

# HIV PREVENTION

## CDC Funding

1993	\$498,253,000
1994	\$543,253,000
1995	\$598,831,000
1996	\$584,080,000
1997	\$616,790,000
1998	\$634,266,000 (request)

One especially interesting program mentioned in the Congressional Justification coordinates prevention and outreach programs in prisons to educate prisoners who will be returning to the general population.

## **Women's Initiative for HIV Care and Reduction of Perinatal and HIV Transmission (WIN)**

*Office of Women's Health, Ritta: 205-1952*

I talked to Ritta and I think she was going to check on this program for me, but I don't know if she ever did.

## **AIDS Education and Training Centers Program (AETC)**

*HRSA, Bruce Martell: (301) 443-6364*

**Program:** The AETC Program is a network of 15 regional centers (with more than 75 local performance sites) that conduct targeted, multidisciplinary HIV education and training programs for health care providers. The mission of these centers is to increase the number of health care providers who are educated and motivated to counsel, diagnose, treat and manage individuals with HIV infection and to assist in the prevention of high risk behaviors which may lead to infection. The 15 regional centers provide coverage for all fifty states, the Virgin Islands, and Puerto Rico.

The three main goals of AETC are:

- 1) To train health care professionals to effectively diagnose, treat and manage HIV infection and to offer interventions to prevent HIV infection.
- 2) To disseminate state of the art HIV information to providers.
- 3) To develop HIV provider materials.

Future priorities for the program include prevention, implementation of the Public Health Service recommendations on ACTG 076, the training of providers in "Ryan White" - funded organizations, and increased emphasis on information dissemination activities related to new treatment protocols, combination drug therapies, and the use of protease inhibitors.

**Clientele:** To date, more than 600,000 providers have been trained by the AETC Program. A 1993 study indicates that AETC-trained providers are more HIV-competent and more willing to treat people with HIV than are primary care providers in the general population.

**Racial/Ethnic/Gender Breakdown of the Program:** Of the 123,303 participants in the

program between June 1, 1995 to May 31, 1996, 72,870 responded to a questionnaire about race and gender. The results are as follows.

**Participants by Race**

11,530	African American
3,439	Asian/Pacific Islander
42,549	Caucasian (non-Hispanic)
1,175	Mexican/American Hispanic
1,115	Native American
3,531	Puerto Rican Hispanic
1,755	Other Hispanic/Latina(o)
1,579	Other
6,179	No response

**Participants by Gender**

34,952	Women
34,674	Men
3,244	No response

**ADAP (AIDS Drug Assistance Program)**

*HRSA, Melanie Whelan: (301) 443-6745*

**Program:** Aids Drug Assistance Programs provide medications to low-income individuals with HIV who have limited or no coverage from private insurance of Medicaid in all 50 States, the District of Columbia, Puerto Rico, the Virgin Islands and Guam.

**Clientele:** In 1995, over 69,000 people were served by ADAP. In 1996, ADAPs served almost 83,000 people with HIV.

Racial breakdown of ADAP's clientele (in reporting period January 1 to December 31, 1995):

White	40.0%
Black	28.5%
Hispanic	27.0%
Asian/Pacific Islander	0.8%
American Indian	0.5%

Gender breakdown in the same reporting period

Male	80.5%
Female	17.5%

**Funding:** ADAP funding has increased from \$105 million in 1995 to over \$115 million in 1996 to \$167 million in FY 1997.

**HOPWA (Housing Opportunities for Persons with AIDS)**

*HUD, 708-1934*

**Program:** The Housing Opportunities for Persons with AIDS program provides housing assistance and support services for low-income persons with HIV/AIDS and their

families. The program is run by HUD (Housing and Urban Development).

**Funding:** In FY 1997, a total of \$196,000,000 was allocated to cities and states, 10% of which was allocated through competitive grants and 90% of which was allocated through a formula.

**Clientele:** HOPWA provided housing to 36,000 people with AIDS, a provision which benefited an additional 9,000 family members of people with AIDS. HOPWA also provided an additional 20,000 people with AIDS with support services.

