



*National Health Promotion and
Disease Prevention Objectives*

**Progress Review:
Black Americans**

October 26, 1998

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HEALTHY PEOPLE 2000 OBJECTIVES FOR BLACK AMERICANS

October 26, 1998

1:00-3:30 p.m.

Live Broadcast - Howard University

Agenda

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Doris McMillon
Moderator

II. **OPENING REMARKS**

David Satcher, MD, PhD
*Assistant Secretary for Health and Surgeon General
Office of Public Health and Science*

III. **OVERVIEW: DEMOGRAPHICS AND HEALTH STATUS**

Clay E. Simpson, Jr., MSPH, PhD
*Deputy Assistant Secretary for Minority Health
Director, Office of Minority Health*

IV. **PROGRESS IN ATTAINING 2000 OBJECTIVES**

Edward J. Sondik, PhD
*Director, National Center for Health Statistics Centers for
Disease Control and Prevention*

V. **DISCUSSION**

Contributing factors to health status of the Black
American population
Health systems measures required to eliminate health
disparities
Role of communities, individuals and others in eliminating
health disparities

Panelists

Viewer call-in from remote downlink sites

VI. **PROGRESS REVIEW SUMMARY**

Linda Meyers, PhD
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VII. **CLOSING REMARKS**

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Biographical Sketches

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Doris McMillon is a veteran journalist, newscaster, producer, media consultant and trainer. She has written and produced news and features covering a wide range of subjects including the Emmy award-winning series, *The Welfare Ripoff* and has been honored for her work by numerous organizations. Ms. McMillon is widely sought as a media consultant and trainer by clients such as AFL-CIO, AARP, National Urban League, US Department of Education, and numerous other public and private organizations.

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Marcia Bayne-Smith, DSW, ACSW is Assistant Professor of Urban Studies at Queens College, City University of New York and chairs the Board of Directors of the Caribbean Women's Health Association. She also serves as a member of the US/UK Collaboration on Racial and Ethnic Health's Culturally Sensitive Access to Health Services Core Workgroup. The author of such works as Race, Gender and Health, Dr. Bayne-Smith has conducted research and published extensively in the US and abroad on primary care services and on minority and women's health.

Norma J. Goodwin, MD is Founder and President of HEALTH WATCH Information and Promotion Service, Inc., an organization committed to improving the health and longevity of minority populations. She is also Clinical Associate Professor of Preventive Medicine and Community Health at the State University of New York Health Science Center at Brooklyn (Downstate) and is a member of the National Institutes of Health Task Force on the Prevention and Treatment of Obesity.

Norge W. Jerome, PhD, an international nutrition scientist and nutritional anthropologist, is Professor Emerita of Preventive Medicine at the University of Kansas School of Medicine in Kansas City, KS. Internationally, she has been involved in cross-cultural food and nutrition studies and has directed one of the largest worldwide nutrition programs for the US Agency for International Development. An expert on culture, human nutrition and health, Dr. Jerome is senior author of Nutritional Anthropology: Contemporary Approaches to Diet and Culture.

Adora Iris Lee, MPH, a Senior Program Manager with the Academy for Educational Development in Washington, DC, supports the Centers for Disease Control and Prevention's national HIV Prevention Community Planning Program. Ms. Lee is also a minister serving in the area of health ministry. She works with the United Church of Christ Commission for Racial Justice helping local churches design programs such as HIV/AIDS ministries and training for pastors and parishioners, women's wellness conferences and health advocacy training.

John E. Maupin, Jr., DDS, MBA is President of Meharry Medical College in Nashville, TN. Prior to that, in Atlanta, GA he was Executive Vice President of the Morehouse School of Medicine and Chief Executive Officer of Southside Healthcare, Inc., a provider of outpatient health care services. Dr. Maupin is a past president of the National Dental Association and a member of numerous other health care organizations. He has served on several professional advisory groups including the National Medical Association's Managed Care Task Force.

Sullivan Robinson, MA is Executive Director of the Congress of National Black Churches, Inc., a Washington, DC based national coalition of historic African American denominations. CNBC collaborates with local churches in effective ministries promoting social and economic justice for children and families in underserved communities. It provides training, education and outreach to help clergy and congregations play a vital role in community building and development. Ms. Robinson also serves on several boards and advisory committees.

The Honorable Louis D. Stokes, JD is serving his 15th term as a Democratic member of the US House of Representatives from the state of Ohio. He has served as Chairman of the Appropriations Subcommittee on Labor-Health and Human Services-Education and is currently the ranking minority member. For 24 years, Congressman Stokes has chaired the Congressional Black Caucus Health Braintrust, which serves as a national forum for health education and advocacy. He is widely considered the "Dean of Health" of the African American community.

Patricia A. Tompkins, RN, MPH is a past Interim Executive Director of the National Black Nurses Association in Washington, DC. She currently serves as Director of its "Campaign to Immunize Our Children," which trains and recruits nurses to vaccinate infants, children and adults. Ms. Tompkins was formerly Chief of the District of Columbia Office of Maternal and Child Health. Her areas of expertise include maternal/women's health, children's health, and family health promotion and education.

Yvonnecris Smith Veal, MD began her career in occupational medicine in 1985 and serves the US Postal Service as Senior Medical Director for the NY Metropolitan Area. Previously, she served as Medical Director of the Kings County Hospital Center in East New York, a "neighborhood in need," and was Medical Director of the Carter Community Health Center in Queens, NY. Dr. Veal is a past President of the National Medical Association, which represents African American physicians in the US, Puerto Rico and the Virgin Islands.

Martin P. Wasserman, MD, JD is Secretary of the Maryland Department of Health and Mental Hygiene. In his role as the top state health official, he has organized and supported anti-smoking initiatives; spearheaded the Medicaid reform program, *HealthChoice*; oversees the Maryland Children's Health Program; and leads a statewide effort to improve both physician awareness of domestic violence and treatment for victims. Dr. Wasserman is a board-certified pediatrician.

**Healthy People 2000
Progress Review for Black Americans**

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Revised September 30, 1998

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Revised 10/7/98

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(Revised 10/7/98)

Healthy People 2000 Progress Review for Black Americans

Overview

Process

In preparation for this progress review, the Office of Minority Health convened a workgroup consisting of representatives from the Office of Minority Health, Administration on Aging, Administration on Children and Families, Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Health Care Financing Administration, Food and Drug Administration, Health Resources and Services Administration, National Institutes of Health, Office for Civil Rights, Office of Disease Prevention and Health Promotion, Substance Abuse and Mental Health Services Administration, South Carolina and California Public Health Departments, academic institutions, and health related organizations within the private sector.

The charge of the workgroup was to shape the context of the progress review. This translated into choosing a theme for the progress review; recommending participants for the October meeting; examining the impact of cross-cutting issues (socioeconomic status, race, service availability and accessibility, and emerging populations of African extraction) on the movement toward the elimination of racial and ethnic disparities in health status; integrating the President's six priority areas into the review process; and providing feedback on the proposed 2010 objectives.

Data collected by the National Center for Health Statistics, the Centers for Disease Control

and Prevention, the Office of Minority Health, and the U.S. Bureau of Census was considered for review. Analysts from these agencies presented their findings at several of the workgroup meetings. The workgroup interpreted the data collectively with meaningful participation from all workgroup members. Most decisions were made by consensus.

Highlights of Workgroup Discussions

The workgroup had twelve meetings over a period of seven months. The following three issues emerged from these discussions that will frame the formal progress review on Oct. 26, 1998:

- 1) Contributing factors to health status of Black American population
- 2) Health systems measures required to eliminate health disparities
- 3) Role of communities, individuals and others in eliminating health disparities

The workgroup examined the 91 Healthy People 2000 objectives or indicators targeted for African Americans and classified them in terms of the number of objectives achieved; the number for which there exists little data; the number approaching their targets and at what rate; the number of objectives showing no change; and the number of objectives moving away from their targets. The results are summarized below in Table 1.

Table 1

Progress	Number	Percentage
Met or surpassed targets	14	15
Moving towards targets	52	53
Moving away from targets	18	20
Showing no change	4	4
No data to determine progress	7	8
Total	95	100

Data obtained from National Center for Health Statistics, 1998

The workgroup chose to feature 20 (of the 95) indicators that revealed the most dramatic trends in the 1998 Progress Review Book. In light of the health indicators that are moving away from their respective targets and the indicators that are moving too slowly to reach their targets by 2000, the workgroup members proposed that public health agencies (community, state, and national) forge linkages with organizations outside of the health arena, such as sororities, fraternities, HBCUs, the prison community, and religious and civic groups. The rationale was that this combination might deliver the “healthy” message and implement the Healthy People 2000 goals more effectively because of the relationships that these "new partners" have with their communities.

The interval of study for this progress review was 1987 through 1996. Mathematical, statistical and political reasoning were used to set the Healthy People 2000 targets. The Healthy People 2000 targets (in the majority of cases) do not address the total elimination of disparities in key health areas. Instead, they were designed to narrow the gap between

African Americans and the overall population. The elimination of disparities in key areas is a bold goal for the new millennium.

State Profiles

The workgroup took a closer look at the health status of African Americans in five states/districts which have the largest numbers of African Americans (District of Columbia, Georgia, Louisiana, Mississippi, and South Carolina) and in five states representing each geographical region in the U.S. (California, Florida, Illinois, New York, and Texas). Specifically, they looked at health status with respect to the President's six priority areas as well as one additional health area – homicide.

Parameters

In summary, the Healthy People 2000 process has revealed a potential for celebration in the African American community if current trends persist, particularly in the areas of breast cancer screening, deaths from unintentional injuries, and neonatology. The review has also signaled areas of "red alert," public health challenges that require immediate attention and resources.

Demographics

The 1996 Current Population Survey counted approximately 33.4 million African Americans; this number represents 12.7% of the U.S. population, making African Americans the largest of any minority group. This figure also reflects an increase of 3.4 million African Americans over the past six years (U.S. Bureau of the Census, Current

Population Survey 1996).

While African Americans are located throughout the U.S., they are in greater concentrations in urban areas and in the southeastern section of the country, particularly in the Mississippi Delta region. In some Mississippi counties, African Americans constitute 50% or more of the population. Coincidentally, higher rates of poverty tended to be found in the southern and southwestern states in 1996 as has been characteristic of those regions in the past (Health, US 1998).

African Americans continue to lag behind the overall U.S. population in material wealth. The median income for African American households in 1996 was \$23,482, \$12,000 less than the average median income for the nation (*Health, US 1998*). The percentage of African Americans living below the poverty level in 1996 was twice that of the overall population. Close to half of the African American population was classified as poor or near poor; and over two-thirds of black children were living in or near poverty during that same year (*Health, US 1998*).

Fewer African Americans advance to the same educational levels as the overall population, and this pattern is reflected in the workplace. In 1996, 20% of the African American population between the ages of 25 and 64 had less than a high school education and 15% had completed at least a baccalaureate degree. In comparison, 15% of the overall population had less than a high school education, and 25% had

completed at least a baccalaureate degree. While 39% of men of all races held blue-collar positions in 1996, nearly one-half of all black men in the workforce held blue-collar positions (*Health, US 1998, p. 45*). Nearly two-thirds of the remaining 50% of the black male workforce held white-collar positions, and almost all of the remainder were employed in the service sector of the economy (*Health, US 1998, p. 45*).

The occupational breakout was slightly different for African American women. Approximately 60% of all African American women in the workforce held white-collar positions; 25% occupied positions in the service industry; and 15% held blue-collar positions (*Health, US 1998, p. 45*).

Employment is a critical component contributing to economic, physical, and emotional well being. In 1996, among the civilian non-institutional population 16 years of age and older, the African American population represented the lowest annual average employment rate of any population group in the United States. Only 57.4 percent of African Americans are in the labor force, as contrasted with 64.1 percent of whites and 60.6 percent of people of Hispanic origin. As a corollary, the annual average unemployment rate for African Americans in 1996 was 11.2 percent, while the annual average unemployment rate for whites was 4.6 percent and for people of Hispanic origin 8.9 percent (U.S. Bureau of the Census, Current Population Survey, 1997).

Those African Americans who advance to the highest levels of the educational system

earn less than their white colleagues. In 1996 African American men who held at least a baccalaureate degree or more earned approximately \$12,000 less than white men with similar educational backgrounds; African American females with baccalaureate degrees or more earned \$4,000 less than white females with similar educational backgrounds (U.S. Bureau of the Census, 1998).

A single parent heads increasing numbers of African American households. In 1990 a single parent headed 50% of all African American households; in 1996 that percentage had risen to 54% with 47% headed by women and 7% headed by men. The median income of families headed by single African American females suggests that this group has not fared well economically. In 1996, the median income was \$15,530 for African American female headed households compared to \$22,370, the median income for white households headed by women (U.S. Bureau of the Census, 1998).

Health Status

According to *Health, US 1998*, "In 1996, life expectancy at birth for black males increased for the third consecutive year to a record high of 66.1 years, following a period of year-to-year declines in life expectancy from 1984-1993." Although black men are living longer, their life expectancies are 7 years less than that for all men. Black women born in 1996 can expect to live to the age of 74 which is five years less than the life expectancy figure for all women.

The leading causes of death for African Americans in 1996 included heart disease, lung cancer, cerebrovascular disease, HIV/AIDS, unintentional injuries, prostate cancer, homicide, diabetic complications, breast cancer, pneumonia, influenza, chronic obstructive pulmonary disease, and perinatal conditions. African Americans died from several of these diseases at dramatically greater rates than the overall population. For example, in 1996 African Americans died at twice the rate from prostate cancer and diabetic complications than the overall population, and the age-adjusted mortality rate for stroke for the black population was two-thirds higher than that for the overall population (*Health, US 1998*).

Two of the ten leading causes of death for the African American population, HIV/AIDS and homicide, did not rank among the top ten leading causes of death for the overall population. To illustrate this point, HIV/AIDS mortality rates for the African American population were 41 per 100,000 compared to 11 per 100,000 for the overall population. Similarly, homicide rates for African Americans were 31 per 100,000 compared to 9 per 100,000 for the overall population in 1996 (*Health, US 1998*).

These numbers just tell part of the story. The other part of the picture is revealed in the patterns that key health indicators (or objectives) have followed since 1987. Twenty health indicators that capture the most dramatic trends and for which significant data exists were selected for review. They are discussed below in the context of the Healthy People 2000 goals. (See charts for reference.)

Healthy People 2000 Priority Targets

The good news is that the Healthy People 2000 target for **cancer deaths** for African Americans has been met, and age-adjusted death rates for this disease continue to decrease. Since 1993, the incidence of **hepatitis B** has been on the decline as well, and in 1996 the target for this indicator was met. Deaths from **lung cancer** and from **unintentional injuries** have been steadily decreasing, also. The target for **lung cancer** has been met, and the African American population is rapidly approaching the target for **unintentional injuries**. However, the rate of decrease for these two indicators must be greater in order for the numbers of African Americans who die from **lung cancer** or **unintentional injuries** to approach the numbers for the overall population.

More encouraging news indicates that increasing numbers of African American women have had **breast exams and mammograms** in the past 2 years. In fact, in 1994 the percentage of black females 50 years and over that had received these services echoed the national norm. If the rate of increase continues at the present pace, the objective will be met by the year 2000. The real challenge rests in increasing the percentage of women who receive mammograms and breast examinations *on a regular basis*.

The area of neonatology offers even more positive indicators of African American health. The percentage of **low birthweight** among black infants decreased from 13.6 to 13.0 % between 1991-96. A related health indicator, **infant mortality**, has been steadily declining from 1990-96 as well. The percentage of **very low birthweight** babies, however, has

remained the same at 3.0 percent. Once again, the rates of decrease for these indicators will have to decrease *further* in order for the African American population to achieve parity with the overall population.

Coronary heart disease deaths have been declining at a steady rate since 1987, more good news. If the age-adjusted death rate continues to decline at this pace, this indicator will reach its Healthy People 2000 target.

Although homicide is one of the leading killers of African American males, the **homicide death rate** for African American males ages 15 through 34 has begun a slow decline since 1991. If the decrease in the number of homicides continues at this rate, the target will be achieved. As noted above, however, the disparity in homicidal death rates between African American males and the overall population is still alarming.

Now for the bad news. Even though several indicators (**breast cancer deaths, incidence of tuberculosis, early prenatal care, hospitalizations for pelvic inflammatory disease, incidence of primary and secondary syphilis, and pneumococcal and influenza vaccinations**) are moving in the right direction, the rate of change is too slow to meet the Healthy People 2000 target.

Finally, the shocking news. HIV incidence has been skyrocketing explosively from 1990-1995 in the following subpopulations of the African American community: heterosexual

females, female intravenous drug users, and homosexual males, all born between 1965 and 1974 (*JAMA*, June 17, 1998). The rise in AIDS incidence has been less dramatic for the entire African American community but nonetheless steadily increasing since 1989. On the other hand, AIDS incidence has remained fairly constant for the overall population over the same time period. In other words, at this rate, by the year 2000 the gap between blacks and others will be wider than ever before.

The age-adjusted **death rate from asthma** in the African American community has been climbing at a rate greater than that of the overall population (National Vital Statistics), and the number of **asthma hospitalizations** has increased since 1987, again moving away from the Year 2000 target. As with AIDS, the trend has been relatively flat for the overall population with respect to asthma hospitalizations.

This pattern of widening disparity, with the burdens of illness and early death increasing in African American population and remaining stable in the overall population, is repeated for **maternal mortality** and **diabetes-related deaths**. In fact, the age-adjusted maternal mortality rates for African American women were five times that for non-Hispanic white women in 1996.

Two indicators related to diabetes-related deaths that are complications of diabetes, **end-stage renal disease (ESRD)** and **lower extremity amputation (LEA)**, are affecting greater numbers of African Americans each year. Unlike the other “shocking” indicators (AIDS, maternal mortality, asthma hospitalizations, and diabetes-related deaths), the trends for ESRD and LEA in the overall population mirror those of the African American

community, but the diseases affect the overall population to a lesser degree.

Health Issues Impacting on Healthy People 2000 and 2010 Goals

As government policymakers, public health professionals and providers, and business and community leaders develop strategies responding to these trends by the years 2000 and 2010, they must confront new challenges and overcome old barriers. These new challenges and old barriers are discussed in the following section in the context of the cross cutting issues defined by the 1985 Report of the Secretary's Task Force on Black and Minority Health.

Health Care Access, Financing, and Seeking Patterns

Health Care Financing

In 1996, Black persons were more likely to be uninsured than were white persons (19.0 and 15.4 percent, respectively). Black persons were also more likely to receive Medicaid than were white persons (24.5 and 9.3 percent, respectively) (*Health, US 1998*, p. 362).

Access and Seeking Patterns

Today, seven out of every ten African Americans receive care through some kind of managed care arrangement, slightly more than the population at large (The Kaiser/Commonwealth Fund 1997 National Survey of Health Insurance). Further, for many adults who are now required to take low-paying jobs that do not offer health insurance, welfare reform has disrupted the continuity of care that Medicaid used to provide.

At the same time, more than one of four African Americans has no insurance at all, compared to not quite two of ten whites. In addition, approximately four out of every ten African Americans reported that they had no regular physician in 1997; whereas one out of every four white persons claimed that they had no regular physician. Fifteen percent of Blacks could not afford prescription medications; ten percent of whites could not afford prescription medications (1997 Medical Expenditure Panel Survey, The Commonwealth Fund). What's more, the percentage of black children with no usual source of care is more than twice that of white children.

The State Children's Health Insurance Program (CHIP), created in 1997 as part of the Federal Balanced Budget Act, was designed to provide about 40 billion dollars over the next ten years for states to provide health insurance to uninsured children. Under this legislation, states may either expand their existing Medicaid programs or develop new health insurance options.

Of the estimated 8-11 million children who go without health insurance, approximately 4.3 million are currently eligible for existing Medicaid insurance, and many more will be eligible under CHIP and under private programs sponsored through Blue Cross/Blue Shield companies in 25 states.

Effective outreach programs to identify and enroll eligible children into these programs will be a challenge for both the state and community-based organizations. Medicaid outreach activities are allowable administrative expenses that are matched 50-50 by the federal government (Alliance for Health Reform, May 1998).

These facts have profound implications. First, far many African Americans have no access to health care. Second, there is growing evidence that with its emphasis on managing cost, managed care may be limiting access to care for the very populations who need it most (*JAMA*, 1996, 276: 1039-1047).

Prospect for Improvement

To improve access to health care, however, both non-financial and financial barriers must be overcome. The capacity to deliver health care services to underserved populations needs to be developed and sustained must include enabling services that assist minority populations to use the health care system effectively.

