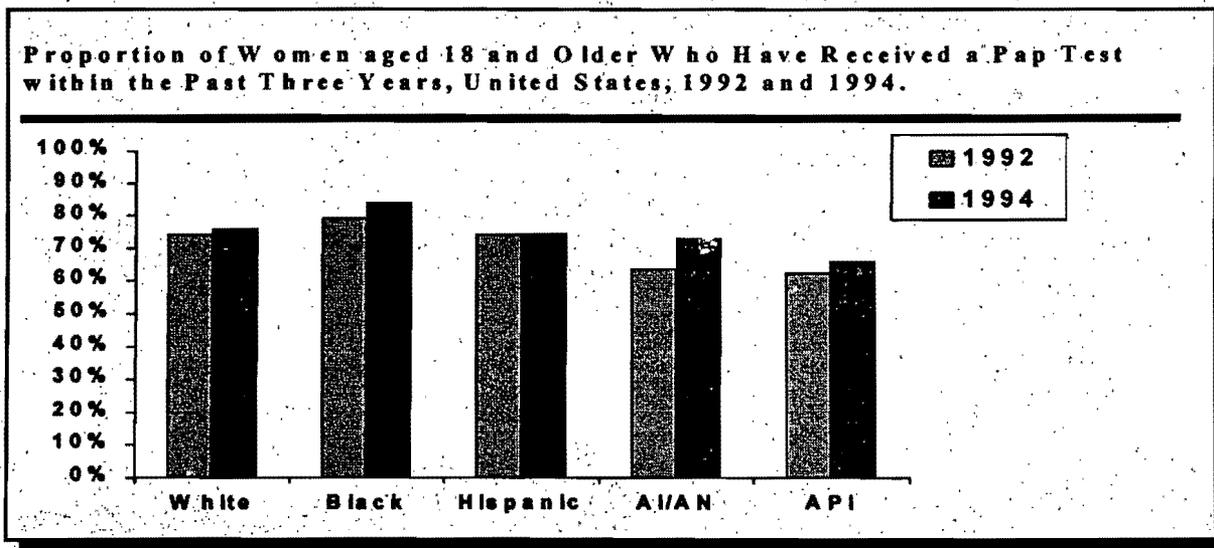
Asian and Pacific Islanders (API): 46% (1994)

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Cervical Cancer:

Our goal for the year 2000 for cervical cancer is to increase to at least 85% the proportion of all women aged 18 and older who have received a Pap test within the preceding three years. This is our goal under *Healthy People*--the nation's health objectives.



Cervical Cancer Screening Rate Baselines for women age \geq 18 years :

Total: 77 % (1994)

White: 76% (1994)

Black: 84% (1994)

Hispanic: 74 % (1994)

American Indian/Alaska Native (AI/AN): 73% (1994)

Asian and Pacific Islanders (API): 66% (1994)

Data Source: National Health Interview Survey, CDC, NCHS

Periodicity of Data Source: Data are available once every three years, six months after the close of the data year.

Discussion: Black women have a 30% greater risk of dying from breast cancer than white women, despite an overall lower risk of acquiring breast cancer in the first place. This higher death rate among blacks is most likely due to later diagnosis and treatment, hence the need for better cancer screening and management among minority populations. Furthermore, the breast cancer death rate *decreased* 10 percent for white women during 1980-1995, while it *increased* 18 percent for black women. These disparities hold true for cervical cancer as well, where the death rates are higher for black (5.2 per 100,000 in 1995) and Hispanic women (3.1 per 100,000) than for the total population (2.5 per 100,000).

Strategy for Achieving the Goal

- Increase public education campaigns to address the benefits of mammography, thereby increasing the proportions of women aged 50-70 who have had a screening mammogram in the prior two years.
- Provide access to optimal care for minority women.
- Establish the Healthy People goal as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 months

- ◇ Increase in the proportion of minority women 50 to 70 years of age who have had a mammogram and clinical breast exam in the past two years as measured by the 1998 National Health Interview Survey.
- ◇ Increase the proportion of minority women aged 18 and above who have had a Pap test in the prior three years as measured by the 1998 National Health Interview Survey.
- ◇ Expand access to screening and treatment to underserved women through the Breast and Cervical Cancer Early Detection Program.

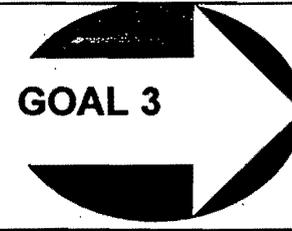
Examples of Programs that Support this Strategy

- **CDC's National Breast and Cervical Cancer Early Detection Program** builds the public health infrastructure for breast and cervical cancer early detection in States through public and provider education, quality assurance, surveillance and partnership development. This program offers free or low-cost mammography and Pap tests to medically under served women, many of whom are minorities. Nearly 1 million screening tests have been performed since the program's inception.