HOPWA's racial breakdown is as follows:

Black	42%
Native American	less than 1%
White	57%
Asian/Pacific Islander	less than 1%

### **Special Projects of National Significance (SPNS)**

*HRSA, Cathy Marconey: (301) 443-6560*

**Program:** SPNS has a legislative mandate to 1) assess the effectiveness of particular models of care; 2) support innovative program designs, and 3) promote replication of effective models. SPNS supports grants to many innovative and exciting projects. They seem to be on the cutting edge and to have a lot of potential for expansion. Some examples of their projects:

**Bay Area Young Positives:** Provides full-time paid young people and volunteers to provide support services for youth with HIV who are under 26 years of age including recreational and social activities, peer counseling, advocacy education, practical support services, and information on youth-sensitive care providers.

**Boston Happens:** Provides outreach to HIV positive, high risk, homeless, and street youth through a diverse and comprehensive network of primary care service providers.

The other 45 projects are listed in the

## **HEART DISEASE PREVENTION**

### **CDC Funding**

1993	\$24,002,000
1994	\$41,194,000
1995	\$45,358,000
1996	\$45,081,000
1997	\$46,049,000
1998	\$61,049,000 (request)

Only 32 states have tobacco-control programs. It seems like these types of programs would be vital in trying to combat heart disease; this may be an area that needs to be expanded.

Increases in funding have been manifested in the form of studies and reports on tobacco

use, local tobacco control programs and advertising materials. There have been no changes in other heart disease control and prevention programs (i.e. community health programs, nutrition programs, school health programs, etc.).

### **The African American Community Cardiovascular Disease Prevention and Outreach Initiative**

*NIH, Sandra Lindsay: (301) 496-9899* (This woman is absolutely amazing -- she'll do research for you right away and send stuff out immediately. She's done a terrific work for us, so if there's ever an event, she should definitely be invited).

**Program:** This program was created to develop and implement professional education training for physicians who provide care to African Americans as well as to develop community-based CVD prevention and education projects for inner-city African Americans. The project facilitated development of cardiovascular health education materials and tools to promote professional and patient/public education activities in the black community regarding prevention and control of CVD and stroke. In addition, the project focused on development of a National Physicians' Network to facilitate future implementation of cardiovascular health activities in local black communities nationwide.

Physicians who are part of the National Physicians network in 30 states have received a speakers' kit to teach them how to conduct training efforts with other health care professionals about coronary heart disease (CHD) in African Americans. The kit contains nine modules with slides and narratives and provides answers to commonly asked questions, recruitment and assessment forms, and supporting documents such as professional guidelines developed by the NHLBI. Recipients of the kit have conducted sessions at the Association of Black Cardiologists and the National Medical Association, as well as at the International Society for Hypertension in Blacks and the Black Nurses Association.

Preparation of a series of easy-to read materials for African Americans is underway. The materials will be disseminated to the 11 states of the "Stroke Belt Region," national Federal nutrition programs, churches and civic organizations, and about 600 community health centers which have many African American members or

**Clientele:** 140 Black Physicians (and many others who are affected).

### **The Latino Community Cardiovascular Disease Prevention and Outreach Initiative (Salud Para Su Corazon)**

**Program:** This program is designed to increase awareness about CVD risk factors among Latinos in the Washington, DC area (including Maryland, Virginia and DC) and to encourage adoption of healthy lifestyle behaviors at an early age. The initiative uses a community-oriented approach to identify Latino consumer health education needs and then develop products and materials to help them. The project is composed of a multidisciplinary team of professional and community experts interested in improving Latino health, including clinics, hospitals, businesses, civic associations, community centers and churches. The project develops bilingual materials, telenovelas and photonovelas, radio spots, a discussion group guide and a guide for trainers.

The project includes over 200 community partners, has a radio program which reaches 58% of Latinos in the area, and has a TV program that reaches an average Sunday audience of about 100,000 Latinos. During one four week period, 2,224 Latinos ordered easy-to-read

heart health materials and recipe books. About 18 group discussion sessions have reached over 1,000 Latinos. In the last 6 months, 16,725 packages of reading materials, 11,145 heart-smart recipe packets, 1,147 posters and 311 videos have been distributed. The program would like to go national, especially to the states with the largest Latino populations (CA, FL NY, TX, AZ, CO, IL, MA, NJ, NM) and Puerto Rico.

### **Building Healthy Hearts for American Indians and Alaska Natives**

**Program:** This program is still in its planning phase. Its goals are to develop and implement an outreach strategy to improve cardiovascular health in American Indians and Alaska Natives. It will focus on increasing awareness and knowledge of CVD risk factors and will develop and implement heart health promotion strategies to address the needs of American Indians and Alaska Natives, incorporating their culture, traditions, lifestyles and values.