Continued attention to the following key issues is required to improve access and financing of services for minority populations: (1) availability of services (health personnel and facilities) for underserved populations; (2) appropriateness of these services, particularly the need to offer primary and preventive care; (3) affordability of health insurance coverage; (4) accessibility of services to populations in need; and (5) acceptability of services, particularly in terms of quality of care and the competence of service providers to deal with client populations with different languages and cultures.

Health Professions Development

African Americans continue to be significantly underrepresented in the health professions. While only 12.8 percent of the nation's population are African American, 7.8 percent are

pharmacists; 2.7 percent are optometrists; 5.7 percent are dentists; 5.1 percent are podiatrists; 3.5 percent are osteopathic physicians; 7.6 percent are allopathic physicians; and 9.0 percent are nurses (AAMC, 1995).

African American Underrepresentation in Health Professions

Both an adequate supply and distribution of African American health professionals are essential to efforts aimed at improving the health status of African Americans.

Need to Encourage African American Youth to Remain in the Health Professions

Pipeline

According to the American Association of Medical Colleges (AAMC), most of the minority students in this country with an interest and prerequisite preparation are already applying to medical school. This finding suggests that more intensive recruiting efforts must occur prior to college graduation in order to significantly increase the number of applicants to health professions schools.

- (1) The Quality Education for Minorities (QEM) Network is initiating a project for the Office of Minority Health, Department of Health and Human Services to strengthen the academic science research infrastructure at Spelman and Bennett Colleges. This is to be accomplished through inquiry-based science instruction, seminars, proposal development workshops, and greater opportunities for students to engage in independent research (unpublished report).

- (2) The AAMC launched “Project 3000 by 2000,” a national campaign whose goal is to enroll 3000 underrepresented minority students in medical school annually by the year 2000. This is to be accomplished by establishing linkages between local school systems, high schools, colleges, and medical schools.

African American Underrepresentation on Faculties of Health Professions

Schools

The Bureau of Health Professions reports a serious underrepresentation of African Americans in faculty positions at health professions schools. A cadre of African American health professionals/academicians is needed to provide leadership; to support and advance recruitment and retention of African American students; to develop curriculum at health professions schools; and to take a lead in the framing of clinical issues, research questions, and health policy.

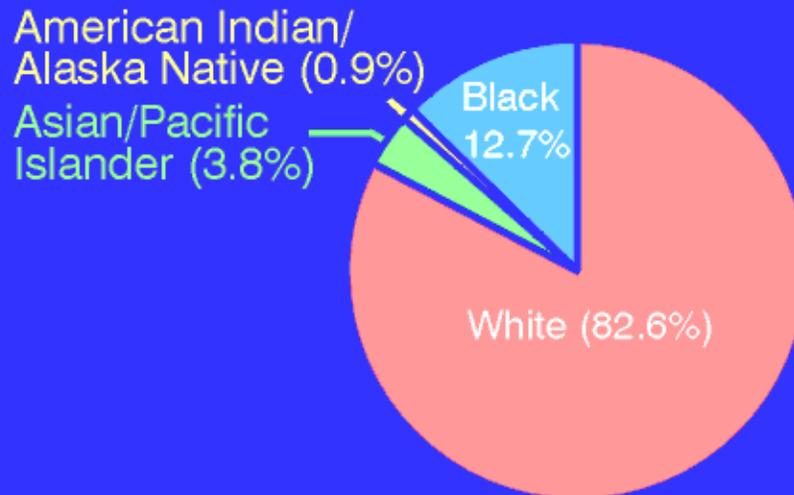
Data Collection and Analysis

Although there has been some improvement in the collection and reporting of data on the health status of African Americans, such is not the case for other underrepresented minority groups or for particular subpopulations within the African American community. In many instances, it is difficult to produce reliable data for African Americans in small geographic areas when drawing from national data sets.

Surveillance Systems

A process should be developed for identifying gaps in the Nation's disease prevention and health promotion data including gaps in the data for racial and ethnic minorities.

Resident population by race, July 1, 1998



NOTE: 11.3 percent of the population is of Hispanic origin, which may be of any race.
SOURCE: U.S. Bureau of the Census, Internet release date August 28, 1998.

Status of Progress on Healthy People 2000 objectives for Black Americans

September 29, 1998

Priority Area	Target met	Moving toward target	Moving away from target	No change	No data to determine progress	Disparity decreasing
Physical Activity and Fitness						
1.1a (2.1a, 3.1a, 15.1a) Coronary heart disease		X				No
1.2b (2.3b,15.10b,17.12b) Overweight prevalence			X			Yes
1.4b Vigorous physical activity		X				No
1.5d No leisure-time physical activity				X		No
1.13b (17.3b) self-care Difficulty performing activities			X			No
Nutrition						
2.2a (16.1a) Cancer deaths	X					Yes
2.4a Growth retardation				X		No
2.10e Iron deficiency			X			?
2.11b (14.9b) mothers: Breastfeeding, black						
period During early postpartum		X				Yes
At age 6 months		X				Yes
2.12c (13.11c) Prevent baby bottle tooth decay					X	?
2.22a (3.18a,15.2a) Stroke deaths		X				Yes
2.23a (16.5a) Colorectal cancer deaths		X				No
2.24e (17.11e) Diabetes prevalence			X			No
Tobacco						
3.2b (16.2b) Slow rise in lung cancer deaths	X					Yes
3.4d (15.12a, 16.6d) Cigarette smoking prevalence		X				Yes
3.17a (13.7a,16.17a) Oral cancer deaths: Black males 45-74 years	X					Yes
3.17b (13.7b,16.17b) Oral cancer deaths: Black females 45-74 years	X					No
Alcohol and other drugs						
4.2a Cirrhosis deaths		X				Yes
4.3a Drug-related deaths			X			Yes

Priority Area	Target met	Moving toward target	Moving away from target	No change	No data to determine progress	Disparity decreasing
Family Planning						
5.1a Adolescent pregnancy			X			Yes
5.2a Unintended pregnancy		X				No
5.3a Infertility prevalence		X				Yes
5.4a Adolescents engaged in sexual intercourse: Black males 15 years		X				No
5.4b Black males 17 years					X	?
5.4c Black females 17 years		X				Yes
5.7a Contraceptive users who become pregnant					X	?
5.12a Females 15-44 years at risk of unintended pregnancy who use contraceptives		X				No
Violent and Abusive Behavior						
7.1 c 15-34 Homicide rate: Black males			X			No
7.1e 15-34 Homicide rate: Black females		X				Yes
7.3a Firearm-related deaths	X					Yes
7.9a Physical fighting: Black males 14-17		X				Yes
7.10a adolescents Weapon carrying: Black 14-17	X					Yes
Educational and Community Based Programs						
8.1a (17.1a, 21.1a) Years of healthy life				X		Yes
8.2b Completion of high school			X			No
Unintentional Injuries						
9.1b Unintentional injury deaths		X				Yes
9.2a hospitalizations Unintentional injury	X					Yes
9.4c Fall-related deaths	X					Yes
9.5c Drowning deaths		X				Yes
9.6c males Residential fire deaths: Black	X					Yes
9.6d females Residential fire deaths: Black	X					No
Environmental Health						

Tab 6-2

Priority Area	Target met	Moving toward target	Moving away from target	No change	No data to determine progress	Disparity decreasing
11.1a and Asthma hospitalizations: Blacks and other nonwhites			X			No
11.4a >15ug/dL		X				No
= or > 25ug/dL		X				No
Oral Health						
13.1c Dental carries prevalence		X				Yes
13.2c Untreated dental carries:						
Black children 6-8 years		X				Yes
Black adolescents 15 years		X				Yes
13.8a children 8 Protective sealants: Black years					X	?
13.8b Protective sealants: Black adolescents 14 years					X	?
13.12a and Oral health screening, referral, followup					X	?
13.14c Dental visits each year		X				No
Maternal and Infant Health						
14.1a Infant mortality among blacks		X				No
14.1e Neonatal mortality among blacks		X				No
14.1h blacks Postneonatal mortality among		X				No
14.2a Fetal deaths		X				No
14.3a Maternal mortality			X			No
14.4b Fetal alcohol syndrome			X			No
14.5a Low birth weight				X		Yes
14.5b Very low birth weight			X			Yes
14.7a pregnancy Severe complications of		X				No
14.11a Prenatal care		X				Yes
14.15 treatment Newborn screening and		X				No
Heart Disease and Stroke						
15.3a incidence End-stage renal disease			X			No
15.5b Taking action to control blood pressure			X			No
15.14a Blood cholesterol checked		X				No

Tab 6-3

Priority Area	Target met	Moving toward target	Moving away from target	No change	No data to determine progress	Disparity decreasing
Cancer						
16.3a	Female breast cancer deaths	X				No
16.4a	Cervical cancer deaths	X				Yes
16.11e	Breast examinations and mammograms	X				Yes
Diabetes and Chronic Disabling Conditions						
17.2c	Limitation in major activity due to chronic condition		X			No
17.4a	Percent of people with asthma experiencing activity limitation	X				Yes
17.9a	Diabetes-related deaths		X			No
17.10a	End-stage renal disease due to diabetes		X			No
17.10c	Lower extremity amputations due to diabetes		X			Yes
17.14c	Patient education for blacks with diabetes	X				Yes
17.16a	Early detection of significant hearing impairment				X	?
17.22 (22.4)	Process to close health data gaps	X				?
HIV infection						
18.1b	AIDS incidence	X				No
18.4d	Condom use at last intercourse		X			Yes
Sexually Transmitted Diseases						
19.1a	Gonorrhea incidence		X			Yes
19.3a	Primary and secondary syphilis incidence	X				No
19.4a	Congenital Syphilis	X				Yes
19.6a	Pelvic inflammatory disease		X			Yes
19.8a	Repeat gonorrhea infection in past year	X				No
Immunization and Infectious Diseases						
20.3h	Hepatitis B		X			No
20.4b	Tuberculosis incidence		X			Yes
20.11a	Immunization, blacks 65 years and over:					

Tab 6-4

Priority Area	Target met	Moving toward target	Moving away from target	No change	No data to determine progress	Disparity decreasing
Pneumococcal		X				Yes
Influenza		X				Yes
Clinical Preventive Services						
21.2	Receipt of recommended services:					
		X				Yes
		X				Yes
		X				Yes
21.3b		X				Yes
21.4c care		X				Yes
21.8 in the		X				?
21.8a		X				?
Surveillance and Data Systems						
22.5a data for up at population		X				?

Number of objectives = 95

TOTALS:

14

52

18

4

7

Healthy People 2000 Objectives For Black Americans

9/15/98

Summary of Progress

There are 319 unduplicated main objectives in *Healthy People 2000*. Subobjectives for minorities and other special populations were established to address increased health risks or disparities compared with the total population. Forty-eight objectives/subobjectives for Black Americans were discussed at the 1994 progress review. Including the subobjectives added during the 1995 Midcourse Review, there are now 95 objectives/subobjectives (hereafter called “objectives”) being tracked for progress. Movement either toward or away from the target is determined by the direction of the change between the baseline and the most recent data point. Some of these changes are relatively small and may be within what could be expected on the basis of sampling or random variation.

The following summary presents the progress of all objectives for Black Americans. The accompanying tables give an overview of the progress for specific objectives.

At the time of the 1994 progress review, 22 (45 percent) of the 48 objectives were moving toward targets. An additional 17 (35 percent) were moving away from targets. Data for 2 objectives (4 percent) showed no change in either direction. There were no data to determine progress for 7 (15 percent) of the objectives.

In 1998, more objectives are moving toward or have met the year 2000 targets. Of the current 95 objectives, 14 (15 percent) have met or surpassed the targets for year 2000. Data for another 52 objectives (55 percent) show progress toward the year 2000 targets. Only 18 (19 percent) are moving away from the targets. Four (4 percent) show no change in either direction. Seven (7 percent) of objectives have no data with which to determine progress. The following table compares the status of the objectives in 1994 with the current status for 1998.

Progress	1994 Progress Review		1998 Progress Review	
	Number	Percent	Number	Percent
Met or surpassed targets	0	0%	14	15%
Moving towards targets	22	45%	52	55%
Moving away from targets	17	35%	18	19%
Showing no change	2	4%	4	4%
No data to determine progress	7	15%	7	7%
Total	48	100%	95	100%

Of the 48 objectives discussed in 1994, 11 have now changed category. Two objectives previously moving toward the targets have now met and surpassed the target rates: Residential fire deaths for black males and females (objectives 9.6c and 9.6d). Three objectives previously moving away from the targets are now moving toward the targets: 7.1e (homicide among black females), 20.4b (tuberculosis incidence), and 21.3b (regular source of primary care). Five objectives previously having no data to determine progress are now moving toward the targets: 5.2a (unintended pregnancy), 5.3a (infertility prevalence), 13.1c (dental caries prevalence), 13.2c (untreated dental caries), and 21.2h (receipt of recommended services). There was one change in the opposite direction as well: Objective 17.10c (lower extremity amputations due to diabetes), previously moving toward the target, is now moving away from the target.

Status of Progress on Healthy People 2000 Objectives for Black Americans

Disparity between black and total population is decreasing (Total number of objectives = 46)

Target met and disparity decreasing (11 objectives)

2.2a (16.1a)	Cancer deaths
3.2b (16.2b)	Slow the rise in lung cancer deaths
3.17a, b (3.7a,b;16.17a, b)	Oral cancer deaths: Black males and females 45-74 years
7.3a	Firearm-related deaths
7.10a	Weapon carrying: Black adolescents 14-17 years
9.2a	Unintentional injury hospitalizations
9.4c	Fall-related deaths
9.6c, d	Residential fire deaths: Black males and females
19.4a	Congenital syphilis

Blacks moving toward target at a faster rate than total population (25 objectives)

2.11b (14.9b)	Breastfeeding: During early postpartum period
2.11b (14.9b)	Breastfeeding: At age 6 months
2.22a (3.18a, 15.2a)	Stroke deaths
3.4d (15.2d, 16.6d)	Cigarette smoking prevalence**
4.2a	Cirrhosis deaths
5.3a	Infertility prevalence
7.1e	Homicide rate: Black females 15-34 years
9.1b	Unintentional injury deaths
9.5c	Drowning deaths
13.1c	Dental carries prevalence*
13.2c	Untreated dental carries: Black adolescents 15 years
14.11a	Prenatal care
16.4a	Cervical cancer deaths
16.11e	Breast examination and mammograms*
17.14c	Patient education for blacks with diabetes*
18.4d	Condom use at last sexual intercourse: Unmarried black females 15-44 years*
19.1a	Gonorrhea incidence
19.6a	Pelvic inflammatory disease
20.4b	Tuberculosis incidence
20.11a	Immunization: Pneumococcal
20.11a	Immunization: Influenza
21.2	Receipt of recommended services: Cholesterol checked*
21.2	Receipt of recommended services: Influenza vaccine in past 12 months
21.2	Receipt of recommended services: Pneumococcal vaccine in lifetime
21.3b	Regular source of primary care

Blacks moving away from target but at a slower rate than total population (4 objectives)

1.2b (2.3b, 15.10b, 17.12b)	Overweight prevalence
5.1a	Adolescent pregnancy
14.5b	Very low birth weight
17.10c	Lower extremity amputations due to diabetes

Blacks moving toward target and total population moving away from target or remaining the same (4 objectives)

5.4c	Adolescents engaged in sexual intercourse: Black females 17 years*
13.2c	Untreated dental carries: Black children 6-8 years
17.4a	Percent of people with asthma experiencing activity limitation
21.4c	Proportion without health care coverage: Blacks under 65 years

No change for blacks but total population moving away from target (2 objectives)

8.1a (17.1a, 21.1a)	Years of healthy life
14.5a	Low birth weight

Disparity between black and total population is increasing (Total number of objectives = 37)

Target met but disparity increasing (3 objectives)

18.1b	AIDS incidence
19.3a	Primary and secondary syphilis incidence
19.8a	Repeat gonorrhea infection within previous year

Blacks moving toward the target but at a slower rate than total population (19 objectives)

1.1a (2.1a, 3.1a, 15.1a)	Coronary heart disease
1.4b	Vigorous physical activity
2.23a (16.5a)	Colorectal cancer deaths
5.2a	Unintended pregnancy
5.4a	Adolescents engaged in sexual intercourse: Black males 15 years
5.12a	Contraceptive users 15-44 years at risk of unintended pregnancy
7.9a	Physical fighting: Black males 14-17 years
11.4a	Blood lead levels: = or > 15 ug/dL
11.4a	Blood lead levels: = or > 25 ug/dL
13.14c	Dental visits each year
14.1a	Infant mortality: Blacks
14.1e	Neonatal mortality: Blacks
14.1h	Postneonatal mortality: Blacks
14.2a	Fetal deaths
14.7a	Severe complications of pregnancy
14.15	Newborn screening and treatment
15.14a	Blood cholesterol checked
16.3a	Female breast cancer deaths
20.3h	Hepatitis B

Blacks moving away from target at a faster rate than total population (11 objectives)

1.13b (17.3b)	Difficulty performing self-care activities
2.24e (17.11e)	Diabetes prevalence
4.3a	Drug-related deaths
8.2b	Completion of high school
14.3a	Maternal mortality
14.4b	Fetal alcohol syndrome
15.3a	End-stage renal disease incidence
15.5b	Taking action to control blood pressure
17.2c	Limitation in major activity due to chronic condition
17.9a	Diabetes-related deaths
17.10a	End-stage renal disease due to diabetes

Blacks moving away from target and total population moving toward target (2 objectives)

7.1c Homicide rate: Black males 15-34 years
11.1a Asthma hospitalizations: Blacks and other nonwhites

No change for blacks but total population moving toward target (2 objectives)

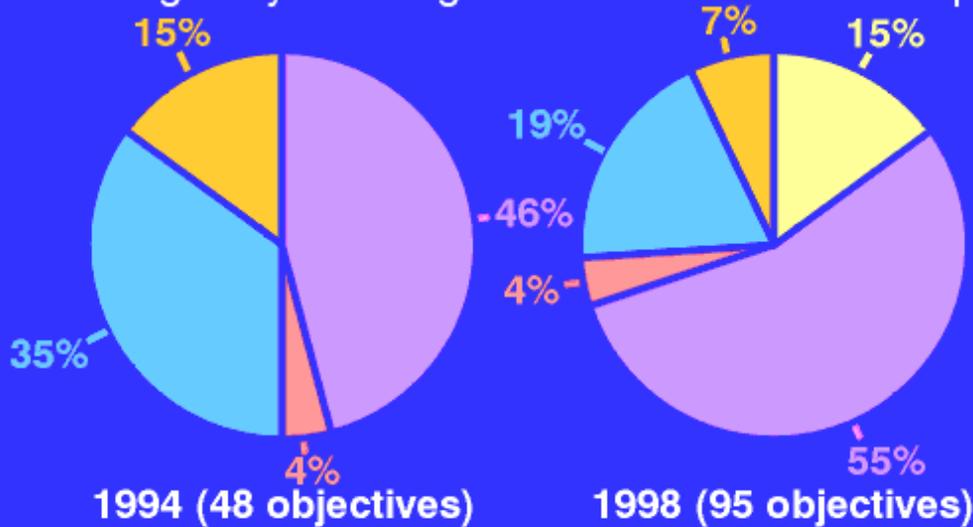
1.5d No leisure time physical activity
2.4a Growth retardation

Data or comparison group not available to assess disparity (Total number of objectives = 12)

2.10e Iron deficiency
2.12c (13.11c) Prevent baby bottle tooth decay
5.4b Adolescents engaged in sexual intercourse: Black males 17 years
5.7a Contraceptive users who become pregnant
13.8a Protective sealants: Black children 8 years
13.8b Protective sealants: Black adolescents 14 years
13.12a Oral health screening, referral, and followup
17.16a Early detection of hearing impairment
17.22 (22.4) National process to identify and establish mechanisms to meet health data gaps
21.8 Racial/ethnic minority representation in the health professions
21.8a Blacks enrolled in nursing schools
22.5a Periodic analysis and publication of data for each racial or ethnic group that makes up at least 10 percent of the State population