- **The National Cancer Institute (NCI)** is funding twelve regional conferences in FY 1997 on the recruitment and retention of minorities in clinical trials.
- **The Minority Based Community Clinical Oncology Program** which is one of the programs responsible for the proportional representation of blacks and Hispanics in NCI sponsored treatment trials.
- **The National Black Leadership Initiative on Cancer and The National Hispanic Leadership Initiative on Cancer** are important public education programs working in concert with the NCI's Office of Cancer Communication.
- **The National Program of Cancer Registries (NPCR)**, which supports comprehensive, timely, accurate cancer registries in 42 States and the District of Columbia. The NPCR enables reporting of cancer data by age, ethnicity and geographic regions and provides critical feedback to States for tracking cancer trends, targeting and evaluating cancer control interventions; and health resource planning.
- **The Information Action Council of the National Action Plan on Breast Cancer has developed a Bridge to Underserved Populations initiative.** This initiative is exploring a variety of strategies for providing hard-to-reach populations with breast cancer information using the Internet. The IAC convened a series of regional meetings across the country to investigate and develop strategies for bridging the gap between the underserved women and the Information Superhighway. The meetings brought together community based organizations, private organizations, and women from underserved communities. The IAC plans to build partnerships with community based organizations in model pilot projects, that will ensure that underserved women have access to the wealth of information about breast cancer available on the Information Superhighway.
- **The Health Care Financing Administration Medicare Mammography Campaign**, which was launched in conjunction with First Lady Hillary Rodham Clinton and the U.S. Public Health Service's Office on Women's Health, encourages older women to use Medicare's mammography screening benefit.
- **Coverage of Mammography and Pap Smears Under Medicare and Medicaid -** Under H.R. 2015, enacted in August 1997, mammography coverage under Medicare will be expanded to include annual screening mammograms for women over 39, with the cost-sharing waived. Pelvic exams, clinical breast exams, and Pap smears will be covered under Medicare every three years, with annual Pap smears for women at risk of developing cervical cancer and those who have not had negative Pap smear in the past three years. Cost-sharing would also be waived. The Health Care Financing Administration has also sent letters to state Medicaid Directors urging them to provide coverage for annual screening mammograms for women aged 40 and older under Medicaid.
- **HCFA will continue projects with medical peer review organizations to measure quality of medical practice and assure that all Americans receive the same high quality health care.**

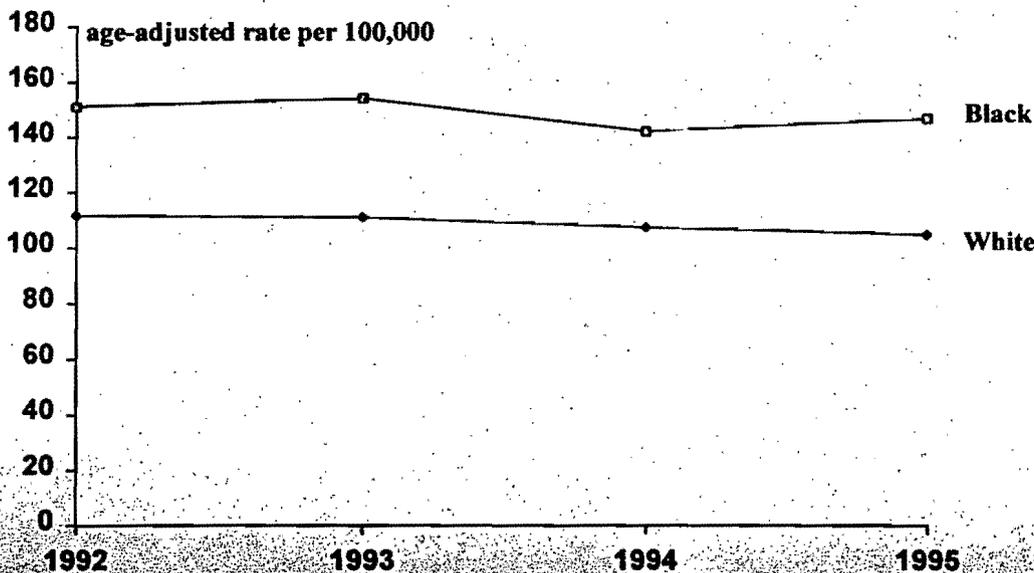
- **The Minority Women's Health Initiative** of the PHS Office on Women's Health (OWH) was developed in response to recommendations made during the PHS OWH Minority Women's Health Conference in January 1997. This initiative will target breast cancer in minority women as a top priority.

- **The Federal Coordinating Committee on Breast Cancer** will be awarding up to \$3 million in fiscal year 1997 to supplement existing programs as well as to support approved but unfunded projects that are targeted towards reducing breast cancer in underserved populations. These funds will be distributed to all agencies of the federal government that carry out breast cancer activities.

**GOAL 3****Eliminate disparities in heart disease and stroke**

Cardiovascular disease, particularly heart disease and stroke, kills nearly as many Americans as all other diseases combined and is also one of the major causes of disability in the United States. Our goal is to continue progress in reducing the overall death rates from heart disease and stroke, and to eventually eliminate disparities among all racial and ethnic groups. In order to have the greatest impact towards that end, we have set near term goals of reducing the heart disease and stroke mortality rates among blacks by 25% from their 1995 level by the year 2000; these are our goals under *Healthy People*--the nation's health objectives. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Rates of Coronary Heart Disease (CHD) Deaths, United States, 1992-1995.