### **WISEWOMAN (Well-Integrated Screening and Evaluation for Women in Massachusetts Arizona North Carolina)**

*Julie Will: (770) 488-6024*

**Program:** The WISEWOMAN program provides screening for heart disease risk factors such as high cholesterol and blood pressure, dietary and physical activity interventions for women with abnormal screening results, referral to medical and social services as needed, and follow-up and evaluation. North Carolina, Massachusetts and Arizona were competitively selected as demonstration sites for the program. WISEWOMAN seeks to demonstrate the feasibility of adding cholesterol and blood pressure measurements, interventions to prevent heart disease, and referral and follow-up to the Breast and Cervical Cancer Early Detection Program; identify successful intervention strategies for financially disadvantaged and minority women; and develop and test screening and intervention models for other states and communities.

WISEWOMAN would like to expand into additional states by first expanding to target all of the 12,000 women participating in the NBCCEDP (see cancer section) in the three demo states and then adding additional states to test translation strategies.

**Clientele:** The program has screened 4000 low-income and uninsured women aged 50 years and older during the first year of operation. Most of these women had high blood pressure, elevated cholesterol, or both. A nutrition and physical activity counseling program has been well-received by many of the women in the program.

### **NHLBI (National Heart Lung and Blood Institute) Sponsored Studies**

The National Heart Lung and Blood Institute has sponsored many studies on the causes and prevention of and the cures for heart disease. In FY 1996, the NHLBI supported a total of \$796,815,000 in CVD research, including \$132,329,000 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.

# CANCER PREVENTION

## Cancer Registries

### CDC

**Program:** These registries are used to gather information necessary for proper cancer control and planning. Before National Registry Program, 10 states didn't have existing registries and some of those in the other 40 states may have been inadequately supported.

**Clientele:** When the registry is fully operational in 50 states, it will collect incidence data on 93% of the population.

### Funding:

1993	\$0
1994	\$16,830,000
1995	\$17,580,000
1996	\$18,349,000
1997	\$22,332,000
1998	\$22,332,000 (request)

With the 1997 funds, 48 states and the District of Columbia will receive grants to enhance their current registries.

## Breast Cancer Prevention

**Program:** CDC's National Breast Cervical Cancer Early Detection Program offers free or low-cost mammography screening to low-income elderly and minority women. Over 500,000 women have been screened by this program.

## Cervical Cancer Prevention

**Program:** CDC's National Breast and Cervical Cancer Early Detection Program also offers Pap tests to low-income women. It has given 690,590 tests and identified 21,000 cases of cervical cancer. Women who receive screening are far less likely to develop invasive cervical cancer.

## Minority Community Health Coalition Demonstration Grant Program

*HHS Office of Minority Health: 1-800-444-6472, Stephanie: (301) 443-5084*

They are sending information about this program in the mail.

## Bilingual/Bicultural Demonstration Program

**Program:** This program was developed to reduce social, cultural and linguistic barriers between providers and clients with limited English proficiency and to improve their access to good health care. It funds a number of education, outreach and prevention programs which are described in the fax they sent us.

## NCI-Sponsored Cancer Research

*NCI: (301) 496-5583, NCI liaison office: (301) 496-5217, fax: (301) 402-1225*

I sent them a fax requesting information on the five areas of study listed in the HHS document. It might take some time for them to respond.

# PRENATAL CARE/INFANT MORTALITY PREVENTION

(The HHS prenatal care program budget is \$825 million.)

## Healthy Start

*Bernice Young: (301) 443-0543*

**Program:** Health Start collaborates with businesses, foundations, city and county health departments, state agencies, managed care organizations, other providers and federal agencies. The program has developed nine models for effective intervention including community-based consortia, outreach and client recruitment, care coordination/case management, family resource centers, enhanced clinical service, risk prevention and reduction, facilitating services, training and education, and adolescent programs.

Original Healthy Start Project Communities include Boston, MA; New York, NY; Philadelphia, PA; Pittsburgh, PA; Baltimore, MD; Washington, DC; Pee Dee Region, SC; Birmingham, AL; Cleveland, OH; Detroit, MI; Northwest IN; Chicago, IL; New Orleans, LA; Northern Plains Indian reservation communities (SD, AND, IA, NE); Oakland, CA. There are also special Healthy Start projects in Dallas, TX; Essex County, NJ; Florida Panhandle; Milwaukee, WI; Mississippi Delta; Richmond, VA; and Savannah, GA.