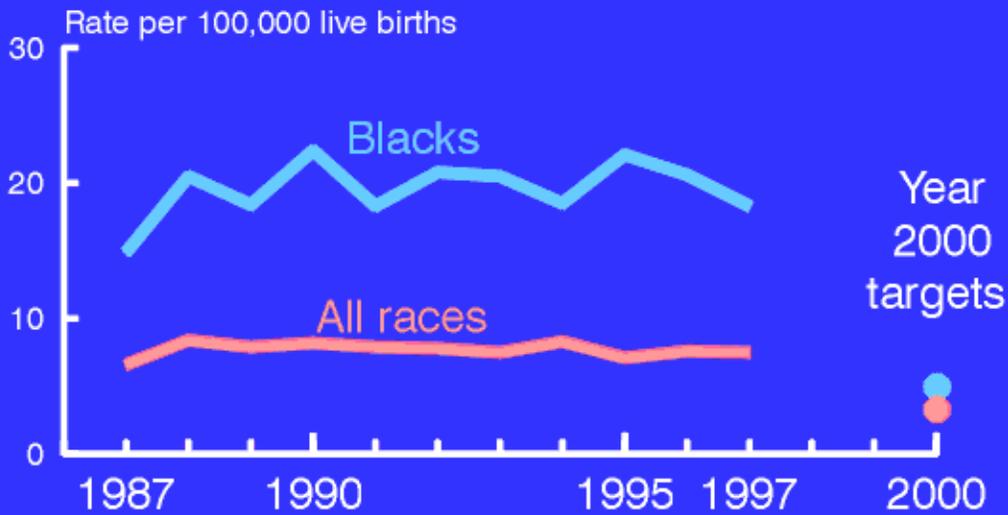
Status of Healthy People 2000 objectives for Black Americans

■ Target met
 ■ Moving toward target
 ■ No change
■ Moving away from target
 ■ No data to determine progress



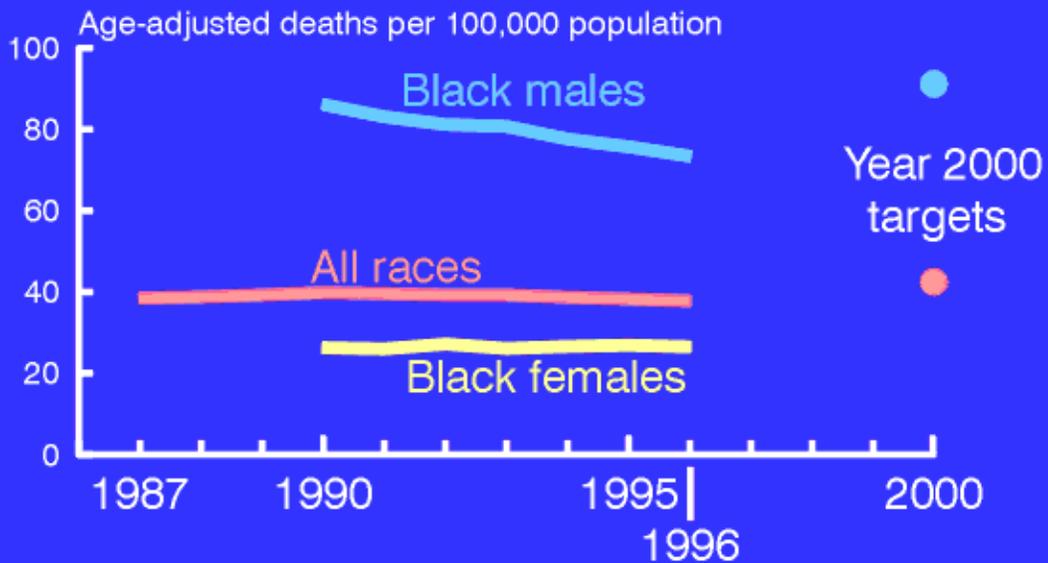
SOURCE: CDC/NCHS, Division of Health Promotion Statistics, 1994 and 1998

Maternal mortality



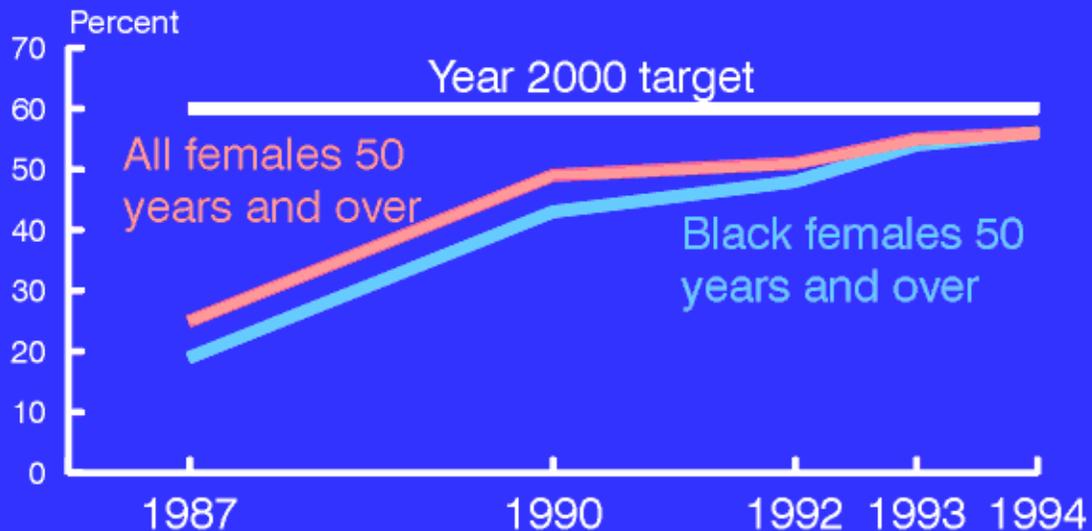
SOURCE: CDC/NCHS, National Vital Statistics System, 1987-97

Slow the rise in lung cancer deaths



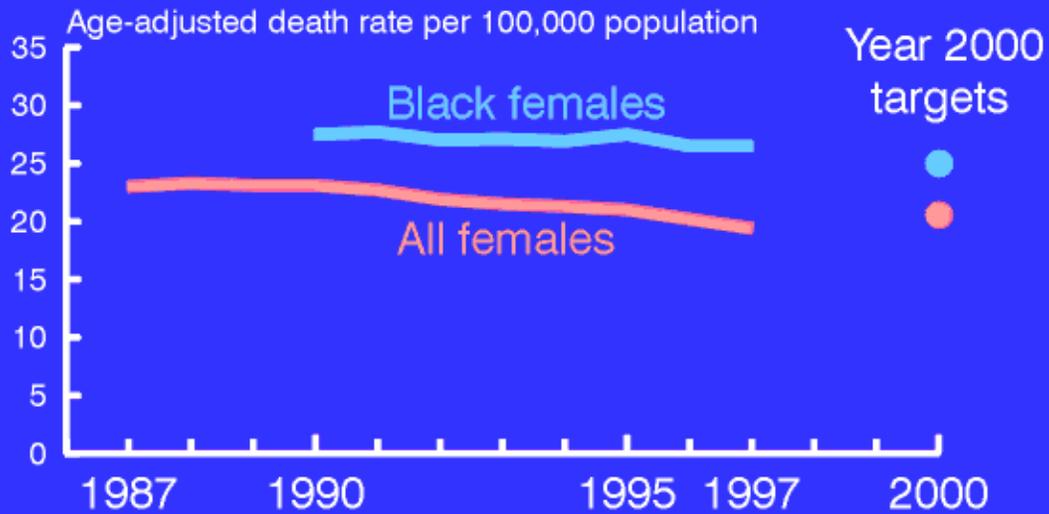
Note: Subobjective for lung cancer deaths for black males was added at the 1995 Midcourse Review.
 SOURCE: CDC/NCHS, National Vital Statistics System, 1987-96

Breast examination and mammogram in past 2 years



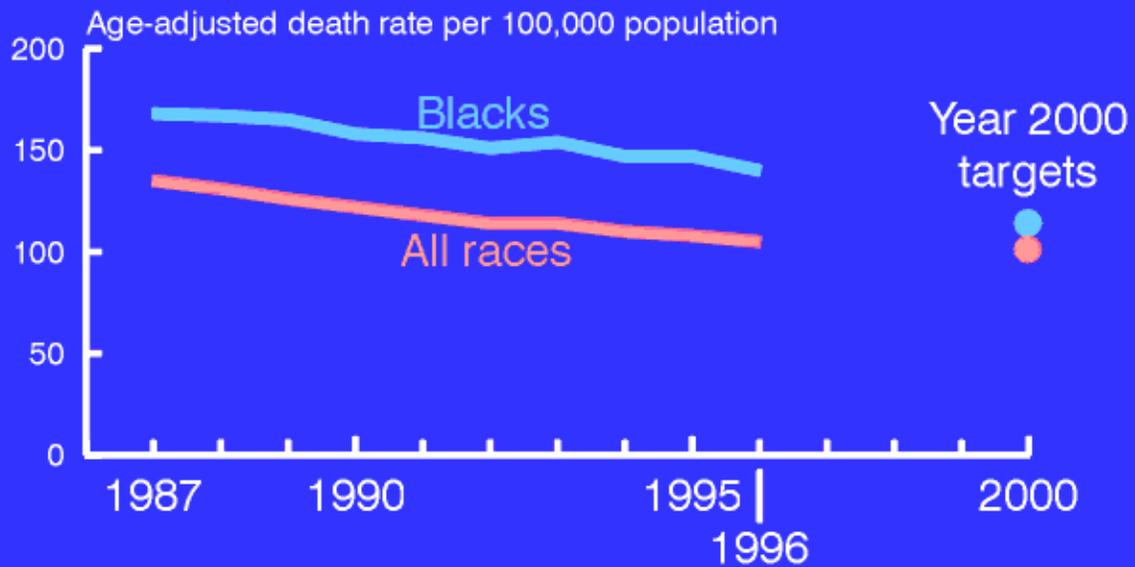
SOURCE: CDC/NCHS, National Health Interview Survey, 1987-94

Breast cancer deaths



Note: Subobjective for breast cancer deaths for black females was added during the 1995 Midcourse Review.
SOURCE: CDC/NCHS, National Vital Statistics System, 1987-97

Coronary heart disease deaths

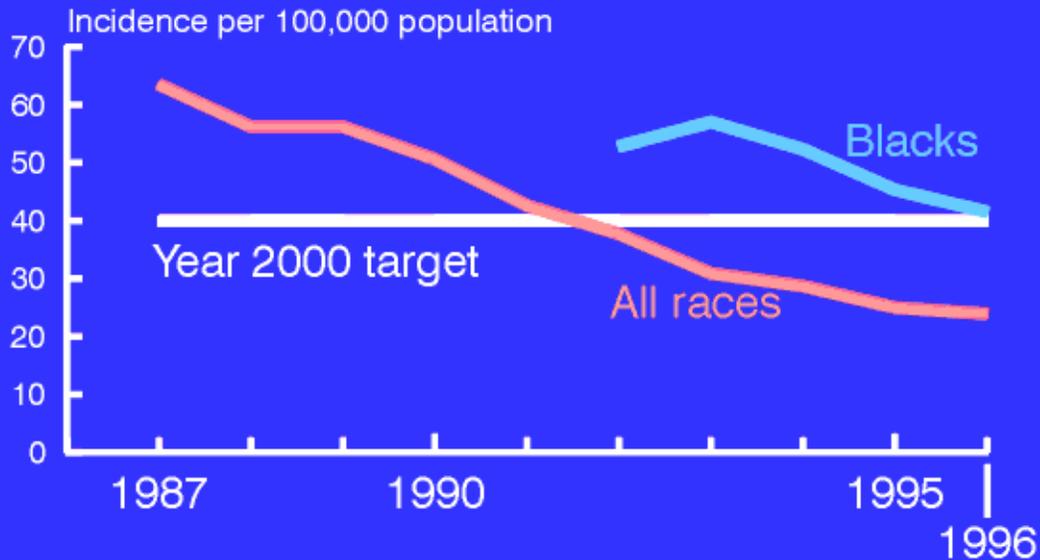


SOURCE: CDC/NCHS, National Vital Statistics System, 1987-96

Diabetes-related deaths

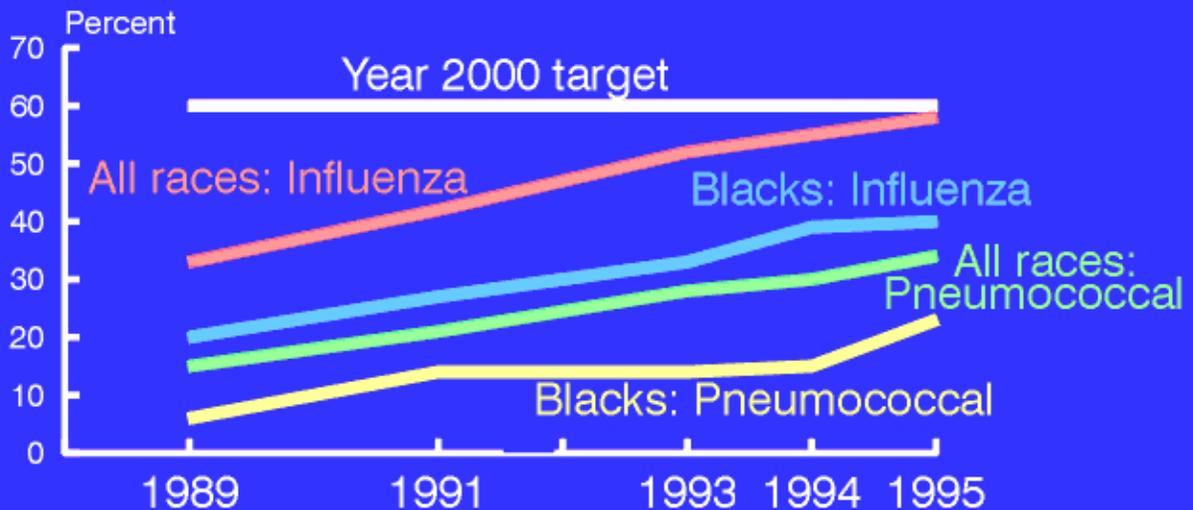
Age-adjusted death rate per 100,000 population Year 2000

Hepatitis B



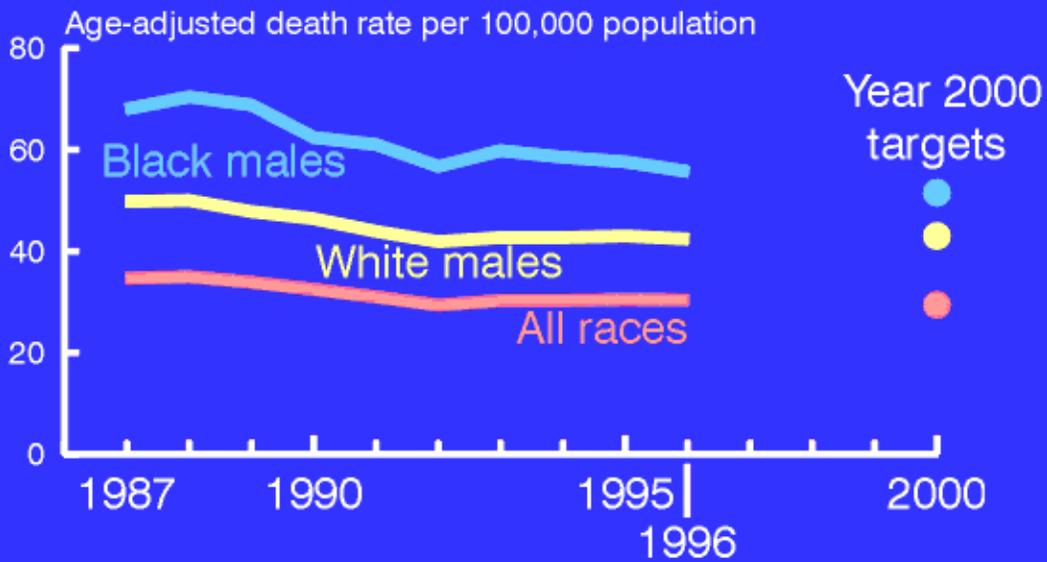
Note: Subobjective for Hepatitis B for blacks was added at the 1995 Midcourse Review.
SOURCE: CDC/EPO, National Notifiable Disease Surveillance System, 1987-96

Pneumococcal and influenza immunizations for people 65 years and over



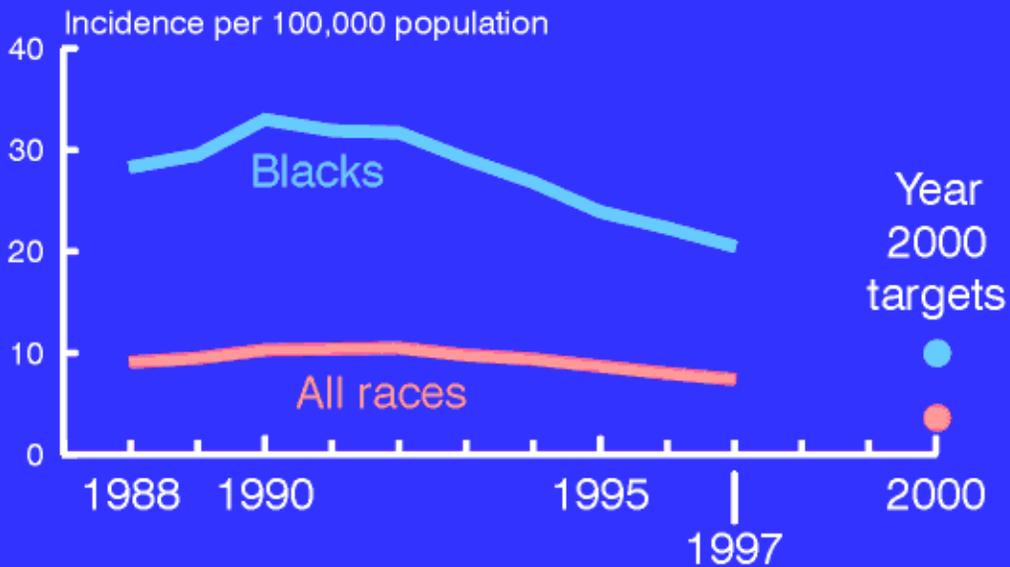
SOURCE: CDC/NCHS, National Health Interview Survey, 1989-95

Unintentional injury deaths



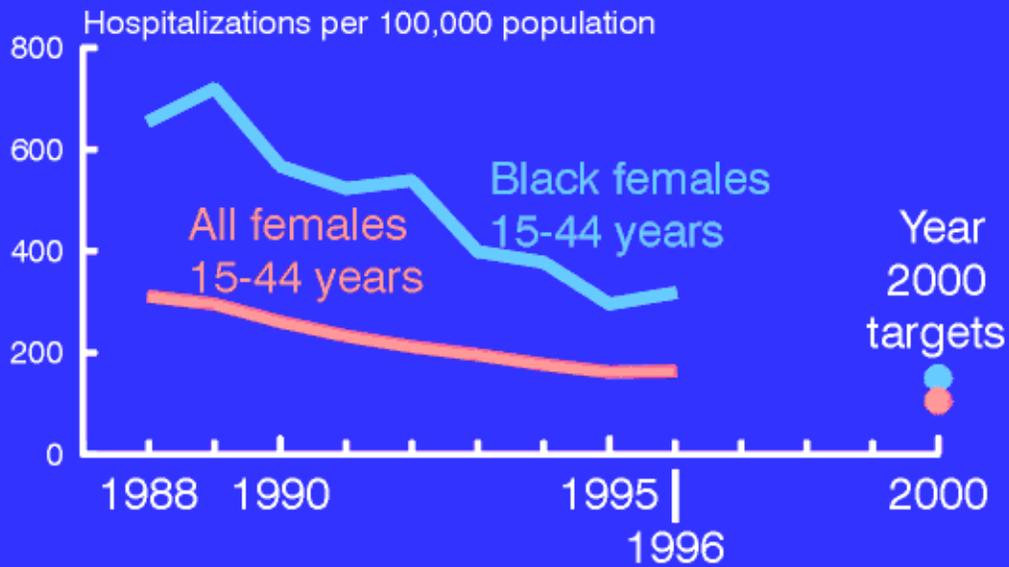
SOURCE: CDC/NCHS, National Vital Statistics System, 1987-96