Coronary Heart Disease Mortality Rate Baselines:

Total: 108 per 100,000 persons (age-adjusted) (1995)

White: 105 per 100,000 persons (age-adjusted) (1995)

Black: 147 per 100,000 persons (age-adjusted) (1995)

American Indian/Alaska Natives: 76 per 100,000 persons (age-adjusted) (1995)

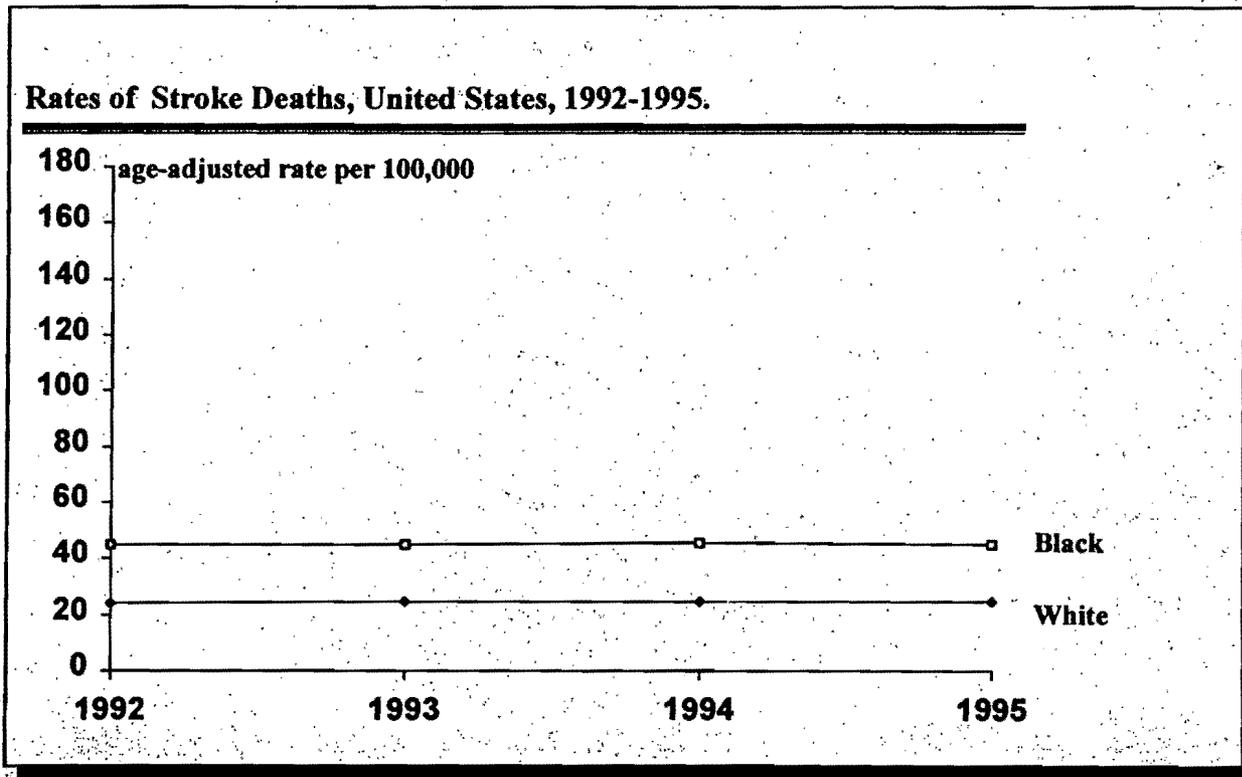
Asian/Pacific Islanders: 63 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Mortality data are collected on minority subgroups; however, denominator data for total Hispanic population requires special data runs from Census to estimate the population sizes as of July 1 of the data year. These data are available approximately 28-30 months following the July 1 date. (1995 data will be available in fall 1997.)

Mortality data are collected on Asian/Pacific Islander subpopulations. However, the latest denominator data available from Census for these subpopulations is 1990.



Stroke Mortality Rate Baselines:

Total: 26.7 per 100,000 persons (age-adjusted) (1995)

White: 24.7 per 100,000 persons (age-adjusted) (1995)

Black: 45.0 per 100,000 persons (age-adjusted) (1995)

American Indian/Alaska Natives: 21.6 per 100,000 persons (age-adjusted) (1995)

Asian/Pacific Islanders: 25.8 per 100,000 persons (age-adjusted) (1995)

Data Source: National Vital Statistics System mortality files, CDC, NCHS

Periodicity of Data Source: Data are currently available on an annual basis approximately 16 months after the close of the data year.

Discussion: The age-adjusted death rate for coronary heart disease for the total population declined by 20% from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Within similarly insured populations such as Medicare recipients, there are significant disparities between blacks and whites in the use of certain diagnostic procedures for heart disease that cannot be explained by differences in the severity of symptoms. Racial and ethnic minorities also have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to be undergoing treatment to control their high blood pressure. Furthermore, the rates for regular screening for cholesterol, another risk factor for heart disease, show disparities for certain racial and ethnic minorities—only 50% of American Indians/Alaska Natives, 44% of Asian Americans, and 38% of Hispanics have had their cholesterol checked within the past two years.

Strategy for Achieving the Goal

- Foster efforts by public and private health-related organizations to disseminate and implement current knowledge about prevention and treatment of cardiovascular disease
- Further explore issues of cardiovascular risk factors to define more clearly those populations that are at increased risk for cardiovascular disease.
- Conduct research to identify genetic determinants of elevated risk.
- Establish the Healthy People goals as performance measures in HRSA Primary Care Programs and as program expectations for community and migrant health centers across the nation.

Action Steps for the Next 12 Months

- Evaluate results of the Latino Community Cardiovascular Disease Prevention and Outreach Initiative and use findings for planning a national strategy.
- Implement selected program outreach strategies as reflected in the NHLBI Ad Hoc Committee on Minority Populations 5-Year Strategic Plan developed in FY 97.
- Initiate a new Asian/Pacific Islander American Cardiovascular Disease Prevention Initiative.
- Initiate a new coronary heart disease professional medical education Website for health professionals who provide care to black patients.
- Disseminate widely the training materials on cultural competence so that health care providers have information that is relevant to greater patient compliance and better outcomes.