On September 1, 1997, Healthy Start will begin 40 new projects.

**Clientele:** Because Head Start will be expanding so dramatically in September, any figure on how many people it serves and their racial and ethnic breakdown determined before that date will soon be obsolete. Bernice Young said to call her back at the very end of August to get an updated figure.

## SIDS Project RIMI (Representation Increase for Minorities and Indigenous)

*Dr. Jody Schafer, President of the Association of SIDS and Infant Mortality: H: (410) 529-4589, W: (410) 706-5062*

**Program:** The purpose of this project is to increase representation of indigenous and minority groups in SIDS organizations at international, national, state and local levels in response to the high rates of SIDS in minority and indigenous babies. The objectives of the program are to assess current levels of representation in national, state and local SIDS organizations; to recommend an increase in representation where there is under representation; to support this with responses to survey feed back about successes and difficulties experienced; to reassess the impact on representation levels after two years; to report progress and results of this project to the International SIDS Conferences in Rouen, France in 1998 and in Auckland, New Zealand in the year 2000.

## Back to Sleep Campaign

*Ruth Dubois: (301) 435-3457 or (301) 496-5133*

**Program:** This campaign is a public-service outreach campaign to try to inform as many people as possible (parents, care-givers, grandparents, babysitters, etc.) of the importance of putting infants on their backs to sleep in order to reduce the incidence of SIDS. The program has a toll-free telephone number for ordering pamphlets, posters and videos. Over 8 million pamphlets have been distributed. It has a web page, public service

announcements and print ads, radio and TV public service campaigns and a back to sleep table top exhibit. It also gets out its message with mailings to newborn nurseries, and to members of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists and various nursing organizations.

Its special minority outreach includes a poster with a white baby and a baby that is part American Indian and part Columbian, a Spanish parent training video, a poster with African American babies, print ads based on the new African American baby poster and a table top exhibit with African American babies.

### **Prevention of Perinatal Substance Abuse**

*Dr. Louise Floyd: (770) 488-7370*

CDC currently designs, implements and evaluates prevention strategies for specific high-risk groups to prevent the occurrence of fetal alcohol syndrome and other alcohol-related birth defects. CDC's major accomplishments include funding the University of Cincinnati and the State of Oklahoma to implement interventions in different settings for women who drink during pregnancy; developing screening instruments and manuals for enhancing case finding; developing an inventory of public and professional training materials on FAS; collaborating to develop a national FAS prevention program directory; funding the development of a teachers' manual for educating students with FAS; and coordinating national FAS prevention conferences in 1991 and 1993. CDC would like to expand the program to develop a data base on FAS prevention activities, develop new intervention models and assist states more thoroughly.

## **ASTHMA**

### **Racial Discrepancies**

- 1994 statistics indicate that similar numbers of black and white individuals are affected by asthma. However, age-adjusted death rates for asthma are three times higher in black males than white males and almost three times higher in black females than white females.

### **Administration Initiatives**

- The NIH is supporting a collaborative multicenter study on various racial and 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. It also supports programs which develop strategies to improve asthma care among Latino and black children. Other DLD projects study asthma medications for children, asthma and pregnancy, asthma and the elderly and new treatment methods.

## **SICKLE CELL DISEASE**

### **Racial Discrepancies**

- Sickle cell disease solely affects African Americans.

### **Administrative Initiatives**

- In 1996, grants were awarded for projects including 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 of Blood Diseases and Resources works to disseminate research findings to the medical community through workshops and conferences. The division also manages a program of grants, contracts, training and career development awards, and academic awards regarding the study of sickle cell disease.

## **PRENATAL CARE**

### **Racial Discrepancies**

- African-American women are nearly 4 times more likely to receive no prenatal care (4.2%) than white women (1.2%). In 1995, only 70.3% of black mothers and 70.4% of Hispanic mothers received prenatal care beginning the first trimester, compared with 83.5% of white mothers. Of those women who began prenatal care 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.

- 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. In 1992, there were 16.8 deaths per 1,000 births for black women compared with only 6.9 deaths per 1,000 births for white women.