Tuberculosis



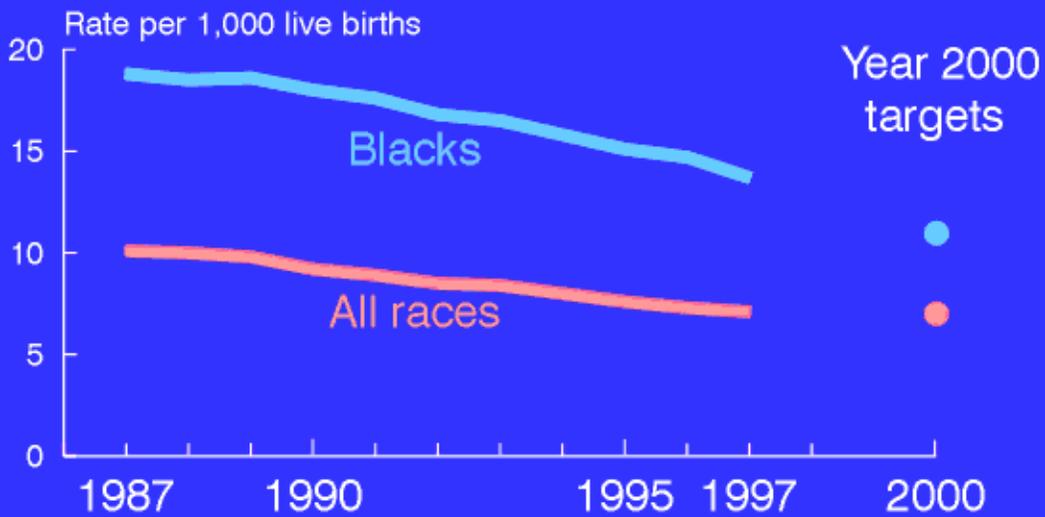
SOURCE: CDC/NCHSTP, Tuberculosis Morbidity Data, 1988-97

Pelvic inflammatory disease



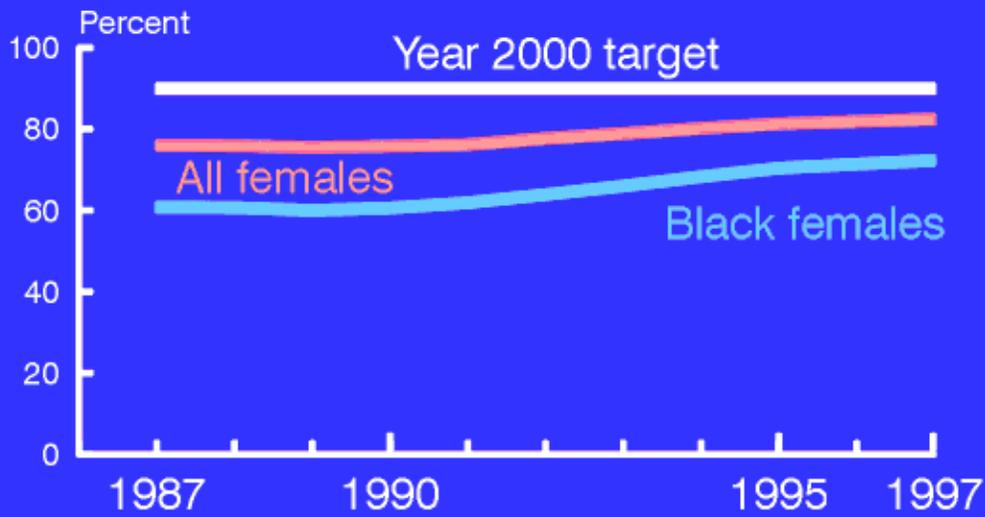
SOURCE: CDC/NCHS, National Hospital Discharge Survey, 1987-96

Infant mortality



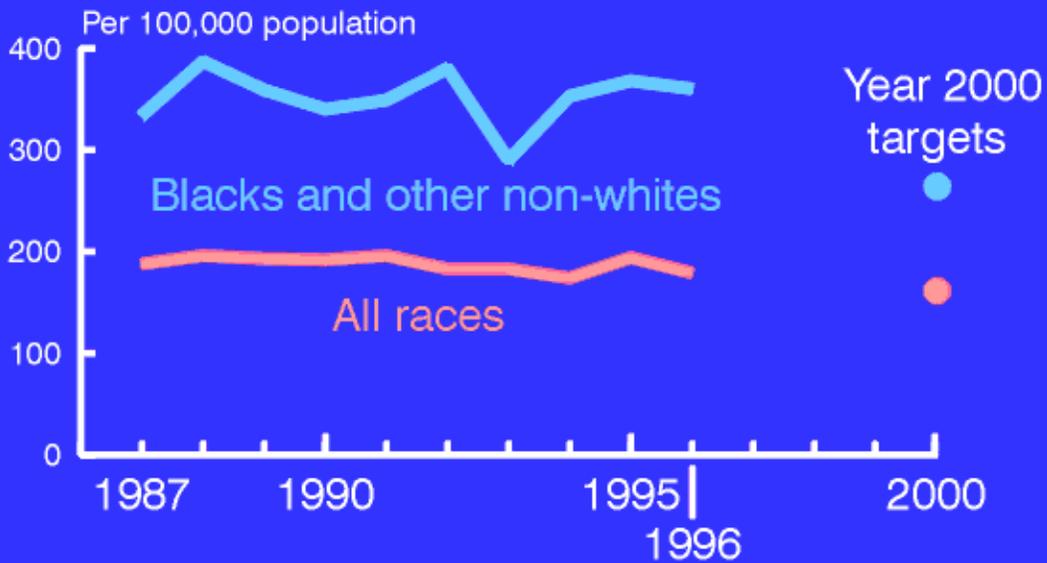
SOURCE: CDC/NCHS, National Vital Statistics System 1987-97

Early prenatal care



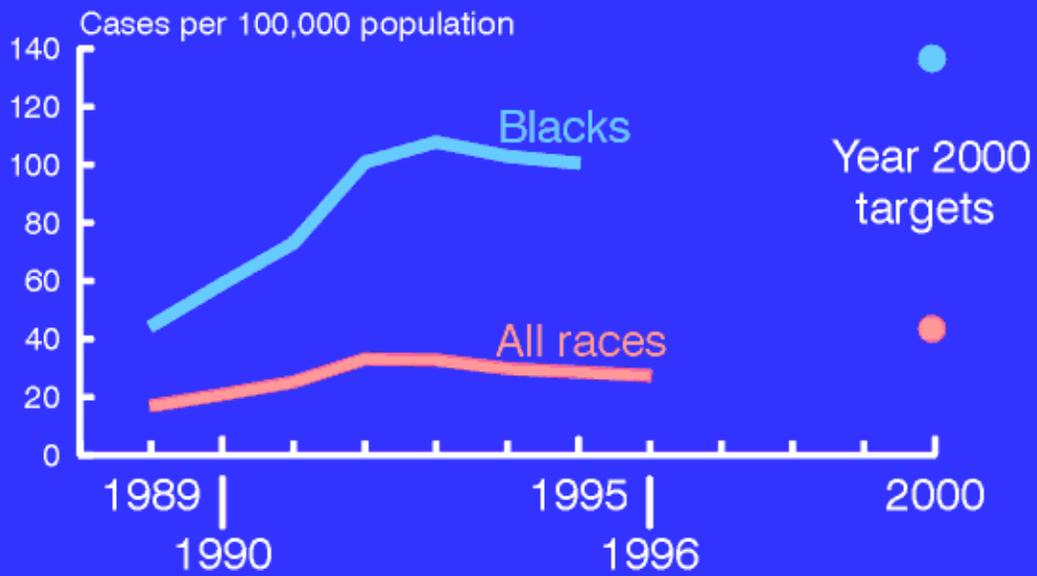
SOURCE: CDC/NCHS, National Vital Statistics System, 1987-97

Asthma hospitalizations

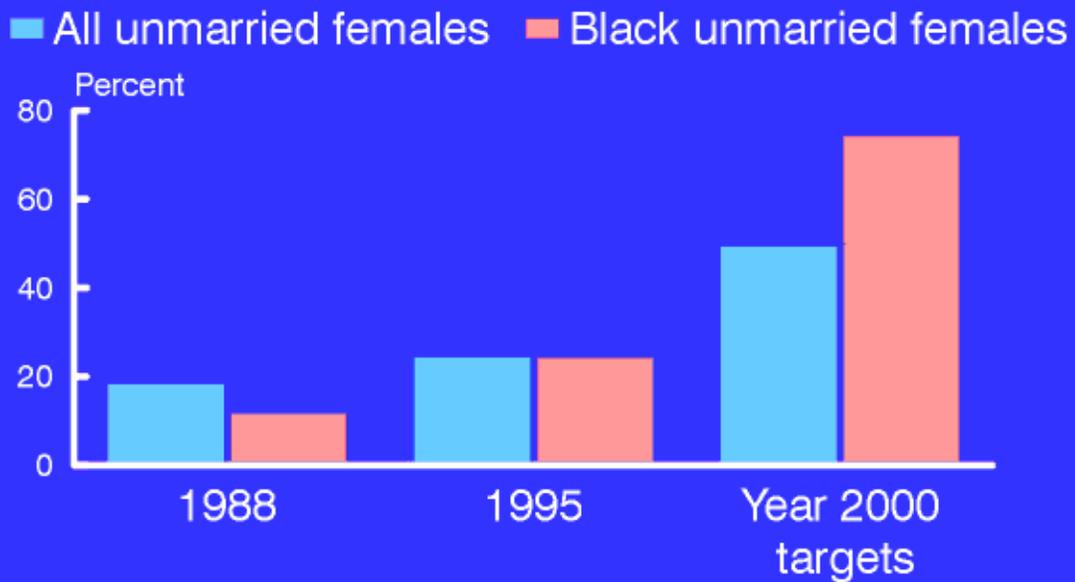


SOURCE: CDC/NCHS, National Hospital Discharge Survey, 1987-96

Slow the rise of AIDS incidence



Condom use at last sexual intercourse



eliminated.
**Disparity almost el

Selected State Profiles

Introduction

This section, the Healthy People 2000 Progress Review on Black Americans State Profiles, examines the progress of ten states in the context of the six health priority areas identified in the President's Race Initiative — coronary heart disease, diabetes, cancer, infant mortality, AIDS, and immunization, and two additional health areas that have a disproportionate impact on Black Americans — homicide and stroke. The states selected to illustrate progress towards the Healthy People 2000 objectives are five with the largest percent of Blacks — the District of Columbia (64.2 percent), Mississippi (35.9 percent), Louisiana (31.6 percent), South Carolina (30.1 percent), and Georgia (27.9 percent) and five with large concentrations of Blacks in urban areas — New York (17.5 percent), Illinois (14.5 percent), Florida (14.5 percent), Texas (12.2 percent), and California (7.7 percent).

Description of Data in Figures and Tables

Figures 1-8 and Tables 1-10 show trend data (except for vaccination coverage rates for which only one year is shown) comparing Blacks with the total population and the Black population in ten states. The data presented in this section were the most current state data (published and unpublished) available when the report was prepared. The six disease areas highlighted in the President's Race Initiative serve as the primary focus for the presentation of the trend data. Included are the age-adjusted

mortality rates per 100,000 population for coronary heart disease, stroke, diabetes, and cancer; mortality rates per 100,000 population for homicide in 15-34 year old men and women; infant mortality per 1,000 live births; AIDS cases reported per 100,000 population; vaccine coverage levels for the combined series of four or more doses of diphtheria, tetanus toxoids, and pertussis vaccine (DTP), three or more doses of polio vaccine, and one or more doses of MCV for children 19-35 months, and for three or more doses of Hepatitis B; and for influenza and pneumococcal vaccination coverage levels among persons \geq (greater than or equal to) 65 years of age.

Mortality rates for coronary heart disease, stroke, diabetes, cancer, infant mortality, and homicide were derived from the National Vital Statistics System. The adult and pediatric reported AIDS cases per 100,000 population were calculated using data by year of report from the Center for Disease Control and Prevention (CDC) HIV/AIDS Surveillance System. Blacks do not include persons of Hispanic origin. The AIDS figure and table do not adjust for the 1993 expansion of the AIDS surveillance case definition or for the lag in reporting cases. The Year 2000 objectives give incidence of cases and reflect cases reported by year of diagnosis. Thus, although similar, they are not the same as the estimates used in this section of the report. The reported case rates are computed as those published in the HIV/AIDS Surveillance Report. The AIDS reported case data are not age adjusted while the mortality data for coronary heart disease, stroke, diabetes, and cancer are age-adjusted. The homicide mortality rates are for ages 15 - 34 and are not age-adjusted and are comparable to the data in the 1997 Healthy People 2000 Progress Review.

The data on vaccine coverage levels for the combined series of four or more

doses of diphtheria, tetanus toxoids, and pertussis vaccine (DTP), three or more doses of polio vaccine, and one or more doses of MCV for children 19-35 months of age, and for three or more doses of Hepatitis B were calculated using the National Immunization Survey (NIS). Blacks may include persons of Hispanic origin in this report. The data on influenza and pneumococcal vaccination coverage levels among persons ≥ 65 years of age is from the Behavioral Risk Factor Surveillance System (BRFSS). Blacks do not include persons of Hispanic origin in this report. Both of these are telephone surveys. The BRFSS did not adjust for non-telephone coverage. The NIS did adjust for non-telephone coverage and nonresponse.

Five percent of all households in the US do not have telephones, however, 13 percent of Black American, 12 percent of Hispanic American, and 23 percent of Native American households are without telephones. Only 4 percent of white American and 2 percent of Asian American households are without telephones. Those households without telephones are more likely to be poor. Thus, if questions about estimates of factors related to poverty, which is true for both adult and childhood immunization, are asked in a survey the estimates will almost certainly be overestimated for Blacks and in general those racial/ethnic groups that are most disadvantaged. This will result in a differential bias that you cannot really adjust for without further household surveys. The sample sizes for Blacks in many states were inadequate to calculate state-specific estimates of vaccination levels from these two surveys. For the childhood coverage rates the ten profile states had sample sizes ranging from 73 in California to 249 for Louisiana. For the data on vaccine coverage levels among persons ≥ 65 years of age, five of the nine states selected had an inadequate sample size (as did most states) to

calculate state-specific estimates. No data were collected on adult immunizations in the BRFSS from persons in the District of Columbia.

When comparing Blacks with white Americans or with total Americans (the Healthy People 2000 objectives were given for the total population) it was found that in some states where Blacks and other minorities were a small proportion of the population the disparities between total population and African Americans were approximately equal to the disparities between the total population and the Black population. However, if the Black population was a higher proportion of the population, this tended to mitigate the difference between the total and Black population in that state. Thus, a state with a higher proportion of a minority group with poorer health outcomes will also show higher mortality rates and/or lower immunization rates compared to other states with a smaller percent of minorities.

Coronary Heart Disease

In 1980, the age-adjusted death rates for coronary heart disease (CHD) were identical for Blacks and whites. Although mortality rates have continued to decline for both, the rate of decline has been slower for Blacks, and therefore by 1994, the CHD death rate was 34 percent higher in Blacks than in whites. A review of data for the ten profile states reflect this trend. (See Figure 1, Table 1.) However, data for Illinois show an increase in the age-adjusted death rate for the state's Black population. The increase represents movement away from the Healthy People 2000 goal for Black Americans. Age-adjusted CHD death rates for New York, Mississippi, and California

are above the rate for US Blacks. The age-adjusted death rates for Georgia, South Carolina, and the District of Columbia are lower than the US age-adjusted rate for Blacks thus reflecting movement towards the Healthy People 2000 target for Black Americans. The decline in CHD deaths has been attributed to lifestyle changes and the rapid translation of promising research into public health programs that are adopted and implemented through public and private partnerships to benefit the public.

Stroke

Cerebrovascular disease (stroke) is the third leading cause of death in the US. It is also the third leading cause of death among Black women and the fifth leading cause of death among Black men. There are several risk factors for stroke, however, hypertension - often referred to as the “silent killer,” is more prevalent in Blacks.

While there were steep declines in stroke mortality in the 1970s and 1980s there was no decline between 1992-1995 in either US Blacks or US total population. The age-adjusted stroke death rates are higher in the southeastern US than in any other area of the country. Age-adjusted stroke death rates are also higher among Blacks in this part of the country. Consequently, the southeastern region of the US has been labeled the Stroke Belt. Several of the states featured in this profile are part of the Stroke Belt. An analysis of the 1992-1995 data presented in Figure 2 and Table 2 indicated that the decline in age-adjusted death rates was minimal for most states, thus lessening the progress toward the Healthy People 2000 target. However, New York not only experienced progress toward the Healthy People 2000 target for Black Americans,

but appears to be moving toward the target set for the US population. But the disparities in the Stroke Belt continue. The age-adjusted death rates for South Carolina and Georgia remain above the age-adjusted death rate for US Blacks. The age-adjusted death rate for Blacks in Mississippi increased between 1992-1995 indicating movement away from the Healthy People 2000 target.

Diabetes

The age-adjusted death rate for diabetes as a cause of death for Blacks was below the national age-adjusted death rates for Blacks in Georgia, Mississippi (with the exception of 1994), Florida, New York, and Texas (with the exception of 1993). In Illinois, the death rate was below the national age-adjusted rate for Blacks for three of the six years profiled, i.e., 1992, 1993, and 1995. In the District of Columbia (except for the base year 1990), South Carolina, and California the rates for Blacks were above the national average. While Louisiana made progress in 1995, its death rates were above the national average for the five years between 1990-1994. The southern states, i.e., the states with the highest proportion of Blacks were as likely to have diabetes mortality rates above the national average as the states with a large concentration of Blacks in urban areas.

Those states where the ratio of Black mortality to total mortality was slightly less were also states with a high proportion of Blacks. Thus, the total population mortality is higher for those states with a higher proportion of Blacks. In all these states the mortality rates for Blacks is approximately twice the mortality rates for whites.

South Carolina is the only state in the profile with an age-adjusted diabetes death

rate for Blacks and state total population that was consistently above the national average both for US total population and for US Blacks. By contrast, Georgia is the only state in the group with the highest proportion of Black population that was consistently below the national averages for both US total population and US Blacks. In 1995, the age-adjusted death rate for Georgia's total population was 40.1 vs. 41.6 for the US total population, and 70.2 for Georgia's Blacks vs. 76.2 for US Blacks. (See Figure 3, Table 3.)

The disparities shown in the state profiles for age-adjusted diabetes deaths indicate a lack of progress towards meeting the Healthy People 2000 objective of 58 deaths per 100,000 for the Black population. Neither do the profiles show progress towards closing the gap between Blacks and total population deaths. It is clear therefore, that unless decisive action is undertaken by federal, state, and local health officials to curtail the human suffering from this chronic and disabling condition, the burden of diabetes on the Black population and the country will continue to increase.

Cancer

Among men, overall cancer incidence rates are highest among Blacks. They also have higher incidence rates for cancers of the prostate, lung, and oral cavity than other groups. The leading cancer sites among Black women are the breast, colon and rectum, lung, corpus uteri, and cervix uteri. Obesity, a major risk factor for cancer, is more prevalent in Black women. During the past 50 years there has been a steady increase in the cancer mortality rate in the US. The age-adjusted rate in 1950 was 158

per 100,000 population. It rose to 172 in 1993. The major cause of this increase has been lung cancer. When lung cancer is excluded, cancer mortality shows a decline of 16 percent between 1950 and 1993.

The age-adjusted cancer death rate for Blacks are higher than the US population cancer death rate. The data in Figure 4 and Table 4 suggest movement toward the Healthy People 2000 target for Blacks. The age-adjusted death rate for Blacks in Mississippi and South Carolina were similar to the rate for US Blacks, but higher than the rates for their respective states or the US total population. Blacks in the District of Columbia, Louisiana, and Illinois experienced excess mortality compared to their respective states or the US total population. The rates were also higher than the national rate for US Blacks. The age-adjusted death rate for Blacks in New York were lower than the rate for Blacks nationally.

Infant Mortality

The rate of infant mortality is a major indicator of the health status of a population. It is related to socio-demographic and physiologic variables. It has been documented that infant mortality is affected by high risk behaviors of mothers, prenatal care, preterm delivery, and nutritional risk factors such as pre-pregnancy weight, gestational weight gain, and alcohol consumption.

The US infant mortality rate was examined for the period 1984 to 1996. The infant mortality rate for the Black population for selected states was compared to the total US population and the total Black population. (See Figure 5, Table 5.) Infant

mortality rates show a steady decline for both the U.S. (10.6 vs. 7.6) and for the Black population (19.0 vs. 15.2), but continues to be a serious public health problem. The US Black population infant mortality rate is still twice that of the total US population, except for a few states such as Texas (16.4 - 12.0), New York (17.1 - 13.6), and Florida (18.6 - 13.4). The infant mortality trends for Blacks in the District of Columbia (24.2 - 19.5) and Illinois (22.7 - 18.6) lag behind that of the US Black population. Infant mortality rates for Blacks in Mississippi (18.3 - 14.7), Louisiana (17.3 - 14.7), South Carolina (20.3 - 14.1), Georgia (18.9 - 15.4), and California (18.4 - 14.5) are comparable to the US Black population. For every state in the profile, the Black infant mortality rate is double (Mississippi and Texas) or more than double the white infant mortality rate.