Examples of Programs that Support this Strategy

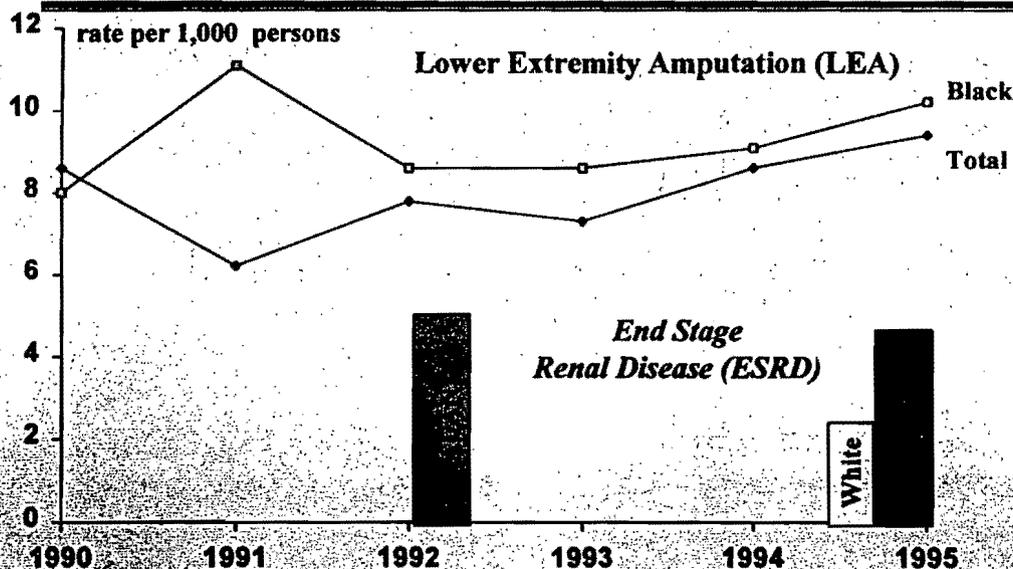
- **The African American Community Cardiovascular Disease Prevention and Outreach Initiative**, established by the **National Heart, Lung, and Blood Institute (NHLBI)** in 1992. As a part of this initiative, the NHLBI works with the **National Medical Association, Association of Black Cardiologists, National Black Nurses' Association**, and historically black medical colleges and universities' medical schools to develop and implement community-based cardiovascular disease prevention and education projects for inner-city blacks.
- **The Latino Community Cardiovascular Disease Prevention and Outreach Initiative**, established in 1995 by the **NHLBI**. This initiative is composed of local projects that involve community members in health promotion and disease prevention programs; develop culturally appropriate and language-specific materials; involve existing community organizations and services; use select influential media; and incorporate positive community lifestyles, values, and beliefs. Plans are underway to transition these local projects to a national effort.
- **Building Healthy Hearts for American Indians and Alaska Natives** was established in 1996 by the **NHLBI**. It seeks to increase awareness and knowledge of risk factors for cardiovascular diseases, which account for nearly a quarter of all American Indians and Alaska Native deaths. The initiative develops heart health promotion strategies that address needs and incorporate culture, tradition, lifestyles and values of Native Peoples.
- **The Smoking Cessation Strategies for Minorities Initiative** has been conducted by the **NHLBI** since 1989 to stimulate development of culturally specific smoking cessation and relapse prevention programs for under served minorities. The program developed data on smoking prevalence, acceptability of programs, and incentives that are effective in recruiting and retaining individuals in smoking cessation programs.
- **Improving Hypertensive Care for Inner City Minorities** is a research program initiated by the **NHLBI** in 1993 to develop and then evaluate the feasibility, acceptability, and effectiveness of various methods of maintaining therapy and control of hypertension in inner city minority groups.
- **The Centers for Disease Control and Prevention's Division of Nutrition and Physical Activity** oversees **WISEWOMAN**, which targets Hispanic women who are 50 years of age or older, do not qualify for Medicaid, and do not have medical insurance. This project, conducted in three states, aims to determine whether a comprehensive program to screen women for cardiovascular disease is feasible and effective, and whether a physical intervention activity is beneficial.

GOAL 4

Eliminate disparities in diabetes-related complications.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting 16 million Americans, with disparities among racial and ethnic groups in the rate of diabetes-related complications. Our goal is to continue progress in reducing the overall rate of diabetic complications among all person with diabetes, and to eventually eliminate disparities among groups. As a major step towards that end, we have set a near term goal of reducing the rate of end stage renal disease from diabetes among blacks and American Indians/Alaska Natives with diabetes by 65% from their 1995 levels by the year 2000. In addition, by the year 2000, we will reduce lower extremity amputation rates from diabetes among blacks by 40% from their 1995 levels. These are our goals under *Healthy People*--the nation's health objectives. Rates of diabetes complications among Hispanics are also high; however, existing data do not permit us to monitor diabetes complications among this group. We will develop strategies to reduce diabetes-related complications among Hispanics, and to improve data collection.

Diabetes-related Complication Rates for End-Stage Renal Disease (ESRD) and Lower Extremity Amputation by Race and Ethnicity, United States, 1990-1995.