### **Administrative Initiatives**

- CDC administers a number of programs to increase prenatal care rates, including the Pregnancy Risk Assessment Monitoring Systems (PRAMS) and many smaller community-based intervention and evaluation projects. Through HHS, the Maternal and Child Health Bureau (MCHB) administers four major programs which, in FY 1997, had a total budget of \$825 million. Each of these programs collaborates with numerous local organizations and programs nationwide to study populations and develop outreach and service programs most appropriate to particular communities.

Definitely room to do more in this area.

## **BREAST CANCER**

### **Racial Discrepancies**

- In 1994, 85% of white women had a relative five-year survival rate compared to only 70% of black women. Moreover, African-American women are far less likely to receive mammograms. Only 54.9% of African-American women over 50 report having had a clinical breast exam and mammogram within the past two years. In 1993, black women were 28% more likely to die from breast cancer than white women.

### **Administrative Initiatives**

- **Screens for Low-Income Women.** CDC's National Breast Cervical Cancer Early Detection Program offers free or low-cost mammography screening to low-income elderly and minority women. On October 1, 1996, Secretary Shalala announced the expansion of the program to all fifty states. The goal is to reduce breast cancer deaths among these women by 30% and cervical cancer deaths by 90% through increased mammographies and pap testing. Over 500,000 have been screened by this program.
- **Educates Older Women to Use the Medicare Mammography Screening Benefit.** The First Lady launched a mammography campaign to inform and encourage older women to use the Medicare mammography screening benefit. First Lady mammography screening campaign this year is focusing its efforts on reaching out to minority women.
- **Covers Annual Mammograms Screening for Medicare Beneficiaries.**

## **CERVICAL CANCER**

### **Racial Discrepancies**

- Nearly twice as many African-American women are diagnosed with cervical cancer every year as white women and nearly three times as many die of it. Further, white women are more likely to have their cancers diagnosed at an early, precancerous state at which they can best be treated: 54% of cervical cancers among white women are diagnosed at a localized stage while only 39% of cancers among African-American women are.

### **Administrative Initiatives**

- Screening program CDC has developed and implemented the National Breast and Cervical Cancer Early Detection Program screens low-income women. It has given 690,590 tests and 21,000 cases have been identified. Women who get cervical cancer screening are far less likely to develop invasive cervical cancer.

## **DIABETES**

### **Racial Discrepancies**

- African Americans are 1.5 times more likely to have diabetes than whites: nearly 6% of African American men and nearly 8% of African-American women have diabetes. African Americans also experience higher rates of at least three of the most serious complications of diabetes: blindness, amputation, and end stage renal disease (kidney failure). Approximately one in every 10 Hispanic adults has diabetes. Population studies among Hispanic women with diabetes show significantly higher death and complication rates during pregnancy. Complications from diabetes are major causes of death and health problems in most Native American populations. In many tribes, more than 20% of the members have the disease.

### **Administrative Initiatives**

- New funding in the balanced budget (particularly focus on Native American population) Existing CDC program for prevention and screening. (Minorities suffer from Type II diabetes at a much higher rate than whites. As you know, budget initiative invests in Type I diabetes.
- NIH funding.

- CDC screening programs in states -- helping doctors recognize diabetes. (Half people who have type II diabetes are not aware they suffer from this condition)

## **HEART DISEASE/HYPERTENSION/STROKES**

### **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. A study of people over 20 years old conducted between 1988 and 1994 indicated that around 20% of whites had hypertension, compared to around 34% of blacks. Between 1980 and 1993, the rate of heart disease was about 67% higher among black women than among white women. Hypertension is a leading cause of strokes and heart disease.

### **Administrative Initiatives**

- NIH supported a total of \$796,815,000 in Cardiovascular Disease (CVD) research, including \$132,329,000 in research on hypertension. Within the total of \$796,815,000 spend 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. Studies include such topics as community-based risk reduction, risk factors and prevention in children, mortality and education.

# FAX COVER SHEET

## OFFICE OF RESEARCH ON MINORITY HEALTH



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

DATE: 7/25/97

TO: Sarah Bianchi

FROM: Lorita Watson

FAX NUMBER: 202-456-5557

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

MESSAGE: more to follow

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# Cancer

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

# AIDS

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

# Substance Abuse

\* Blacks of all ages experienced twice as many cocaine related emergency room episodes as did Whites in 1992.

# Infant Mortality

1992

Blacks -- 16.8 deaths per  
1,000 births

Whites -- 6.9 deaths per  
1,000 births

# Homicide

- \* Homicide is the most common cause of death for Black men between the ages of 15 and 34

# Diabetes

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

# Cardiovascular Disease and Stroke

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

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

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

# Pancreatic Cancer

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

# Prostate Cancer

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

# Breast Cancer

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

→ Weekly Report.