The disparity in the infant death rates between Blacks and total US population is partially accounted for by the higher rate of preterm delivery. Other factors that may explain the disparity are quality of prenatal care, stress, education, socioeconomic status, environmental contaminants, and lack of access to quality health care.

AIDS

The September 17, 1997, MMWR reported that AIDS incidence (as measured by the number of cases diagnosed with AIDS using the 1993 definition criteria after adjustments for reporting delays) declined for the total US population. There was also a continued decline in AIDS deaths. The 1997 HIV/AIDS Surveillance Report indicate that most states and metropolitan statistical areas reported a decrease in the number of AIDS cases for 1997 compared to the number reported in 1996. The report also

describes the decline in AIDS incidence and in the continued decline of AIDS deaths and illustrates the distorting effect of the change in the case definition on AIDS incidence and deaths trends. These trends are no longer affected by the change in the disease definition but they are affected by HIV treatments. This same Surveillance Report also shows a decline in the AIDS cases reported in 1997 compared to 1996. The report states that the findings indicate that HIV therapies are having an impact on the rate of HIV disease progression in the US.

Figure 6 and Table 6 show similar distortions of the 1993 case definition in the adult and pediatric reported AIDS cases per 100,000 population. There are considerable variations in the reported AIDS cases per 100,000 population between states for both the state total population and state Blacks. For example, the rates for the total population in the District of Columbia and New York are more than three times greater than in Illinois for all years shown. The reported case rates for both total population and Blacks in the selected states are highest in the District of Columbia followed by New York, Florida, and California. The lowest rates were found in Mississippi, South Carolina, and Louisiana.

There are huge differences between the total state population and the Black population in every state thereby mirroring the national pattern. These differences are increasing and indicate a need for more targeted outreach and more effective prevention strategies in the Black community. Thus, while there has been success in slowing the rise in incidence of disease, no progress has been made in closing the huge disparities between the Black case rate and the total case rate. It is clear that the changing distribution and characteristics of the affected populations indicate the need to

monitor and detect changes in geographic, demographic, and risk trends. In addition to a need for resources to describe the changing epidemic, resources need to be allocated to target the Black population with prevention programs and for medical and other services for infected persons. These medical and other services will be especially important as more HIV therapies become available.

Homicide

Homicide is an epidemic that is destroying communities across the US at higher rates than in any other developed country in the world. Originally considered to be a problem for the criminal justice system, more recently homicide is being investigated by the public health sector as a cause of mortality that demands effective preventive measures. Homicide not only places a financial burden on the nation, it is claiming many of our youth and endangering the future of the nation. The national homicide death rate in 1995 was three times higher among Black women than among the total female population and four times higher among Black men than among the total male population. It is the leading cause of death for Black men age 15-34 years of age.

Among the ten states profiled in this report by gender, the trends vary. The 1995 rates for Black men in South Carolina (52) and Georgia (70.4) meet the Year 2000 goal (72.4). (See Figure 7, Table 7.) The rates for Black women in South Carolina (12.5), Florida (13.9) and New York (12.8) are below the Year 2000 goal (16.0) for U.S. Black women. (See Figure 8, Table 8.) While most other groups are moving toward the Year 2000 goal, the District of Columbia men and Illinois women are moving away from their

respective goals. Of the groups that are moving toward the Year 2000 objectives, only Mississippi men and women, Texas men and women, Georgia women, New York men, and Florida men either have reached or are moving at a rate that should enable them to meet the Year 2000 goal. Even among these groups, trends have been inconsistent between 1991 and 1995.

In comparison to the national trends for homicide death rates among Black women, South Carolina, Florida, New York, and Texas appear to have had lower rates and have shown greater improvement between 1993 and 1995. During that same period Black men in Georgia, Mississippi, South Carolina, Florida, and Texas have had homicide rates lower than the national rate for Black men. New York and Texas homicide rates for Black men are declining faster than the national rate for Black men.

Homicide is a very complex public health issue because the factors that contribute to it are diverse. Its roots are embedded in many of the dysfunctions in our broader society (ie. poverty, inferior community services, poorer quality education, unemployment, racism, discrimination, and hopelessness) as well as other psychological, environmental, and lifestyle problems.

Immunizations

The data on vaccine coverage levels for the combined series of four or more doses of diphtheria, tetanus toxoids, and pertussis vaccine (DTP), three or more doses of polio vaccine, and one or more doses of MCV for children 19-35 months of age and for children receiving 3 or more doses of Hepatitis B (Table 9) indicate that progress is

being made toward reaching the goal of 90 percent immunization coverage by the Year 2000. Coverage rates have increased or remained stable for all racial and ethnic groups. There are, however still large differences between vaccine coverage for those at or above the poverty level and those below the poverty level for every racial/ethnic group. Some states, those with the highest proportion of Blacks (Georgia, Louisiana, Mississippi, and South Carolina) show similar vaccine coverage levels in their state for Blacks and the total population as did California. Immunization rates for Hepatitis B especially are quite high, although some states still show somewhat lower rates of coverage in Blacks than for the total population, e.g. Illinois, New York, and Texas.

While much progress has also been made for immunization of older persons, there are significant differences between Blacks and the total population in every state for which data were available and for the total US. (See Table 10.) Again many factors, poverty, lack of access to health providers, and differences in quality of health care provided to minority patients are related to these differences in vaccination coverage between Blacks and the total populations.

To ensure that all population groups receive the benefits of vaccination, we will need to have adequate sample sizes on vaccination coverage for each racial/ethnic group in each state because states vary not only in total state coverage rates but also in the coverage rates between nonminority and minority groups. At a minimum these data need to be shown for each state and then resources need to be made available to eliminate the disparities in vaccination coverage between minorities and nonminorities.

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TABLE 13.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA ESTIMATED
PREVALENCE AND RELEVANT STATISTICS FOR EVER SMOKED*

DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED

BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL	
ALABAMA	450	31.5	2.8	(26.0	36.9)
ARKANSAS	210	32.5	4.4	(23.9	41.1)
CALIFORNIA	210	45.7	3.8	(38.2	53.2)
COLORADO	50	48.1	7.8	(32.7	63.4)
CONNECTICUT	128	47.9	4.6	(39.0	56.9)
DELAWARE	411	42.4	2.9	(36.7	48.1)
DISTRICT OF CO	983	32.6	1.8	(29.2	36.1)
FLORIDA	370	28.1	2.7	(22.8	33.4)
GEORGIA	590	25.4	2.1	(21.2	29.5)
ILLINOIS	334	44.8	3.1	(38.8	50.8)
INDIANA	143	46	4.9	(36.4	55.5)
KANSAS	118	33.2	4.9	(23.6	42.8)
KENTUCKY	251	49.3	4	(41.6	57.0)
LOUISIANA	406	33.4	2.7	(28.1	38.7)
MARYLAND	852	38.9	2	(35.0	42.9)
MASSACHUSETTS	72	37.8	7.8	(22.5	53.1)
MICHIGAN	298	44	3.3	(37.6	50.5)
MINNESOTA	116	40.7	5	(30.8	50.5)
MISSISSIPPI	472	33	2.7	(27.7	38.3)
MISSOURI	225	51.5	4.5	(42.7	60.3)
NEBRASKA	188	39.9	4.4	(31.2	48.6)
NEVADA	90	50.3	9.3	(32.0	68.5)

NEW JERSEY	269	39.2	3.4	(32.4	45.9)
NEW YORK	459	38.3	2.7	(33.0	43.6)
NORTH CAROLINA	753	39.2	2.2	(34.9	43.4)
OHIO	436	42.5	3	(36.7	48.3)
OKLAHOMA	115	41.7	5.3	(31.3	52.0)
PENNSYLVANIA	288	42.2	3.5	(35.4	49.0)
RHODE ISLAND	60	42.3	8	(26.7	58.0)
SOUTH CAROLINA	570	33.8	2.3	(29.3	38.3)
TENNESSEE	436	30.3	2.8	(24.8	35.8)
TEXAS	233	33.9	3.6	(26.8	40.9)
VIRGINIA	576	39.2	2.8	(33.8	44.7)
WASHINGTON	75	49	11.6	(26.2	71.8)
WEST VIRGINIA	53	39.7	7.3	(25.5	54.0)
WISCONSIN	62	40.4	8.5	(23.8	57.1)
PUERTO RICO	170	33.4	4	(25.5	41.3)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 37 MEDIAN = 39.7 RANGE = 25.4-51.5

* SMOKED AT LEAST 100 CIGARETTES IN LIFETIME

September 29, 1998

TABLE 14.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR CURRENT SMOKERS*
 DENOMINATOR EXCLUDES MISSING, DON'T KNOW AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL
ALABAMA	450	16.1	2.2	(11.9 20.4)
ARKANSAS	210	19.8	4.1	(11.8 27.8)
CALIFORNIA	210	26.3	3.4	(19.6 32.9)
COLORADO	50	23.2	6.5	(10.4 35.9)
CONNECTICUT	128	36.3	4.2	(28.1 44.6)
DELAWARE	411	24.9	2.7	(19.5 30.2)
DISTRICT OF CO	982	20.1	1.5	(17.1 23.0)
FLORIDA	370	17.3	2.3	(12.8 21.8)
GEORGIA	590	17.4	1.8	(13.9 20.9)
ILLINOIS	334	24.2	2.7	(19.0 29.4)
INDIANA	143	26.8	4.2	(18.6 34.9)
KANSAS	118	21.9	4.4	(13.4 30.5)
KENTUCKY	251	33	3.6	(25.8 40.1)
LOUISIANA	406	19.8	2.5	(14.9 24.6)
MARYLAND	852	20.6	1.6	(17.4 23.8)
MASSACHUSETTS	70	15.4	4.2	(7.2 23.8)
MICHIGAN	298	24.4	2.8	(18.9 29.9)
MINNESOTA	116	28.6	4.6	(19.6 37.6)
MISSISSIPPI	472	17.6	2.1	(13.5 21.8)
MISSOURI	225	38.4	4.3	(30.0 46.8)
NEBRASKA	188	26.2	3.9	(18.5 33.9)
NEVADA	90	25.6	8.5	(8.9, 42.3)
NEW JERSEY	269	23.5	2.9	(17.9 29.1)

NEW YORK	459	22.9	2.3	(18.3	27.4)
NORTH CAROLINA	753	26.3	2	(22.3	30.3)
OHIO	436	25.7	2.5	(20.8	30.6)
OKLAHOMA	115	24.5	4.6	(15.5	33.5)
PENNSYLVANIA	288	32.8	3.3	(26.3	39.3)
RHODE ISLAND	60	29.1	8.1	(13.1	45.0)
SOUTH CAROLINA	570	19.4	2	(15.5	23.4)
TENNESSEE	436	20.3	2.5	(15.4	25.3)
TEXAS	233	25.2	3.4	(18.5	31.8)
VIRGINIA	576	21.9	2.1	(17.8	26.0)
WASHINGTON	75	33.4	12.4	(9.0	57.8)
WEST VIRGINIA	53	19.6	5.8	(8.1	31.0)
WISCONSIN	62	17.5	5.1	(7.5	27.4)
PUERTO RICO	170	17.8	3.5	(11.0	24.6)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 37 MEDIAN = 23.5 RANGE = 15.4-38.4 YEAR 2000 OBJ. 3.4

* A CURRENT SMOKER (EVERYDAY OR SOME DAYS)

September 29, 1998

TABLE 23.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR FLU SHOT*
 DENOMINATOR EXCLUDES MISSING, DON'T KNOW AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL
ALABAMA	88	54.8	6.7	(41.8 67.9)
DELAWARE	54	61.8	7.3	(47.5 76.1)
DISTRICT OF COL	183	49.2	4.2	(41.0 57.4)
GEORGIA	60	38.1	6.6	(25.2 51.1)
LOUISIANA	57	55.6	6.9	(42.0 69.2)
MARYLAND	101	46.2	6.2	(34.0 58.4)
MISSISSIPPI	86	44.2	6.3	(32.0 56.5)
NORTH CAROLINA	124	44.5	5.1	(34.4 54.5)
OHIO	104	58.4	6.5	(45.8 71.1)
SOUTH CAROLINA	104	71.5	4.6	(62.4 80.5)
TENNESSEE	61	46.6	7.5	(31.9 61.2)
VIRGINIA	67	43.3	8.2	(27.3 59.4)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 12 MEDIAN = 47.9 RANGE = 38.1-71.5 YEAR 2000 OBJ.
 20.11

* HAD FLU SHOT WITHIN PAST 12 MONTHS, AGE 65 AND OVER

September 29, 1998

TABLE 41.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR MAMMOGRAM - FEMALES*
 DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL	
ALABAMA	191	82.4	3.2	(76.1	88.6)
ARKANSAS	88	56.7	6.1	(44.7	68.6)
DELAWARE	151	91.1	2.5	(86.1	96.0)
DISTRICT OF CO	368	86.6	1.8	(83.1	90.1)
FLORIDA	115	90.3	2.8	(84.8	95.8)
GEORGIA	180	78.9	3.6	(71.8	85.9)
ILLINOIS	116	88.3	3.2	(82.0	94.6)
KENTUCKY	87	71.3	5	(61.6	81.0)
LOUISIANA	132	80.7	3.9	(73.0	88.4)
MARYLAND	282	85.6	2.7	(80.2	91.0)
MICHIGAN	104	81.4	4.4	(72.7	90.0)
MISSISSIPPI	189	66.7	3.9	(59.1	74.3)
MISSOURI	82	88.5	4.4	(80.0	97.1)
NEBRASKA	67	86	4.6	(76.9	95.1)
NEW JERSEY	84	83.9	4.3	(75.6	92.2)
NEW YORK	156	90	2.2	(85.7	94.4)
NORTH CAROLINA	279	84.6	2.6	(79.5	89.8)
OHIO	171	84.3	4.6	(75.3	93.3)
PENNSYLVANIA	94	89.6	3.2	(83.3	95.8)
SOUTH CAROLINA	217	84.7	2.7	(79.4	90.0)
TENNESSEE	143	71.6	4.6	(62.6	80.7)
TEXAS	76	81	5.4	(70.3	91.6)

VIRGINIA 211 88.7 2.4 (84.0 93.3)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 23 MEDIAN = 84.6 RANGE = 56.7-91.1

* EVER HAD A MAMMOGRAM, FEMALES AGE 40 AND OLDER September 30, 1998

TABLE 42.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR MAMMOGRAM - FEMALES*

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL
ALABAMA	188	65.6	4	(57.8 73.5)
ARKANSAS	86	46.1	6.2	(33.9 58.3)
DELAWARE	150	78.3	3.7	(71.1 85.6)
DISTRICT OF CO	366	77.3	2.3	(72.8 81.8)
FLORIDA	113	78.9	4.1	(70.8 87.0)
GEORGIA	179	63.9	4.2	(55.7 72.1)
ILLINOIS	116	71.1	4.8	(61.7 80.4)
KENTUCKY	87	64.9	5.3	(54.6 75.3)
LOUISIANA	129	72.2	4.6	(63.2 81.1)
MARYLAND	278	78.9	3	(73 84.8)
MICHIGAN	103	74.7	4.8	(65.3 84.1)
MISSISSIPPI	187	56.9	4	(49.2 64.7)
MISSOURI	80	76.8	5.9	(65.2 88.3)
NEBRASKA	67	74	6.2	(61.9 86.1)
NEW JERSEY	83	73.2	5.5	(62.3 84.0)
NEW YORK	156	81.4	3.2	(75.1 87.7)
NORTH CAROLINA	276	75.5	3	(69.7 81.3)
OHIO	171	75.1	5.1	(65 85.2)
PENNSYLVANIA	92	85.7	3.6	(78.7 92.8)
SOUTH CAROLINA	214	70.3	3.5	(63.5 77.1)
TENNESSEE	142	60.8	4.8	(51.5 70.2)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 23 MEDIAN = 74.0 RANGE = 46.1-85.7

* HAD A MAMMOGRAM WITHIN TWO YEARS AGE 40 AND OVER

October 1, 1998

TABLE 44.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR BREAST EXAM - FEMALES*
 DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL	
ALABAMA	190	83	3	(77.1	88.9)
ARKANSAS	86	74.4	5.1	(64.5	84.4)
CALIFORNIA	62	96.1	2	(91.6	100)
DELAWARE	151	96.3	1.9	(92.7	99.9)
DISTRICT OF CO	368	93.7	1.3	(91.1	96.3)
FLORIDA	115	86.3	3.1	(80.2	92.4)
GEORGIA	179	88.8	2.7	(83.6	94.0)
ILLINOIS	116	91.6	2.5	(86.7	96.6)
KENTUCKY	87	89.4	3.3	(82.9	95.9)
LOUISIANA	132	84	3.8	(76.7	91.4)
MARYLAND	281	96.3	1.2	(94.0	98.7)
MICHIGAN	104	89.6	3.4	(82.9	96.4)
MISSISSIPPI	188	80.8	3.1	(74.6	86.9)
MISSOURI	82	92.5	3.4	(85.8	99.1)
NEBRASKA	68	89	4	(81.1	96.8)
NEW JERSEY	83	88.4	4.1	(80.5	96.4)
NEW YORK	155	91.9	2.7	(86.5	97.3)
NORTH CAROLINA	280	92.8	1.7	(89.5	96.1)
OHIO	170	92.5	2.2	(88.2	96.9)
PENNSYLVANIA	94	81.3	5	(71.5	91.1)
SOUTH CAROLINA	217	91.3	2.2	(86.9	95.6)
TENNESSEE	143	87.2	3.2	(81.0	93.4)

TEXAS	75	93.1	3.5	(86.3	99.9)
VIRGINIA	209	85.2	3	(79.3	91.0)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 24 MEDIAN = 89.5 RANGE = 74.4-96.3

* EVER HAD A BREAST EXAM BY A DOCTOR, FEMALES AGE 40 AND OLDER September 30, 1998

TABLE 45.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR BREAST EXAM - FEMALES*
 DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL	
ALABAMA	118	73	4.2	(64.7	81.3)
ARKANSAS	50	57.6	7.8	(42.2	73.0)
DELAWARE	98	84.3	4.1	(76.2	92.4)
DISTRICT OF CO	240	82.2	2.7	(76.9	87.4)
FLORIDA	64	76.6	5.3	(66.1	87.0)
GEORGIA	97	78.7	4.3	(70.2	87.1)
ILLINOIS	73	79.5	4.8	(70.2	88.8)
KENTUCKY	56	73.2	6.4	(60.7	85.7)
LOUISIANA	74	72.6	6.2	(60.4	84.7)
MARYLAND	153	83.9	3.7	(76.6	91.1)
MICHIGAN	50	71.8	6.9	(58.3	85.4)
MISSISSIPPI	122	59.4	5.3	(49.1	69.7)
MISSOURI	52	79.2	7	(65.5	92.9)
NEW YORK	80	90.4	4.1	(82.3	98.4)
NORTH CAROLINA	174	82.2	3.4	(75.7	88.8)
OHIO	131	87.5	3.3	(81.1	93.9)
PENNSYLVANIA	63	78.6	6.5	(65.8	91.4)
SOUTH CAROLINA	137	75.7	4	(67.8	83.6)
TENNESSEE	86	79.3	5	(69.6	89.0)
VIRGINIA	127	71.7	4.8	(62.2	81.2)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 20 MEDIAN = 78.6 RANGE = 57.6-90.4

* HAD A BREAST EXAM WITHIN TWO YEARS, AGE 50 AND OVER

September 30, 1998

TABLE 48.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR PAP SMEAR*
 DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL
ALABAMA	322	98.5	0.7	(97.1 99.8)
ARKANSAS	134	93.2	2.3	(88.7 97.7)
CONNECTICUT	86	84.4	1.3	(81.8 86.9)
DELAWARE	270	97.1	1.6	(93.9 100)
DISTRICT OF CO	654	96.4	0.8	(94.7 98.0)
FLORIDA	242	95.1	1.5	(92.1 98.0)
GEORGIA	378	96.7	1	(94.7 98.8)
ILLINOIS	222	96.4	1.4	(93.8 99.1)
INDIANA	87	97	2.4	(92.3 100)
KANSAS	70	99.1	0.9	(97.4 100)
KENTUCKY	166	95.7	1.6	(92.6 98.8)
LOUISIANA	277	95.1	1.4	(92.3 97.8)
MARYLAND	535	95.7	0.9	(93.9 97.6)
MICHIGAN	203	94.1	2.1	(89.9 98.2)
MINNESOTA	56	93	3.6	(86.0 99.9)
MISSISSIPPI	336	96	1	(94.0 97.9)
MISSOURI	152	95.1	2.6	(90.0 100)
NEBRASKA	124	95.1	2.6	(90.1 100)
NEW JERSEY	179	90.4	2.4	(85.6 95.2)
NEW YORK	307	96.1	1.1	(94.0 98.2)
NORTH CAROLINA	500	94.5	1.3	(91.9 97.1)
OHIO	282	95.3	1.3	(92.7 97.9)