Lower Extremity Amputation Rate Baselines:

Total: 9.4 per 1,000 persons with diabetes (1995)

Black: 10.2 per 1,000 person with diabetes (1995)

Data Source: Numerator: National Hospital Discharge Survey, CDC, NCHS
Denominator: National Health Interview Survey, CDC, NCHS

Periodicity of data source: Data are currently available on an annual basis, 22 months after close of the data year.

End Stage Renal Disease Baselines:

Total: 3.0 per 1,000 persons with diabetes (1992-1995)

White: 2.4 per 1,000 persons with diabetes (1992-1995)

Black: 5.2 per 1,000 person with diabetes (1992-1995)

American Indian/Alaska Native: 5.4 per 1,000 person with diabetes (1992)

Data Source: Bureau of Data Management and Strategy; HCFA Program Statistics; PHS, IHS

Periodicity of Data Source: Data are available on an annual basis; data can be made available 12 months after the close of the data year.

Discussion: While remaining the same or decreasing for whites, prevalence and mortality rates for diabetes among American Indians/Alaska Natives and blacks have been increasing; the prevalence rate of diabetes among American Indian/Alaska Natives is more than twice that for the total populations (73 per 1,000 in 1994 compared to 30 per 1,000). Diabetes rates are also high for Puerto Ricans, Mexican-Americans, Cuban-Americans, Native Hawaiians and certain subgroups of Asian Americans. Rates for diabetes-related complications such as end-stage renal disease and amputations are also higher among blacks and American Indians as compared to the total population. Even with similarly insured populations such as Medicare recipients, blacks are more likely than whites to be hospitalized for amputations, septicemia and debridement--signs of poor diabetic control. Complication rates as outcome measures may not be sensitive indicators of progress regarding this initiative on eliminating racial disparities. We will continue to monitor behavioral practices and health care access issues as indicators of success in achieving a reduction in disparities. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of glucose, clinic visits, diabetic foot care, dilated eye exams. These measures can be tracked by modifications of some currently available sources that will provide annual data.

Strategy for Achieving the Goal

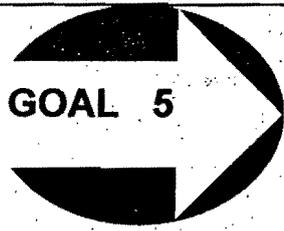
- Expand research efforts through the NIH that are inclusive of racial and ethnic minorities.
- Establish comprehensive community-directed and community-based efforts to reduce the incidence of Type II diabetes and its complications among American Indians and Alaska Natives.
- Enhance educational efforts for public and provider groups.
- Continue strong partnerships with national and local private sector interests.

Action Steps for the Next 12 Months

- ◊ Develop a major national outreach and consensus intervention initiative to reduce diabetes-associated disease and death, especially in racial and ethnic minorities.
- ◊ Establish cooperative agreements which focus on comprehensive community-directed and community-based efforts to reduce the incidence of type II diabetes, reduce its complications, and lower mortality among minority populations.
- ◊ Implement the Indian Health Service Diabetes Initiative.

Examples of Programs that Support this Strategy

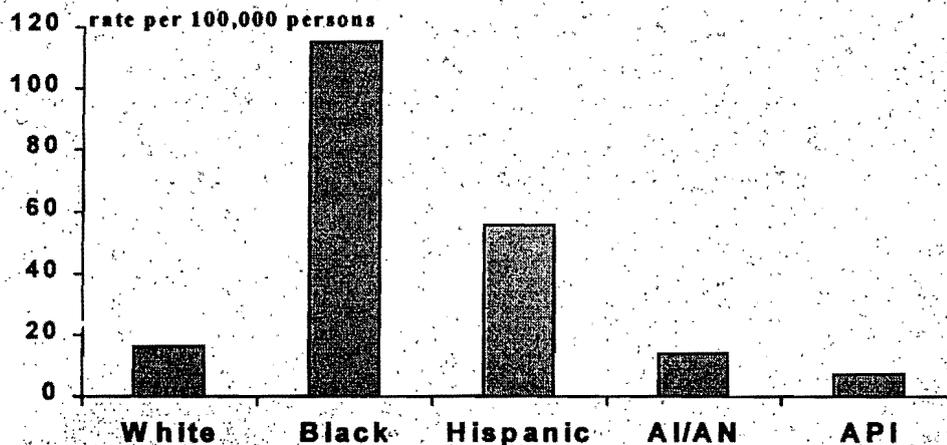
- **National Diabetes Education Program:** Involves both public and private partners to design ways to improve treatment and outcomes for people with diabetes, to promote early diagnosis, and ultimately to prevent the onset of the disease.
- **The Diabetes Prevention Program Clinical Trial:** Designed 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.
- **Diabetes Prevention Studies in Minority Populations:** The NIDDK continues to encourage increased research efforts on the disproportionate impact of diabetes in minority populations, including blacks, Hispanics, Asian and Pacific Islanders, Alaska Natives, and Native Americans and Hawaiians.
- **National Diabetes Data Group (NDDG):** The NDDG continues its collaboration with the National Center for Health Statistics in the diabetes component of the Third National Health and Nutrition Examination Survey. The NDDG also is continuing analyses of the diabetes component in the 1989 National Health Interview Survey of the NCHS. In addition, the NDDG recently published *Diabetes in America, 1995*. This important publication is a compilation of epidemiologic and public health data on diabetes, including data about the incidence, prevalence, and impact of diabetes and its complications on minorities.
- **The HRSA Lower Extremity Amputation Prevention (LEAP) program** will expand its partnerships with diabetes associations, pharmaceutical corporations, and community groups. Emphasis is on underserved populations, teaching patients to properly test and care for their feet to eliminate causes of amputation.
- **The Indian Health Service** has established 19 model diabetes centers to address the prevention and treatment of Type II diabetes. In 1998, the IHS will begin a 5 year effort to substantively increase its treatment and prevention capacity with funds (\$30 million per year) provided by the Budget Reconciliation Act.