→ Medicare.

↓ per agreement

→ \$115 b.

→ at 10 years

→ ~~un~~ unprecedented

new

health

PSOs PPOs

managers \$4 b prev

brand new program reforms

empower comp.

market mechanism

## Department of Health and Human Services

*National Institutes of Health*

## DIABETES FUNDING - Fiscal Years 1994 - 1998

	1994 Actual	1995 Actual	1996 Actual	1997 Estimate	1998 House Level
National Institute of Diabetes and and Digestive and Kidney Diseases.....	\$191,409,000	\$193,597,000	\$197,542,000	\$209,100,000	229,000,000
National Cancer Institute.....	1,279,000	1,070,000	938,000	981,000	1,050,000
National Heart, Lung and Blood Institute.....	19,779,000	20,393,000	21,010,000	22,275,000	23,500,000
National Institute of Dental Research.....	2,505,000	2,577,000	2,395,000	2,568,000	2,721,000
National Institute of Neurological Disorders and Stroke.....	5,717,000	4,535,000	3,793,000	3,972,000	4,150,000
National Institute of Allergy and Infectious Diseases.....	4,898,000	4,737,000	5,545,000	5,767,000	5,766,000
National Institute of General Medical Sciences.....	1,704,000	1,762,000	1,850,000	1,955,000	2,065,000
National Institute of Child Health and Human Development.....	12,329,000	12,631,000	13,373,000	14,200,000	15,000,000
National Eye Institute.....	22,605,000	22,001,000	21,509,000	22,855,000	24,327,000
National Institute of Environmental Health Sciences.....	415,000	318,000	358,000	374,000	387,000
National Institute on Aging.....	6,666,000	6,652,000	7,598,000	7,830,000	8,070,000
National Institute of Mental Health.....	2,036,000	1,230,000	1,668,000	1,801,000	1,930,000
National Institute on Alcohol Abuse and Alcoholism.....	329,000	302,000	0	0	0
National Center for Research Resources.....	18,577,000	19,501,000	17,952,000	19,044,000	19,698,000
National Institute for Nursing Research.....	1,130,000	1,276,000	718,000	770,000	800,000
National Human Genome Research Institute.....	2,181,000	2,603,000	2,671,000	2,800,000	2,910,000
Fogarty International Center.....	56,000	0	0	0	0
<b>Total, NIH.....</b>	<b>293,615,000</b>	<b>295,185,000</b>	<b>298,920,000</b>	<b>316,292,000</b>	<b>341,374,000</b>

MEMORANDUM

TO: TOM FREEDMAN, MARY L. SMITH  
 FROM: DREW HANSEN  
 RE: IMPACTS OF SELECTED CAUSES OF DEATH ON MINORITIES  
 DATE: JULY 29, 1997

*Sarah + Chris  
 Here are  
 some  
 statistics  
 regarding  
 diseases  
 affecting  
 minorities  
 May*

SUMMARY

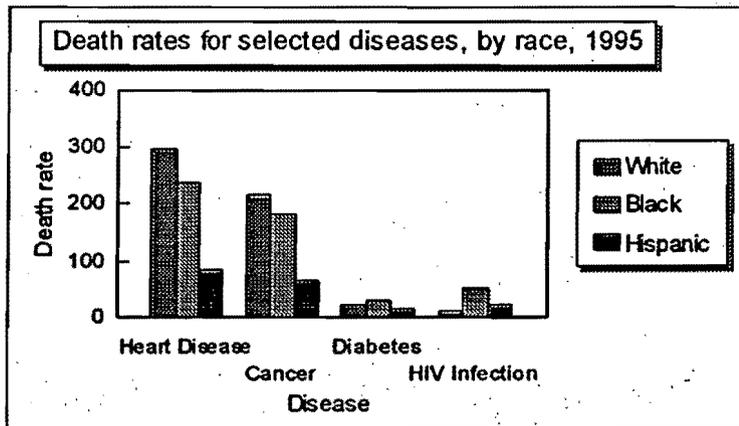
The following data summarizes the impact of selected causes of death (AIDS, cancer, diabetes, heart disease, hypertension, and infant mortality) on members of minority groups.