OKLAHOMA	68	97.5	2.1	(93.4	100)
PENNSYLVANIA	185	94.3	2	(90.4	98.2)
SOUTH CAROLINA	392	97.7	0.8	(96.1	99.3)
TENNESSEE	306	95	1.5	(92.1	97.9)
TEXAS	155	96.4	2.1	(92.4	100)
VIRGINIA	395	97.4	1.1	(95.3	99.6)
PUERTO RICO	75	81.1	6	(69.3	92.8)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 29 MEDIAN = 95.7 RANGE = 81.1-99.1 YEAR 2000 OBJ
16.11

* EVER HAD A PAP SMEAR, AGE 18 AND OLDER

September 30, 1998

TABLE 50.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR LAST PAP SMEAR*
WITH UTERINE CERVIX
BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL	
ALABAMA	219	91	1.9	(87.2	94.7)
ARKANSAS	100	83.7	4.1	(75.7	91.7)
CONNECTICUT	70	69.9	4.7	(60.8	79.0)
DELAWARE	208	91.7	2.4	(87.0	96.5)
DISTRICT OF CO	558	91.9	1.3	(89.5	94.4)
FLORIDA	196	88.7	2.4	(83.9	93.5)
GEORGIA	303	94.4	1.4	(91.8	97.1)
ILLINOIS	178	91.3	2.2	(86.9	95.6)
INDIANA	67	97	3	(91.2	100)
KANSAS	58	96.4	2.7	(91.1	100)
KENTUCKY	123	90.1	2.8	(84.7	95.5)
LOUISIANA	208	91.3	2.1	(87.2	95.5)
MARYLAND	432	93.3	1.2	(91.0	95.7)
MICHIGAN	163	88.9	2.9	(83.2	94.6)
MISSISSIPPI	251	87.3	2.1	(83.3	91.4)
MISSOURI	119	87.8	4.2	(79.5	96.2)
NEBRASKA	90	86.3	4.4	(77.5	95.0)
NEW JERSEY	149	83.7	3.6	(76.7	90.7)
NEW YORK	266	92.6	1.9	(88.9	96.2)
NORTH CAROLINA	368	87.6	2	(83.7	91.6)
OHIO	205	91.2	2.3	(86.6	95.8)
PENNSYLVANIA	151	92.9	1.9	(89.2	96.6)

SOUTH CAROLINA	302	93	1.7	(89.7	96.3)
TENNESSEE	237	89.4	2.3	(84.9	93.9)
TEXAS	123	88.1	3.6	(81.1	95.2)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 27 MEDIAN = 91.0 RANGE = 69.9-97.0

* LAST PAP SMEAR WITHIN LAST 3 YEARS, AGE 18 AND OLDER

October 1, 1998

TABLE 57.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
ESTIMATED PREVALENCE AND RELEVANT STATISTICS
FOR BMI GREATER THAN / EQUAL TO "25.0" BODY MASS INDEX*
DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED
BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL
ALABAMA	427	69.9	2.7	(64.7 75.1)
ARKANSAS	196	60	4.3	(51.5 68.5)
CALIFORNIA	209	60.7	3.7	(53.4 68.1)
CONNECTICUT	119	66.3	6.3	(53.9 78.6)
DELAWARE	394	63.3	2.8	(57.9 68.7)
DISTRICT OF CO	973	63.9	1.8	(60.3 67.5)
FLORIDA	360	60.4	3	(54.6 66.2)
GEORGIA	570	66.3	2.5	(61.4 71.3)
ILLINOIS	321	65.9	3.1	(59.8 72.1)
INDIANA	140	67.1	5	(57.3 76.9)
KANSAS	104	58.4	5.3	(47.9 68.9)
KENTUCKY	245	67.9	3.4	(61.2 74.5)
LOUISIANA	388	64.3	2.9	(58.6 70.1)
MARYLAND	800	63.5	2.1	(59.4 67.6)
MASSACHUSETTS	68	59.2	8	(43.6 74.8)
MICHIGAN	289	67.2	3.1	(61.1 73.3)
MINNESOTA	114	62.5	4.9	(52.9 72.2)
MISSISSIPPI	442	72	2.6	(66.8 77.1)
MISSOURI	217	61.7	4.3	(53.4 70.0)
NEBRASKA	178	68.1	4.6	(59.1 77.2)
NEVADA	88	45.6	9.6	(26.8 64.3)

NEW JERSEY	255	71.6	3.3	(65.1	78.1)
NEW YORK	441	60.5	2.8	(55.0	66.0)
NORTH CAROLINA	687	65.1	2.2	(60.8	69.3)
OHIO	415	69.6	2.8	(64.1	75.0)
OKLAHOMA	109	48.5	5.1	(38.6	58.4)
PENNSYLVANIA	278	62.2	3.4	(55.6	68.8)
RHODE ISLAND	56	67.2	8.2	(51.1	83.3)
SOUTH CAROLINA	548	66.8	2.4	(62.0	71.5)
TENNESSEE	411	60.9	3	(55.1	66.8)
TEXAS	224	59	3.7	(51.8	66.3)
VIRGINIA	547	70.3	2.7	(65.1	75.6)
WASHINGTON	69	71.1	5.5	(60.3	81.8)
WEST VIRGINIA	51	72.3	7.2	(58.2	86.4)
WISCONSIN	62	75	6.3	(62.6	87.3)
PUERTO RICO	163	63	4.2	(54.7	71.3)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 36 MEDIAN = 64.7 RANGE = 45.6-75.0 YEAR 2000 OBJ.
2.3

* BODY MASS INDEX GE 25.0 FOR MALES AND FEMALES

September 30, 1998

TABLE 6.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR NO HEALTH INSURANCE*
 DENOMINATOR IS PERSONS AGE 18-64 YEARS
 DENOMINATOR EXCLUDES MISSING DON'T KNOW AND REFUSED
 BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL	
ALABAMA	357	28.1	2.7	(22.9	33.3)
ARKANSAS	171	28	4.3	(19.6	36.4)
CALIFORNIA	187	13	2.8	(7.6	18.4)
CONNECTICUT	114	18.4	3.9	(10.8	26.1)
DELAWARE	356	22.7	2.9	(17.0	28.3)
DISTRICT OF CO	795	14.3	1.6	(11.3	17.4)
FLORIDA	325	24.3	2.8	(18.7	29.9)
GEORGIA	527	16	2.2	(11.7	20.3)
ILLINOIS	289	17.2	2.5	(12.4	22.0)
INDIANA	126	19.4	3.9	(11.8	27.0)
KANSAS	100	6.8	2.9	(1.2	12.4)
KENTUCKY	212	18.1	3.4	(11.6	24.7)
LOUISIANA	343	38.9	3.2	(32.7	45.1)
MARYLAND	742	17.8	1.8	(14.3	21.2)
MASSACHUSETTS	65	15.9	4.9	(6.3	25.4)
MICHIGAN	259	16.1	2.9	(10.4	21.8)
MINNESOTA	109	10.9	3.2	(4.7	17.2)
MISSISSIPPI	380	24.8	2.7	(19.6	30.0)
MISSOURI	192	23.6	3.7	(16.3	30.9)
NEBRASKA	153	16.2	3.4	(9.4	22.9)
NEVADA	81	6.7	3.9	(0	14.3)

NEW JERSEY	238	15.8	2.6	(10.7	21.0)
NEW YORK	413	23.7	2.6	(18.7	28.7)
NORTH CAROLINA	625	22.4	2.1	(18.2	26.6)
OHIO	331	14.9	2.6	(9.8	20.1)
OKLAHOMA	94	19	4.9	(9.5	28.6)
PENNSYLVANIA	244	17.5	2.8	(12.0	23.0)
SOUTH CAROLINA	458	26.5	2.7	(21.2	31.8)
TENNESSEE	367	15.8	2.5	(10.9	20.7)
TEXAS	211	25.1	3.5	(18.3	31.8)
VIRGINIA	506	18.9	2.7	(13.7	24.1)
WASHINGTON	67	11.1	3.7	(3.8	18.3)
WISCONSIN	59	39.3	9.2	(21.3	57.3)
PUERTO RICO	143	16.1	3.7	(8.8	23.3)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 34 MEDIAN = 18.0 RANGE = 6.7-39.3 YEAR 2000
OBJECTIVE 21.4

* HAVING NO HEALTH CARE PLAN

September 29, 1998

TABLE 1.1 1997 BEHAVIORAL RISK FACTOR SURVEILLANCE DATA
 ESTIMATED PREVALENCE AND RELEVANT STATISTICS FOR SELF REPORTED HEALTH
 STATUS*

DENOMINATOR EXCLUDES MISSING, DON'T KNOW, AND REFUSED

BLACK POPULATION ONLY

PARTICIPANT	SAMPLE SIZE	PERCENT	STANDARD ERROR	95% CONFIDENCE INTERVAL
ALABAMA	448	25.2	2.6	(20.1, 30.2)
ARKANSAS	209	30.5	4.5	(21.8, 39.2)
CALIFORNIA	210	19.2	3.1	(13.2, 25.1)
COLORADO	51	16.6	5.8	(5.3, 27.8)
CONNECTICUT	129	10.6	3.2	(4.4, 16.8)
DELAWARE	408	22	2.8	(16.5, 27.4)
DISTRICT OF CO	981	13.4	1.3	(10.8 15.9)
FLORIDA	368	26	2.6	(20.9 31.1)
GEORGIA	589	12.4	1.7	(9.1 15.8)
ILLINOIS	332	15.2	2.2	(10.9 19.4)
KANSAS	118	9.9	2.8	(4.4 15.3)
KENTUCKY	253	4.3	2.9	(18.5 30.1)
LOUISIANA	405	20.5	2.2	(16.2 24.8)
MARYLAND	853	13.5	1.4	(10.8 16.1)
MASSACHUSETTS	71	13.8	4.2	(5.6 22.0)
MICHIGAN	297	23.2	2.8	(17.7 28.7)
MINNESOTA	116	11.8	3.1	(5.8 17.8)
MISSISSIPPI	473	28.4	2.4	(23.6 33.1)
MISSOURI	225	20	3.3	(13.6 26.5)
NEBRASKA	190	20	3.4	(13.3 26.7)
NEVADA	90	18.6	6.5	(5.8 31.3)

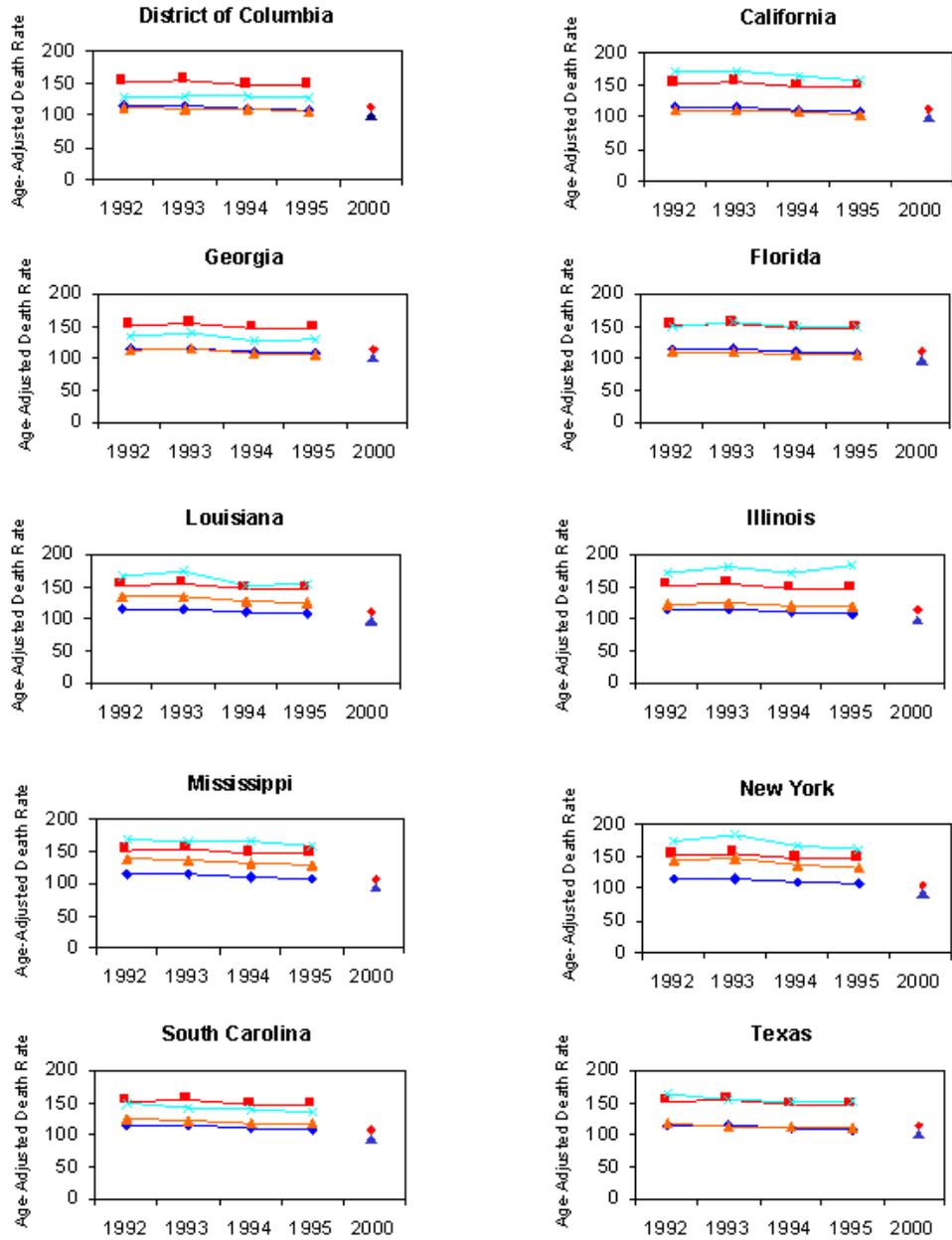
NEW JERSEY	269	23.9	3.1	(17.9 30.0)
NEW YORK	461	19.8	2.1	(15.7 24.0)
NORTH CAROLINA	759	19.7	1.6	(16.5 22.8)
OHIO	436	18.9	2.6	(13.9 23.9)
OKLAHOMA	115	15.6	3.4	(8.9 22.3)
PENNSYLVANIA	288	17.9	2.7	(12.6 23.1)
RHODE ISLAND	60	18.8	5	(9.1 28.5)
SOUTH CAROLINA	571	21.1	2.2	(16.9 25.4)
TENNESSEE	434	20.6	2.2	(16.3 24.8)
TEXAS	235	18.5	2.8	(13 23.9)
VIRGINIA	573	17.6	2	(13.7 21.5)
WASHINGTON	75	13.5	4	(5.7 21.3)
WEST VIRGINIA	53	26	6.9	(12.5 39.5)
WISCONSIN	63	14.2	4.5	(5.3 23.1)
PUERTO RICO	170	30.1	3.8	(22.7 37.6)

SUMMARY STATISTICS: NO. OF PARTICIPANTS = 37 MEDIAN = 19.2 RANGE = 9.9-30.5

* HEALTH STATUS IS FAIR OR POOR

September 29, 1998

Fig. 1. Age-Adjusted Death Rate per 100,000 Population for Coronary Heart Disease, U.S. and Selected States



Legend

- ◆ U.S. Total Population
- U.S. Blacks
- ▲ State Total Population
- × State Blacks
- ▲ Year 2000 Goal (Total Population)
- ◆ Year 2000 Goal (Blacks)

Source: CDC/NCHS, National Vital Statistics System, Data computed by Division of Health Promotion Statistics

Fig. 2. Age-Adjusted Death Rate per 100,000 Population for Stoke, U.S. and Selected States