**GOAL 5**

Reduce disparities in AIDS case rates among racial/ethnic populations through increased knowledge of HIV serostatus and improved access to early medical treatment

HIV infection/AIDS has been a leading cause of death for all persons 25-44 years of age for several years regardless of race or ethnicity. Although racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, they account for more than 50 percent of all AIDS cases. Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and assuring access to appropriate health services for all, and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act will assure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75% of low income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to assure that the current standard of clinical care is achieved for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

AIDS Case Rates in Persons \geq 13 years of age by Race/Ethnicity, United States, 1996



Adult (\geq 13 years) AIDS Case Rate Baselines:

Total: 31.4 per 100,000 1996
White: 16.2 per 100,000 1996
Black: 115.3 per 100,000 1996
Hispanic: 55.8 per 100,000 1996
American Indian/Alaska Native (AI/AN) 14.1 per 100,000
Asian and Pacific Islanders (API) 7.5 per 100,000

Data Source: Adult/Adolescent AIDS Reporting System, CDC

Periodicity of data source: Annual. Data are available three months after the close of the data year.

Pediatric (< 13 years) AIDS Case Rate Baselines:

Total: 1.3 per 100,000 1996
White: 0.3 per 100,000 1996
Black: 5.7 per 100,000 1996
Hispanic: 1.7 per 100,000 1996
American Indian/Alaska Native (AI/AN) 0.6 per 100,000
Asian and Pacific Islanders (API) 0.0 per 100,000

Data Source: Pediatric AIDS Case Reporting System, CDC

Periodicity of Data Source: Annual. Data are available three months after the close of the data year.

Discussion: Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities. AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 3/4 were among minority populations (50% African American and 24% Hispanic). During 1995-96, AIDS death rates declined 19% for the total U.S. population, while declining only 10% for blacks and 16% for Hispanics. Contributing factors for these mortality disparities include late identification of disease, lack of health insurance to pay for drug therapies, differential access to HIV primary care, and inconsistency in the level of HIV education and experience among physicians treating historically disenfranchised groups. The cost of efficacious treatment, between \$10,000-\$12,000 per patient per year, is a major hurdle in the effort to assure equitable access to available drug therapies.

Strategy for Achieving the Goal

- Increase the percentage of minority populations that know their HIV serostatus and receive early access to primary care to prevent or delay progression of AIDS.
- Increase the number of racial/ethnic individuals, especially those with high risk factors, who receive counseling and treatment services in public settings.
- Increase access to counseling and testing and therapies that will prevent vertical transmission of HIV between mother and child, with a special emphasis on women of color and their children.

Action Steps for the Next 12 Months

- Continue to work with directly funded community based organizations to target individuals at high risk for HIV infection within racial/ethnic communities to increase counseling, referral services, and access to testing.
- Continue to work with state, city, and territorial health departments to support the HIV Prevention Community Planning process. Through this process, community planning groups work with health departments to develop a comprehensive prevention plan that reflects prioritized needs and is directly responsive to high risk racial/ethnic communities.
- Develop an initiative which creates an epidemiological profile of racial/ethnic communities throughout the country, examines current available programs serving these communities, identifies unmet needs, and develops strategies to address these needs.
- Increase access to prevention and supportive services, and efficacious medications, to assure that individuals from specific racial and ethnic groups receive services in proportion to their representation in the overall epidemic.
- Assure that the composition of the HIV prevention community planning groups reflect the epidemiologic profile of the jurisdiction and increase those groups with linkages to correction and drug treatment facilities.
- Implement the Office of Drug Pricing rebate program for the AIDS Drug Assistance Programs to increase the buying power of Federal, State, and local funds allotted to these programs.

Examples of Programs that Support this Strategy

- The CDC HIV Counseling and Testing Data System began operating in 1985 to increase the availability of HIV counseling and testing services for persons who wanted to know their HIV status. Health departments in 65 States, cities, and territories collect information on the characteristics of persons seeking these services. In 1995, nearly 10,000 sites performed nearly 2.4 million HIV tests and reported results to CDC.
- CDC provides financial and technical assistance to community-based organizations working to prevent HIV infection, both directly and indirectly through health departments. This program primarily targets high-risk individuals within racial and ethnic communities. CDC also provides funds to National and Regional Minority organizations to identify the prevention needs of community-based organizations that work with racial and ethnic minorities.