1. TOTALS, SELECTED DISEASES

Deaths and death rates for selected diseases, by race, 1995

Cause of death	White		Black		Hispanic Origin	
	Number	Rate	Number	Rate	Number	Rate
Cancer	468897	215	60603	182.9	17419	64.7
Diabetes	47475	21.8	10402	31.4	4194	15.6
Heart Disease	649089	297.6	78643	237.3	22403	83.3
HIV Infection	25509	11.7	17139	51.7	6110	22.7

Source: CDC, Monthly Vital Statistics Report, Vol. 45, No. 11(S) 2, June 12, 1997



*chr*

## 2. AIDS

### AIDS cases and annual rates per 100,000 population, by race/ethnicity and age group, reported in 1996, United States

Race/Ethnicity	Adults/Adolescents		Children <13		Total	
	No.	Rate	No.	Rate	No.	Rate
White, not Hispanic	26229	16.2	98	0.3	26327	13.5
Black, not Hispanic	28346	115.3	429	5.7	28775	89.7
Hispanic	12966	55.8	145	1.7	13111	41.3
Asian/Pacific Islander	561	7.5	1	0	562	5.9
Amer. Indian/Alaska Native	207	14.1	3	0.6	210	10.7

Source: U.S. Dept of Health and Human Services, "HIV/AIDS Surveillance Report," Vol. 8 No. 2, 1996.

## 3. CANCER

### 5 Year Relative Cancer Survival Rates, by Site: White and Black Patients 1986 to 1992

Site	White	Black
Thyroid	95.5	90.3
Testis	95.4	85.8
Prostate	88.6	73.2
Melanomas of Skin	87.6	72.2
Corpus and Uterus, NOS	85.5	55.9
Breast	85	69.8
Bladder	82.4	59.5
Hodgkin's Disease	81.5	71.9
Cervix	71.4	56.4
Larynx	68.3	52.3
Colon	62.9	53.4
Rectum and Rectosigmoid Junction	60.5	52.8
Kidney and Renal Pelvis	59.6	54.6
Oral Cavity and Pharynx	55.2	33.4
Non-Hodgkins Lymphomas	52.1	43.8
Ovary	45.6	40
Leukemias	42.6	34
Brain and CNS	28.8	31.8
Multiple Myeloma	28.4	29.8
Stomach	19.3	20.3
Lung and Bronchus	14	11.2
Esophagus	11.7	7.9
Liver and IBD	6.5	5.3
Pancreas	3.5	5.1

Source: National Cancer Institute, Data from SEER program, 1986-1991.

#### 4. DIABETES

##### Diabetes Prevalence and Death Rate, by Race (1993)

Race/Ethnicity	Prevalence	Death Rate	Death Rate/Whites
<i>White</i>	6.2%		
<i>Black</i>	9.0%		
*men	4.1%	26.3	115.6%
*women	4.9%	26.9	169.0%
<i>Amer. Indian/Alaska natives</i>	9.2%		
*men	4.2%		
*women	5.0%		
<i>Asian/Pac. Islander</i>	5.8%		
*men	3.4%		
*women	2.4%		
<i>Hispanic</i>	7.2%		
*men	3.7%		
*women	3.5%		

Source: American Heart Association. "White" rate is from U.S. General Accounting Office, Diabetes: Status of the Disease Among American Indians, Blacks, and Hispanics," 1992.

#### 5. HYPERTENSION

##### Persons Reporting High Blood Pressure, 1990

Race/Ethnicity	Percent, 18yrs +
White	15.9%
Black	21.3%
Hispanic	10.1%
Non-Hispanic	16.8%

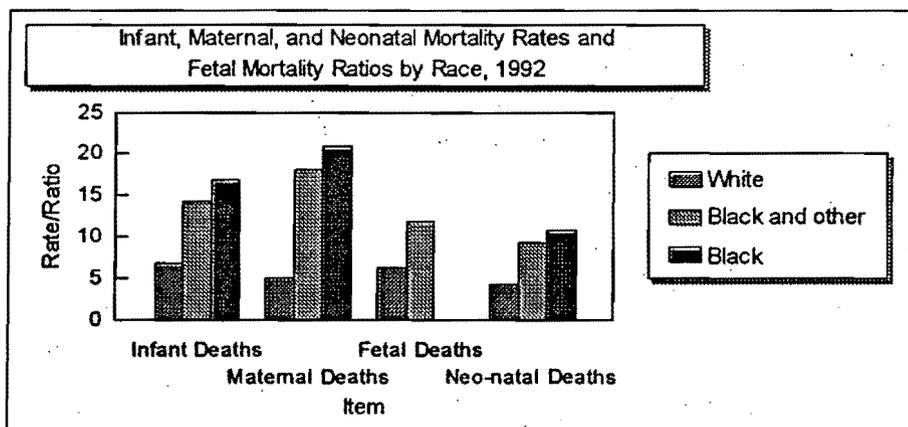
Source: Statistical Record of Health and Medicine, 1995