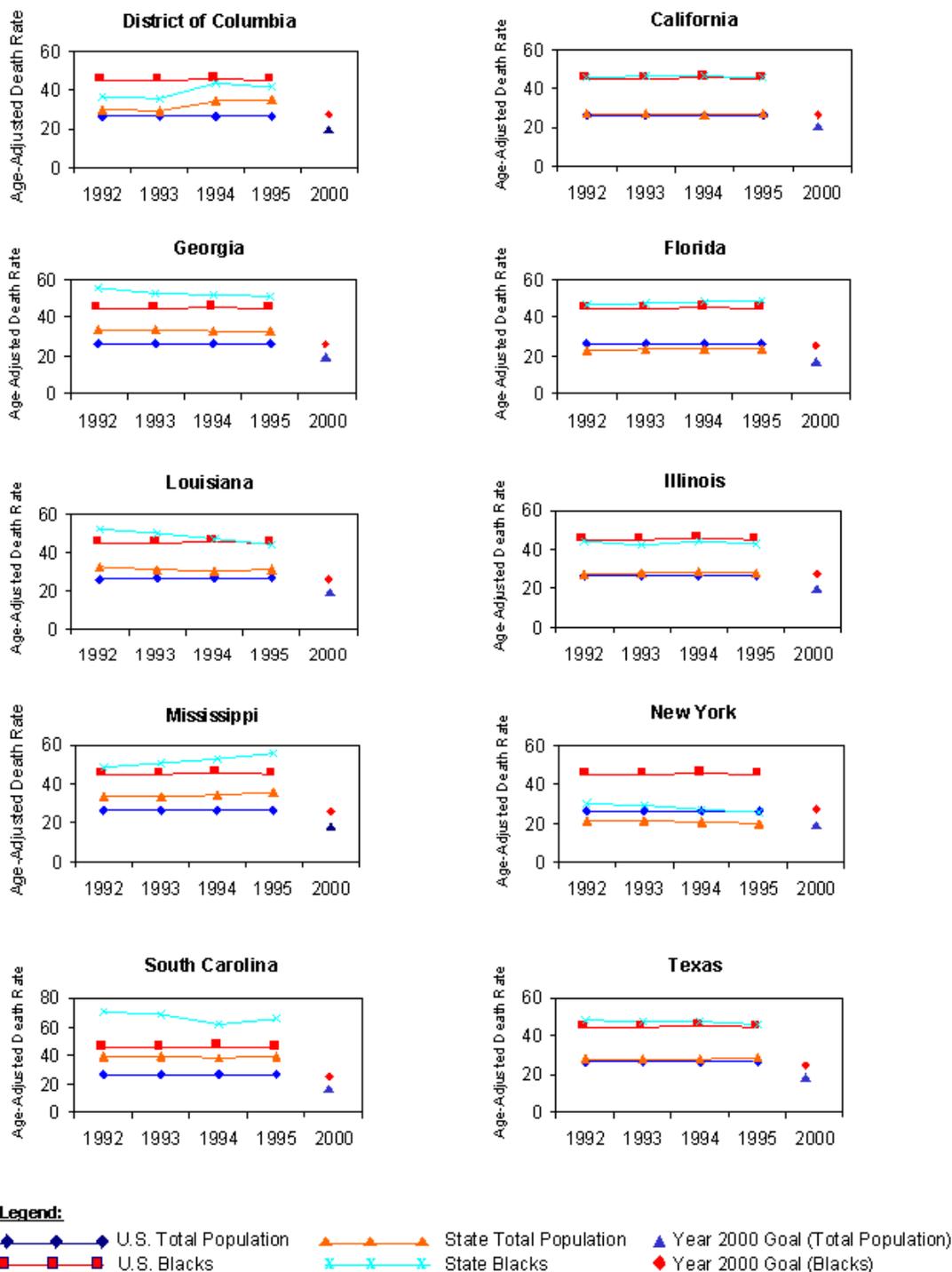
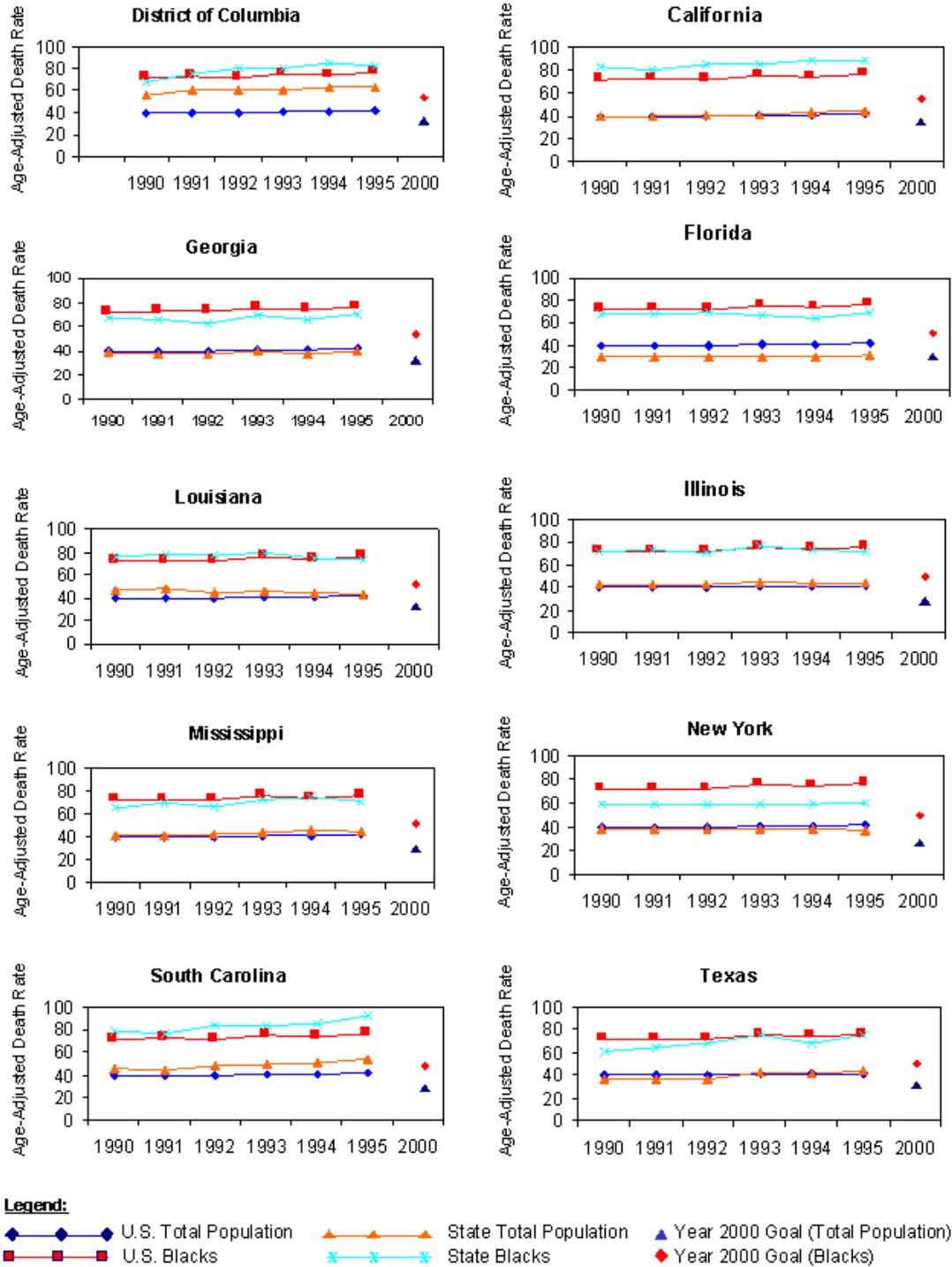
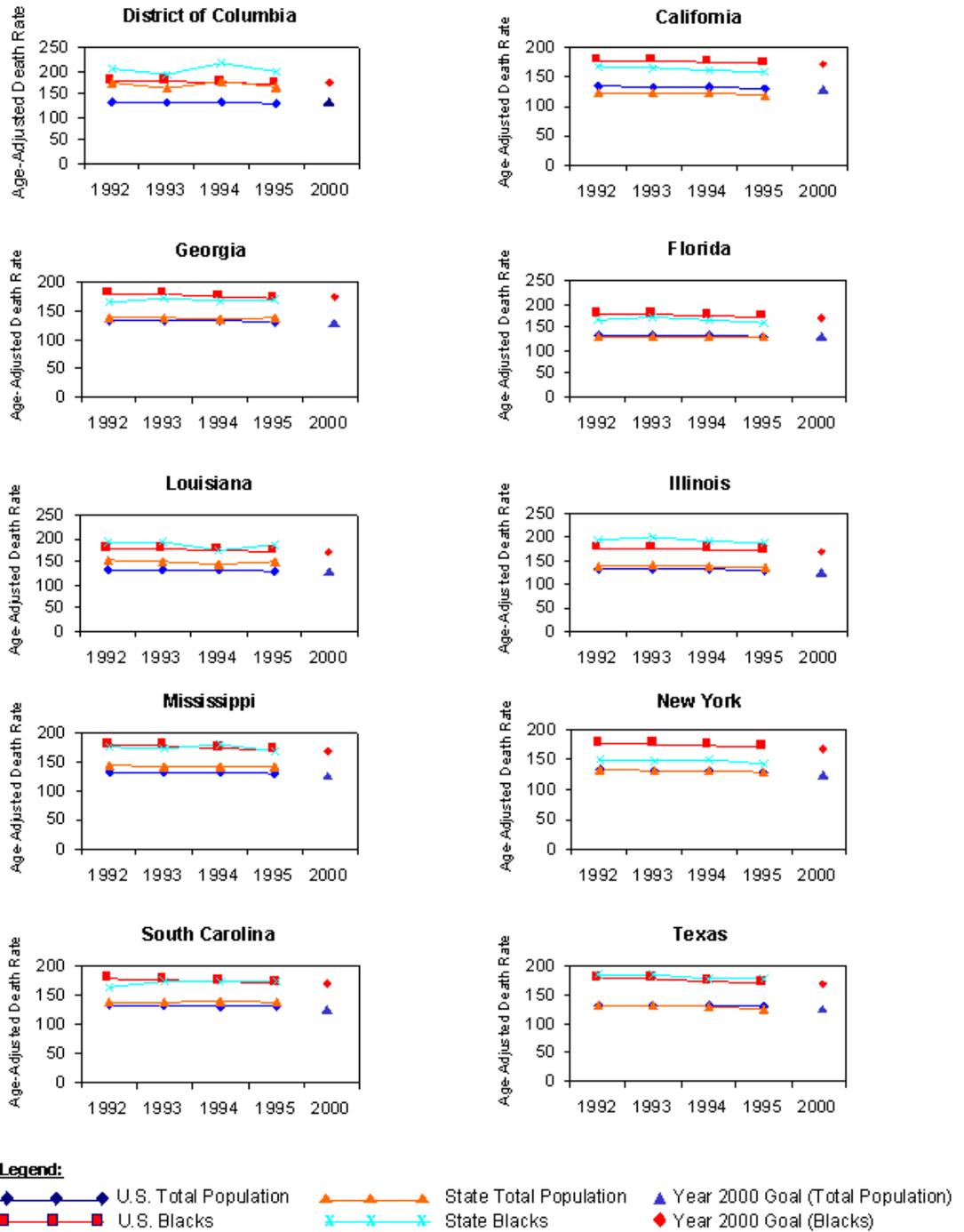


Fig. 3. Age-Adjusted Death Rate per 100,000 Population for Diabetes, U.S. and Selected States



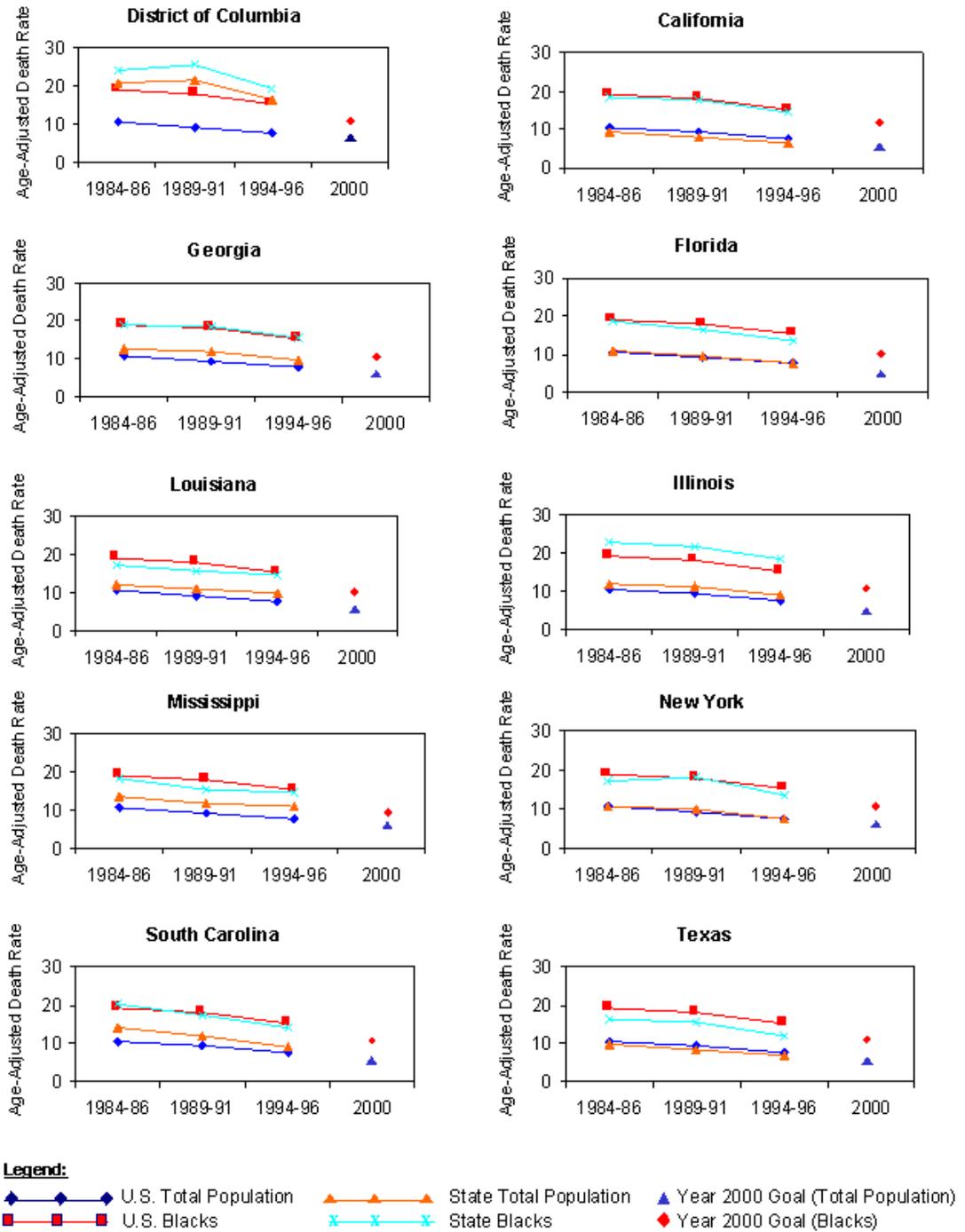
Source: CDC/NCCDPHP, Division of Diabetes Translation, Surveillance Section

Fig. 4. Age-Adjusted Death Rate per 100,000 Population for Cancer, U.S. and Selected States



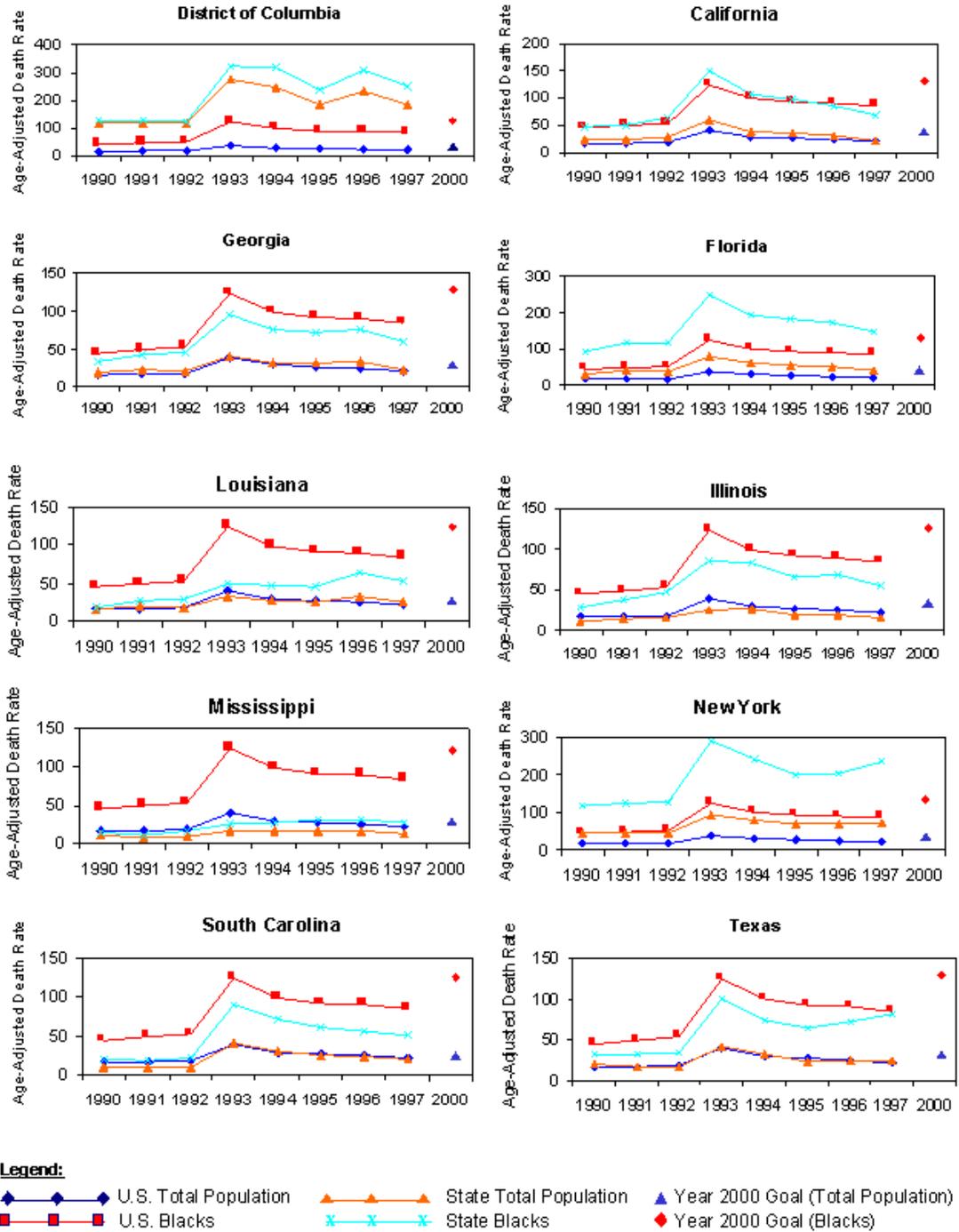
Source: CDC/NCHS, National Vital Statistics System, Data computed by Division of Health Promotion Statistics

Fig. 5. Infant Mortality per 1000 Live Births, U.S. and Selected States



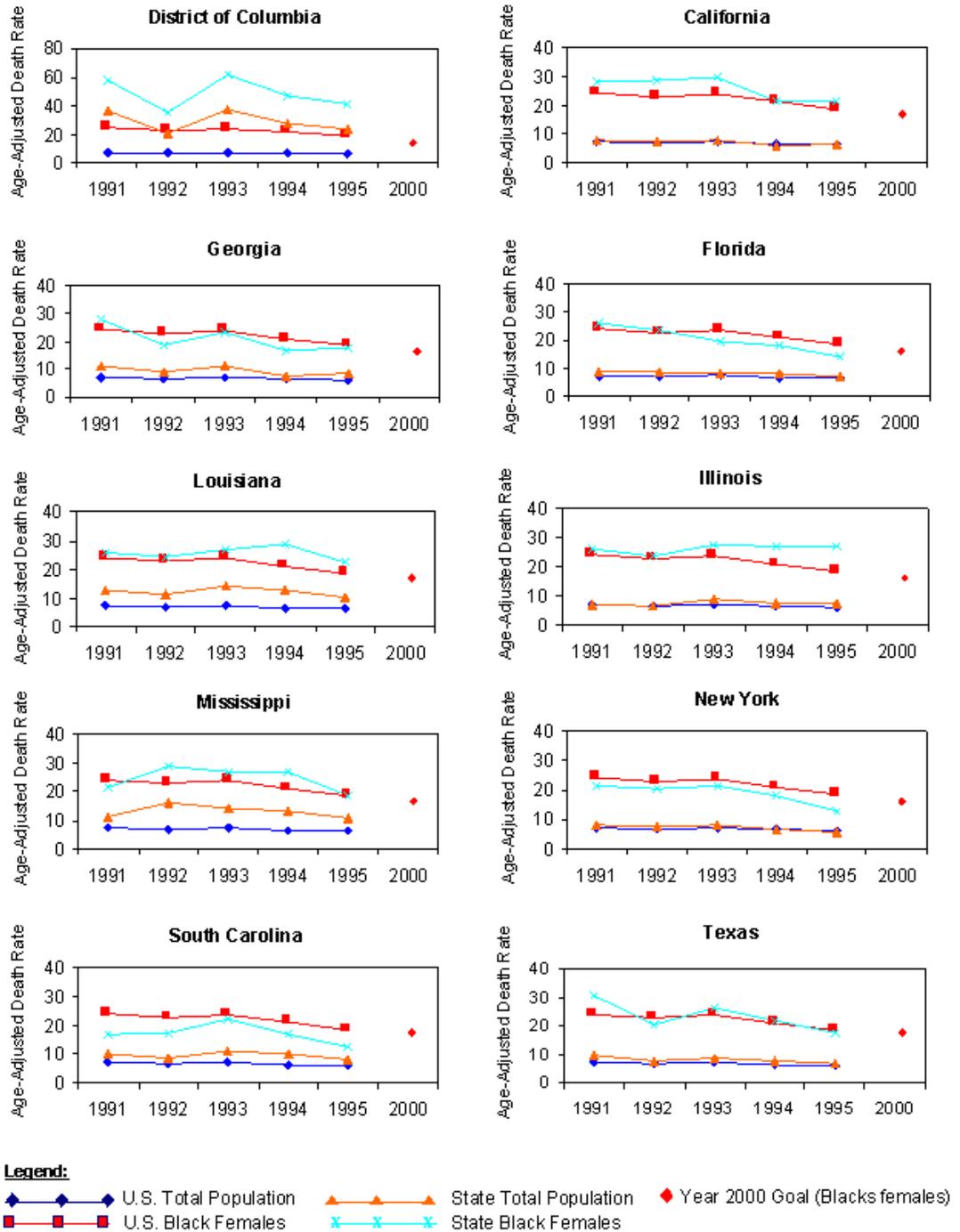
Source: CDC/NCHS, National Vital Statistics System, Data computed by Division of Health Promotion Statistics

Fig. 6. Adult and Pediatric Reported AIDS Cases per 100,00 population, U.S. and Selected States