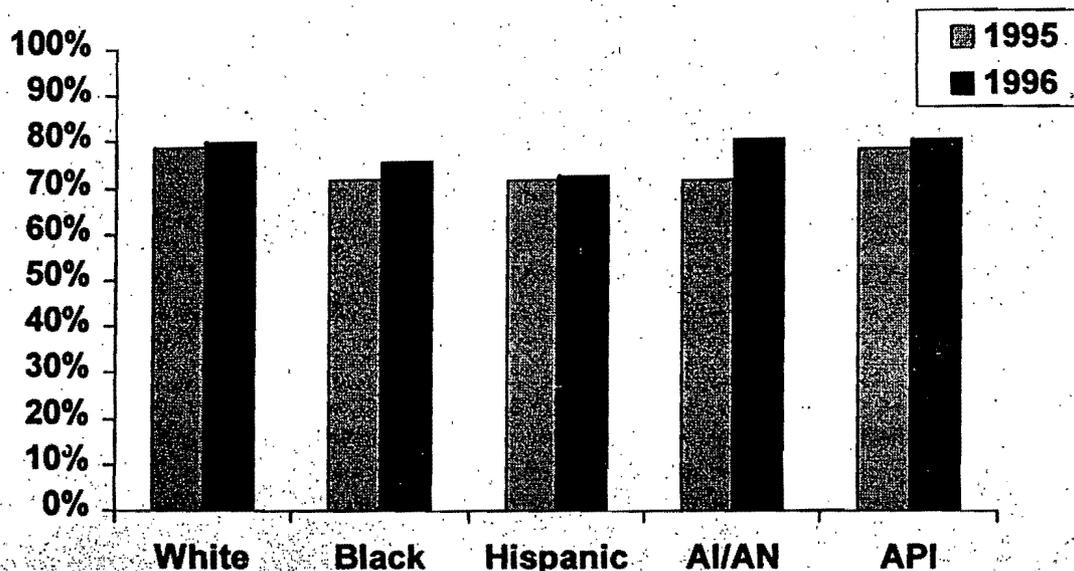
- **The Young African-American Men's Study** is a CDC, 2-year formative study to prevent HIV/AIDS in young black men. Data are being collected in Chicago and Atlanta through interviews, observations and group discussions with community leaders, health care providers, and young men who have sex with men.
- **HRSA's AIDS Education and Training Center (AETC)** have a legislative mandate to provide training for minority providers and providers who treat minority populations in appropriate HIV therapeutics.
- The majority of **HRSA's Special Projects of National Significance (SPNS) Program** grants develop new models of HIV care for individuals from minority racial and ethnic populations. The SPNS Program currently is funding support service grants to increase access to HIV/AIDS care and related services for Hispanic populations living on the U.S./Mexico border, urban blacks dually diagnosed with HIV and substance abuse, Native Americans and Alaska Natives who were not accessing HIV services, and Asian and Pacific Islanders in New York City.
- **HRSA's Title III Early Intervention Services Program** provides grant support for outpatient HIV early intervention and primary care services for low-income, medically underserved individuals, primarily people of color in existing primary care systems. The objective of these programs is to maximize access to comprehensive and continuing clinical and supportive care for populations that have been disproportionately affected by the AIDS epidemic. Currently, approximately two-thirds of the clients who receive primary care services at Title III programs are members of racial and ethnic minority groups.
- **HRSA continues to publish "HIV Care Access Issues"** -- a technical assistance series of reports that identify barriers and strategies to overcome barriers to HIV care among specific population groups, e.g., black, Hispanics, Native Americans, and Asian Americans.
- **HRSA's AIDS Drug Assistance Programs (ADAP)** serve individuals from racial/ethnic minorities in approximate proportion to their cumulative representation in the epidemic to date.
- **HCFA estimates that in excess of 50% of people with AIDS, and over 90% of children with AIDS are served through Medicaid.**

GOAL 6

Eliminate disparities in child and adult immunization rates

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. Although immunization rates have been lower in minority populations compared to the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. Our goal is to sustain current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives.

Childhood Immunization Rates* by Race and Ethnicity, United States, 1995-1996



*Immunization rates reflect those children ages 19-35 months of age who have received 4 doses of DTP (diphtheria, tetanus, pertussis), 3 Polio, and 1 MMR (measles, mumps, rubella).

Childhood Immunization Rate Baselines:

Total: 78% (1996)

White: 80% (1996)

Black: 76% (1996)

Hispanic: 73% (1996)

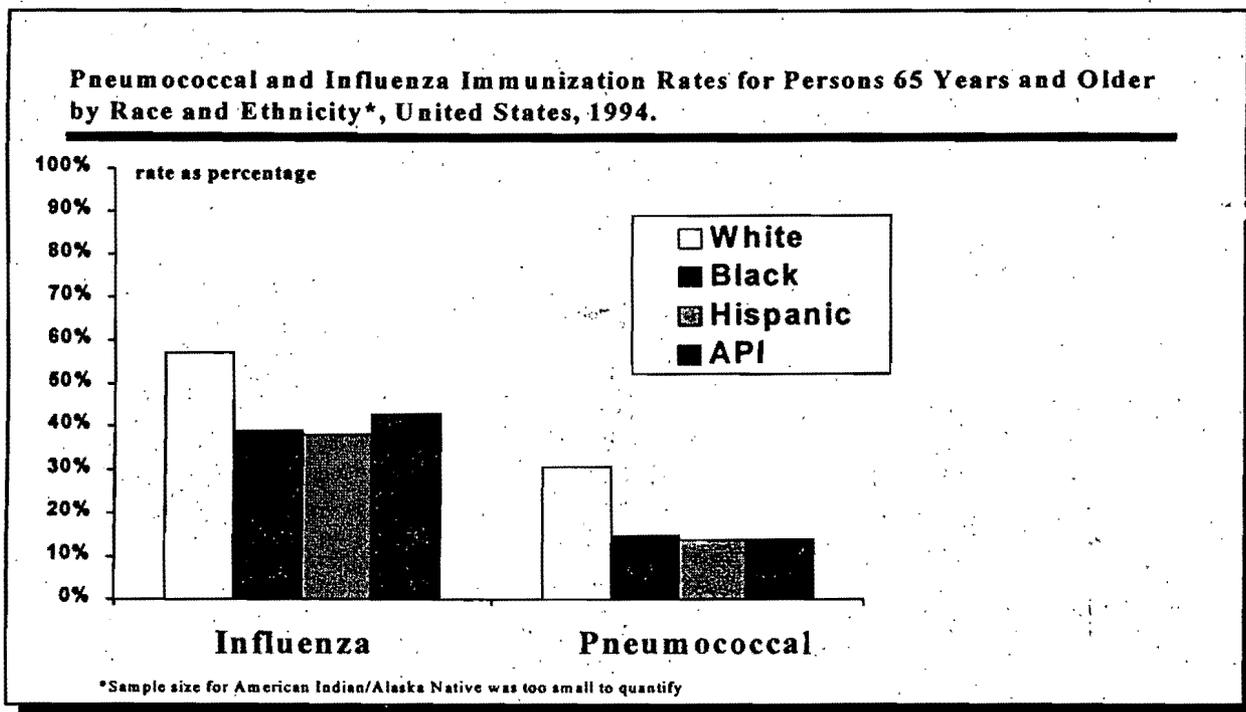
American Indian/Alaska Native (AI/AN): 81% (1996)