## 6. INFANT MORTALITY

### Infant, Maternal, and Neonatal Mortality Rates and Fetal Mortality Ratios by Race, 1992

Item	Total	White	Black and other	Black
Infant Deaths	8.5	6.9	14.4	16.8
Maternal Deaths	7.8	5	18.2	20.8
Fetal Deaths	7.4	6.3	11.7	NA
Neo-natal Deaths	5.4	4.3	9.2	10.8

Source: Statistical Abstract of the United States, 1996.



## RACE AND HEALTH

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

Sarah

### AIDS

#### Racial Differences:

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

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. *Children*

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

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

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

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

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

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

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

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

#### Administrative Action:

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

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

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

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

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

The Centers for Disease Control and Prevention has conducted other studies finding

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

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

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

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

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

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

CDC has also conducted studies and surveys focusing on women and HIV including such topics as the female condom, the effectiveness of hierarchical prevention messages for women of color (e.g. grading various prevention choices from most to least effective),

communication between partners, nonoxynol-9 and spermicide preferences. CDC has also done research on the effectiveness of female condoms.

From 1990 to 1995, percentages of high school students having intercourse remained steady, but overall condom use was up from 46% in 1990 to 53% in 1995 with female and African-American students indicating the greatest increases in condom use.

#### NIH STUFF TOO:

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

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

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

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

ASTHMA

#### Race discrepancies:

In 1994, a total of 56.2 white people per 1000 and 56.4 black people per 100 had asthma. Asthma among the population in general was much higher in 1994 than it was in 1984. Death rates for African American individuals are substantially higher than those for white individuals. Age-adjusted death rates for asthma are three times higher in black males than white males; almost three times higher in black females than white females; and slightly higher for females in general than males. ~~In fact, age-specific death rates are much higher in blacks than in whites in nearly every age group.~~ The black-white gap in asthma mortality is widening, with rates much higher in blacks than whites. \*

#### Administrative Response:

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

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

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

#### SICKLE CELL DISEASE

**R**acial 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 increase these proportions to 90% across the board.

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

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

committed individuals work together to help protect the health of mothers and babies through such efforts as providing health and social services (including housing), doing neighborhood outreach, and offering education and childbirth and infant care.

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

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)

- Murray
- Jeffords
- Dean
- Kennedy

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

DATE: 7/25/97

TO: Sarah Bianchi

FROM: Lovita Watson

FAX NUMBER: 202-456-5557

Number of Pages (Including Cover Sheet) 37.22

MESSAGE:  
more to follow

# AIDS

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

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

# Substance Abuse

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

# Infant Mortality

\* Infant mortality among Native

Americans is nearly one-third higher

than for all Americans.

# Homicide

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

# Suicide

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

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

# Diabetes

\* The prevalence of diabetes in Native

Americans is so great that in many

tribes more than 20 percent of the

members have the disease.

# Cancer

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

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

# AIDS

\* The AIDS prevalence rate for

Asians and Pacific Islanders is below

that of Caucasians

# Alcohol Abuse

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

# Diabetes

\* Native Hawaiians have twice the  
death rate from diabetes as Caucasians  
in Hawaii.

# Cardiovascular Disease

\* Cardiovascular disease (CVD)  
rates among first-generation Asian  
American and Pacific Islander (AAPI)  
immigrants are generally intermediate  
between that of the country of origin  
and of the U.S.

# Cardiovascular Disease and Stroke

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

273 per 100,000 persons

compared with

190 per 100,000 persons

for the total U.S. population.

# Cancer

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

# AIDS

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

# Infant Mortality

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

# Homicide

\* In 1989-91 the homicide rate for

young Hispanic males was about 3.5

times the rate for White males.

# Diabetes

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

# Cardiovascular Disease

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

# Stomach Cancer

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

# Prostate Cancer

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

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