Asian/Pacific Islanders (API): 81% (1996)

Data Source: National Immunization Survey, CDC, NCHS

Periodicity of Data Source: Data are reported semi-annually, eight months after the close of the respective data period.

Adult immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. There is a disproportionate burden of these vaccine-preventable diseases in minority and under served populations. Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent, and to eventually eliminate disparities among groups. This is our goal under *Healthy People*--the nation's health objectives. In order to reach this goal, by the year 2000 we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asian and Pacific Islanders and to *quadruple* the 1994 pneumococcal immunization rates among these groups.



Immunization Rate Baselines for Adults 65 years and older:

Influenza:

- Total: 55% (1994)**
- White: 57% (1994)**
- Black: 39% (1994)**
- Hispanic: 38% (1994)**
- Asian/Pacific Islander: 43% (1994)**

Pneumococcal:

- Total: 30% (1994)**
- White: 31% (1994)**
- Black: 15% (1994)**
- Hispanic: 14% (1994)**
- Asian/Pacific Islander: 14% (1994)**

Data Source: National Health Interview Survey (NHIS), CDC, NCHS

Periodicity of Data Source: Data will be available annually, approximately six months after the close of the data year. Data have previously been collected as part of supplements, but are currently in the adult core questionnaire. Data collected as part of the core using the new computer assisted personal interview procedure should be available approximately six months following the close of the data year. This system is currently being implemented.

Discussion: Though coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of under-immunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas within traditionally underserved populations, they have the potential to spawn outbreaks of vaccine-preventable diseases. Each year, an estimated 45,000 adults die of influenza, pneumococcal infections and liver cancer due to chronic hepatitis B infection despite the availability of safe and effective vaccines to prevent these conditions and their complications. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the Healthy People Year 2000 targets.

Strategy for Achieving the Goal

Childhood

- The **Childhood Immunization Initiative (CII)** was launched to reduce most diseases preventable by childhood vaccination to zero and to establish a sustainable system to ensure that all 2-year olds receive required vaccines by the year 2000 and beyond. The CII is a comprehensive effort designed to marshal efforts of the public and private sectors, health care professionals and volunteer organizations.

Adult

- Increasing provider awareness of the need for timely immunizations in adults.
- Assuring effective vaccine delivery mechanisms for adults.
- Intensifying vaccine-preventable disease program evaluations, surveillance activities, and investigation of reported outbreaks or unusual occurrences of disease.
- Encouraging outreach to all seniors through Medicare beneficiary education efforts, with special efforts to target minorities.

Action Steps for the Next 12 Months

- ☞ Develop and promote use of software to assess vaccination practices and track vaccinations levels.

- ◇ Increase emphasis on immunizations by supporting collaborative activities to enhance influenza and pneumococcal vaccination levels among Medicare beneficiaries.
- ◇ Develop and test assessment tools for documenting adult immunization levels and practices in Community/Migrant Health Center sites.
- ◇ Continue to support the Department-wide Asian and Pacific Islander Americans (APIA) Action Agenda to ensure that susceptible APIA children and adolescents receive a hepatitis B vaccine series.
- ◇ As directed by the President, hold a national conference for the establishment of State and community immunization registries.

Examples of Programs that Support this Strategy

Childhood

CDC is working with its partners to:

- Develop and implement State and community immunization registries as a cornerstone to increase and sustain vaccination coverage rates to prevent outbreaks of disease.
- Target a range of interventions to address pockets of need in each State or major city.
- Continue implementing proven interventions, such as WIC/Immunization linkages and assessment of coverage levels in provider settings.

Adult

- The DHHS Action Plan for Adult Immunization identifies key steps for each agency to implement to increase adult immunization levels, including efforts targeted at populations with an increased burden of vaccine-preventable diseases.
- The National Coalition for Adult Immunization (NCAI), with about 100 members, cooperates in nationwide informational and educational programs to promote adult immunization activities.
- HCFA's Horizon's Pilot Project targets black Medicare beneficiaries in eight southern States by working with Historically Black Colleges and Universities and HCFA's Quality Improvement Organizations to improve influenza vaccination levels.
- CDC is collaborating with HRSA to conduct a quality improvement project in a limited number of Community/Migrant Health Center (C/MHC) sites targeting adults.