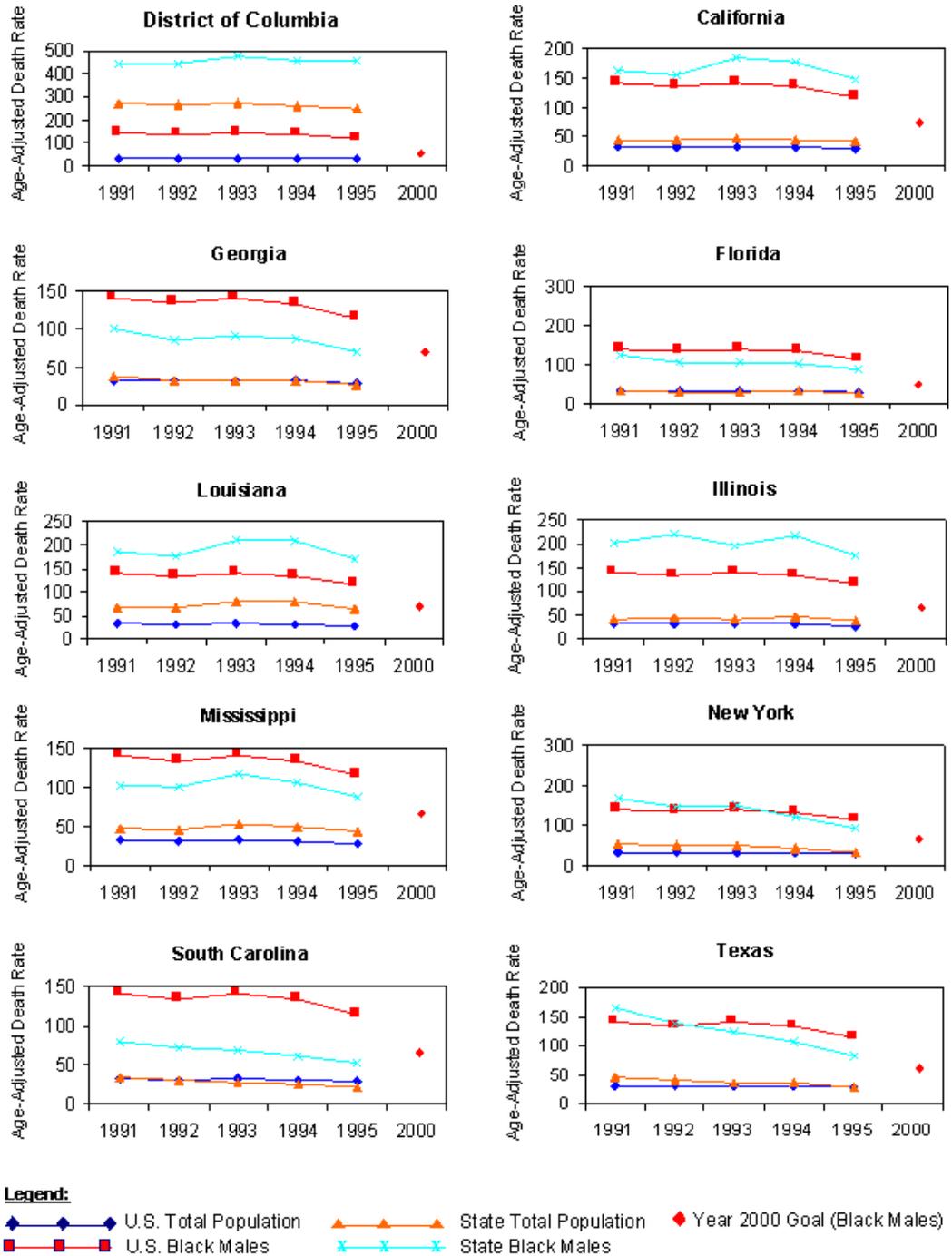
Source: CDC/NCHSTP, Division of HIV/AIDS Prevention

Fig.7. Death Rate per 100,00 population for Homicide--Females Ages 15-34, U.S. and Selected States



Source: CDC/NCHS, Mortality data from the NCHS National Vital Statistics System

Fig.7. Death Rate per 100,00 population for Homicide--Males Ages 15-34, U.S. and Selected States



Source: CDC/NCHS, Mortality data from the NCHS National Vital Statistics System

HEALTH ISSUES IMPACTING HEALTHY PEOPLE 2010 OBJECTIVES FOR THE BLACK AMERICAN POPULATION

Access to Quality Care

Emphasis in Healthy People Objectives stress primary prevention. However, this mechanism for health promotion may not conform with the Black American's model of health seeking behavior. As a group, Black Americans have been historically disenfranchised from mainstream medical and educational opportunities, often the origin of primary prevention messages. Therefore, the adoption of the Healthy People Objectives emphasis on primary prevention as universal should be accompanied by alterations in development of primary prevention messages, and delivery systems that will facilitate access and quality care to those who are disenfranchised and not likely to access mainstream systems of health care delivery.

- ◆ *Greater attention should be paid to involving primary prevention methods into community based programs, schools, churches, clubs, neighborhoods, etc. to accommodate multiple health seeking modalities and behaviors.*
- ◆ *Schools should have an integrative curriculum that teaches children on several levels the positive benefits of primary prevention of diseases.*
- ◆ *Communities should be involved in collaborative processes that provide access to healthy behavior, e.g., proper nutrition and safe environments for physical activity. Collaboration on the development of policies that ensure comprehensive prevention modalities, such as advertising, alcohol and tobacco in neighborhoods should be implemented.*

Data Issues

Systems for data collection and reporting with respect to minorities are uneven and sometimes outdated. The sample sizes are often inadequate to give reliable estimates of progress toward objectives for the different racial/ethnic groups and subgroups of the population in each state, e.g, prenatal care, immunizations, dental care. In other cases existing data may be collected but is not analyzed for racial/ethnic groups (or subgroups) for individual states and/or rural vs. urban areas within states.

- ◆ *Federal agencies, state and other agencies/programs should be required to ensure that health-related data are collected by race and ethnicity, in order to document eligibility, enrollment, participation, utilization and health outcomes.*
- ◆ *Where data exists with identification for racial/ethnic groups for individual states and urban and rural areas, the data should, jointly with representatives of the respective communities of color, be analyzed, interpreted and disseminated to states, local governments and communities of color.*
- ◆ *Funding should be increased to permit larger sample sizes for racial/ethnic groups within states, e.g., in measuring immunization levels, access to dental care for children and adults, screening for breast and prostate cancer, etc.*
- ◆ *Develop a plan for new and/or improved racial and ethnic data collection for states for different health conditions, disabilities, hospitalization, access to health care, access to dental care, health insurance, occupational and environmental exposures and related health outcomes, etc. Determine and evaluate different options for collecting this data, e.g, targeting states with larger proportions of minorities, over-sampling, add-ons, etc., and type of collection (census, sample*

survey, institutional surveys, administration records), costs, etc.

- ◆ *Develop systems to measure the well-being, health, medical and dental care, nutritional intake, etc., of the disenfranchised, the homeless (both rural and urban), farm and migrant workers and their children, persons in jails and prisons, mental institutions and nursing homes.*
- ◆ *The HP 2010 planning group must clearly define what data is available, what additional data should be collected to measure progress toward reaching the year 2010 goals, including who will provide data and to what year data are age-adjusted to, who will collect the data and measure progress toward the goal, and what actions are to be taken if no progress is made. Data agencies and statisticians must be included in all planning and progress reviews.*
- ◆ *Monitoring disease prevention and health promotion for Black Americans during the next decade will encounter several challenges: (1) New Federal standards for racial and ethnic data, (2) New age-adjustment standard policy, (3) Developmental objectives, and (4) Census sampling.*
 - *New Federal standards for racial and ethnic data were revised in October, 1997. Three changes may affect data for Blacks: the new option to indicate more than one race, use of the term "Black/African-American" instead of "Black" and stronger recommendation that race and Hispanic ethnicity data be collected separately. Since Federal agencies have until January of 2003 to implement the new standards, a crosswalk of the old and new standards will be needed for Healthy People 2010 objectives to ensure that baseline data collected in the late 1990's and subsequent*

monitoring data are comparable.

- *New age-adjustment standard policy - Effective September 1, 1998, for deaths occurring in 1999 and beyond, all HHS agencies and programs using age-adjusted death rates must change the population standard used from 1940 to the year 2000 population (based on Bureau of the Census's projections). Use of the new standard will produce mortality data that are uniform throughout the Department, and that are more consistent with the current population structure (older) than the 1940 population standard (younger) that it replaces. In addition, it will reduce the statistical burden on State and local health agencies, and result in more effective communication with the public. This will affect the size of the mortality disparity between Blacks and Whites. Using the 1940 standard, Blacks have an age-adjusted death rate 60 percent higher than that for the White population, under the new standard Blacks will have an age-adjusted death rate 40 percent higher than that for Whites. The widening or narrowing of the race gap in mortality will be approximately the same when the same standard is used even if the magnitude of the gap itself is different.*
- *Developmental objectives - Healthy People 2010 proposed objectives include "developmental objectives" for which baseline data are not currently available. Monitoring of these objectives will require that baseline and monitoring data will need to be collected.*
- *Census sampling -- The Bureau of the Census plans to count all persons*

in the U.S. in the decennial Census in year 2000. Following up the census with sampling would improve the accuracy of the count especially for young men. For young Black/African American men especially, this under-count in the last Census was significant and can impact on the accuracy of corresponding health data and statistics. For example, an undercount of young Black American men, could result in an over-estimation of death rates for homicide and other causes for young Black American men. The decennial Census serves multiple purposes, including redistricting.

- ◆ *Occupational hazards are known to be distributed differentially, and workers with specific biologic, social, and/or economic characteristics are more likely to have increased risks of work-related diseases and injuries. Research is needed to define the nature and magnitude of risks experienced and to develop appropriate intervention and communication strategies. These research needs can be addressed by:*
 - *Identifying the interaction between psychosocial stressors (such as low pay and racial conflict.*
 - *Identifying where African Americans are working, the conditions of work, and the extent and severity of disease and injury among these workers.*
 - *Identifying chemical, physical, and biological agents which may place African American workers at excess risk for occupational morbidity and mortality.*

- ◆ *Augmenting current surveillance systems to identify and follow-up the*

occupational problems associated with these traditionally underserved minority populations. For example, special emphasis could be placed on obtaining records from health care providers serving primarily African American populations.

Research

Historically, African Americans and other minorities have been under represented in all phases of the biomedical research process. Systems for data collection and reporting with respect to minorities are uneven and sometimes outdated. Researchers have rarely examined the connection between race, poverty, occupational exposures, health disparities, as well as treatment outcomes. Blacks have traditionally been excluded both in planning and implementing biomedical and health related research, including epidemiological, behavioral and community based research and clinical trials, nor have they been included in adequate numbers to provide statistically valid estimates of health outcomes and differences if they exist. Greater participation by and for African Americans in all biomedical research is needed and this will require:

- ◆ *Development and implementation of a process to shift and increase funding to programs designed for and by the communities and minority institutions/researchers.*
- ◆ *Resources/funding that are targeted toward the minority groups that show the greatest disparities for each particular disease or other health outcome.*
- ◆ *Programs and activities that especially address primary prevention, e.g., preventing injury or the transmission of infection vs. treating injury or infection*

after it occurs.

- ◆ *Emphasis on: a) working with the communities to find out what the communities believe their problems are and support them both with funding and technical support to solve these problems and b) with the community develop, evaluate, and implement prevention and intervention strategies that are appropriate for their community.*

Cultural Competency

As we move beyond simplistic, blame-oriented social programs, more focus should be placed on incorporating community prevention that honors culture, and recognizes that no one methodology or strategy is considered right. Community prevention efforts should recognize the inherent value of multiple approaches, and ultimately multiculturalism. The Western paradigm is not always the most effective approach for communities of color.

- ◆ *Health care providers and public health professionals need to have an understanding of cultural issues relevant to minority populations and be able to provide services in a culturally competent manner if we are to get beyond the “one-size” fits all mentality of program development and implementation. Preparing public health professionals to understand the complex issues of culture and health is critical to eliminating disparities.*
- ◆ *There is a need for the development of a culturally appropriate paradigm for health promotion in African American, and other racial and ethnic communities that is not based.*

- ◆ *Cultural competency should be incorporated into all health care curriculum and health facilities.*

Infrastructure and Capacity Building

- ◆ *The development of infrastructure and capacity in communities of color to engage and participate in the health promotion and disease prevention process is imperative. This includes making resources available for the fostering of community leadership and provisions for meaningful community input into the development of programs as the norm, and an environment where health care stakeholders are fully aware of the perceptions, and needs of communities.*
- ◆ *To enhance the use of media, assuring the inclusion of multiple, concurrent strategies of ongoing communication - based on the culture of the targeted minority populations in all outreach and education efforts.*

Expanded Partnerships

Meeting Healthy People 2000 targets is challenging enough. Targets in most instances do not yet project the elimination of gaps, but rather the reduction of the huge disparities that existed in 1987 between African Americans and the society as a whole.

- ◆ *New traditional and non-traditional partners will be need to enhance those already committed. Reaching out to new partners outside the traditional health arena will be essential. These include but not limited to institutions representing the faiths community, community-based organizations, state and local*

government and the business community.

- ◆ *Assure the survival and expansion of those educational and research institutions that educate and train substantial numbers of minority health professionals, including HBCUs and HSIs, so that they can serve their respective communities.*
- ◆ *Research new methods on how best to reach underserved populations.*

EMERGING SUBPOPULATIONS

Demographics

"Diversity" is becoming a descriptor of the U.S. black population as it is of the population as a whole. Of the 33.4 million persons of African descent in the United States in 1996, two million were immigrants of African extraction (U.S. Bureau of Census, Current Population Survey, 1996.)

In 1996, approximately 6 percent of blacks in this country were foreign born; blacks comprised 8 percent of all foreign born individuals in the United States. A recent study concludes that children in immigrant families are the fastest growing component of the U.S. child population, particularly children of color (From Generation to Generation - The Health and Well-Being of Children in Immigrant Families, National Research Council and the Institute of Medicine, September 1998).

From FY 1983 to FY 1995 the United States admitted 1,264,258 refugees, entrants and Amerasians to this country. From FY 1983 to FY 1996 71,576 refugees were admitted from African countries and from Haiti. As of 1996, the U.S. Bureau of Census reports the following states and the District of Columbia as having significant numbers of black refugees: California, Florida, Georgia, Illinois, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, New Jersey, Pennsylvania, South Dakota, Texas, Virginia and Washington.

Implications for Research and Health Care Delivery

The emergence of these subpopulations has important implications for research and health care delivery in the year 2000 and beyond. Policy-makers and health care providers must be prepared to revamp current practices to meet these newcomers' needs.

First, it is important to use existing systems, such as the U.S. Census, and to establish other methods to track and document the health status of these emerging subpopulations.

Just as significant health status differences have been found among Asians (e.g., Japanese as compared with Vietnamese), evidence is mounting that there are similar distinctions among immigrants and between foreign- and native-born persons of African descent. Yet, at present, data on black subpopulations are nearly non-existent.

Second, health providers must acquire a far better understanding of health-related practices, customs and traditions, and language differences among these populations.

Further, they must be able to identify potential and actual barriers to health care access and coverage which may relate to immigrant status as well as cultural differences.

Addressing Health from a Wholistic Perspective

There are several barriers to adequate health care associated with immigrant or refugee status. For example, since passage of the Balanced Budget Act by the U.S. Congress in 1997, some immigrants, particularly undocumented individuals, no longer have health care coverage or are reluctant to seek care for fear of being reported.

Black immigrants, like all immigrants, also must also deal with challenges associated with

finding gainful employment, inadequate housing conditions, language barriers, drastically different mores and values, as well as societal influences that can undermine the family structure. It is important therefore to recognize their special needs in the development of comprehensive programs and support services which will contribute to health and well-being.

Health Impacts of Imported Cultural Practices

The practice of female genital mutilation is an example of a custom that poses significant health challenges. Despite growing opposition on the African continent and around the world, this is a convention still observed by many Africans, particularly in Muslim societies.

The World Health Organization (WHO) estimated in 1993 that between 85 and 114 million girls and young women worldwide have undergone these procedures (World Health Forum 1993:15:416). A recent survey in Sudan revealed that 89 percent of all women and girls in the northern region of that country undergo some sort of genital mutilation (Obstetrical and Gynecological Survey, vol.52, no. 19, 1997).

This ritualistic practice is associated with serious medical complications, long-term health risks and mental health consequences. Women subjected to mutilation may fear exposure to American health care professionals, who in turn may be unprepared to deal with the condition. There are also possible legal consequences which must be considered when seeking and providing care.

As immigrants from Africa and the Middle East have become part of the American tapestry,

their cultural practices and traditions come with them. It is imperative therefore that they have access to medical, educational and support services that are culturally and linguistically appropriate. They have every right to expect that health providers who serve them are culturally competent and respectful of their experiences and traditions.

Lessons to be Learned

Studies of the health of immigrants in comparison to that of African Americans can be instructive in another respect. They can shed light on the relative impact and interaction of genetics, culture and environment. Lessons can be learned from research such as the referenced work by the National Research Council. Investigators examined the physical and mental health of immigrant children and their adaptation to life in the United States.

The authors were surprised to find that, although children in immigrant families (all races) in 1990 experienced a somewhat higher rate of poverty, these immigrant children tended to be as healthy or healthier than children of U.S. born parents. This health advantage deteriorated over time and by the third generation, had disappeared.

Yet another surprise was the finding that there are fewer low birth weight babies and infant deaths in immigrant families. The lower rates persisted for blacks and other ethnic groups even though U.S. born mothers have greater access to prenatal care.

The researchers called this finding an "epidemiological paradox". They suggested that immigrant mothers are less likely to smoke or use drugs or alcohol, may eat healthier

foods and may have stronger family bonds than women who have lived in the U.S. longer.

This study's authors called for new research, emphasizing the value of making comparisons between today's children in immigrant families and U.S. born black children.

They underscored the critical importance of achieving the goals of Healthy People 2000, Healthy People 2010 and the President's Race Initiative by concluding:

African American children, in particular, whose historical legacy arises from one of this nation's earliest immigration policies and from the abiding significance of race in American culture, face life chances that are often characterized by the same risks and foreclosed opportunities that are thought to apply to many immigrant children.

Additional research on the health and living conditions of emerging black subpopulations is urgently needed. It is clear that understanding and addressing their issues can result in new insights for the achievement of health equity within and among all populations in America.

"CUTTING EDGE" EMERGING RESEARCH ISSUES

Data presented for this progress review reveal often alarming disparities in health status between African Americans and the overall population. What is the driving force behind these persistent gaps is the subject of active debate in recent public health literature. Much of that literature is devoted to issues concerning socioeconomic variables, access, racism, life-style, environment and genetic predispositions to certain diseases, conditions and addictions.

The Role of Socioeconomics

Many analysts attribute racial disparities in health status to socioeconomic factors. Their premise is that advanced education brings greater awareness of health issues and preventive practices, while material resources buys access to health services. It follows then that African Americans who, on average, earn less and attain lower educational levels bear a greater burden of illness. Some researchers even maintain that there is no evidence for the hypothesis that genetic or biologic factors might explain differences in risk factors for diseases ("Health News", The Washington Post, July 28, 1998).

Racial Differences in Treatment - A Contributor to Health Inequity

Recent studies suggest on the other hand that socioeconomics alone does not adequately explain health disparities between African Americans and other racial/ethnic groups in this nation. Here are some examples:

- o In 1996, Gornick et al. found that although income had effects, there were still striking differences between even the most affluent blacks and whites

concerning treatment they received in hospitals for heart disease. Rates for angioplasty and coronary artery bypass graft (CABG) surgery were dramatically lower (N. Engl. J. Med. 1996;335:791-799).

- o In the same year, Allison et al. concluded that there were racial differences in the medical treatment of elderly African American Medicare patients who had suffered a heart attack. Twice as many whites as blacks (17% vs. 9%) were given clot-busting (thrombolytic) medications. Racial differences in treatment preference were ruled out as an explanation for these results (Journal of General Internal Medicine 11, pp. 736-743).

- o In 1997, Peterson et al. reported that blacks with severe heart disease are 32% less likely to undergo bypass surgery and 13% less likely to undergo angioplasty. These treatment differences correlate to poor survival among blacks, who are 18% more likely to die than are whites within 5 years (N. Engl. J. Med. 1997; 336:480-486).

Evidence of patterns of disparity in treatment based on race and ethnicity is mounting, even when incomes are comparable and health insurance is equally available. Whatever is at work to explain these differences, clearly institutional racism, the disproportionate, inequitable and predictable allocation of health services based on race, must be addressed as a factor. Such findings cry out for systematic data collection and examination of racial disparities in the use of services, as well as preventive, diagnostic

and therapeutic interventions at every level, particularly in federally-funded programs and systems of care.

The Role of Genetics in Explaining Racial Disparities

A second body of "cutting-edge" research deals with data of a different sort. These findings point to either 1) genetic differences between African Americans and the overall population; 2) the biologic effects of racism; or 3) a combination of the two, as explanations of racial disparities in health.

Perhaps the best known and researched example of a genetic predisposition among persons of African descent is sickle cell disease. An example of recent research that suggests a genetic predisposition comprises results from the Advanced Glaucoma Intervention Study, which indicate that blacks with advanced glaucoma benefit more from a regimen that begins with laser surgery, while whites benefit more from one that begins with an operation called a trabeculectomy (Ophthalmology 1998: 105, pp. 1146 -1164).

Similarly, two studies in a July 1998 edition of the Journal of the American Medical Association offered new evidence on the effects of tobacco on African American smokers.

One group of researchers found that there were higher serum cotinine levels among blacks as compared with white or Mexican American smokers. The other authors concluded that higher levels of cotinine per cigarette (related to slower clearance of the substance) could be related to higher intake of nicotine (JAMA 1998; 280:152-156).

These results could explain why African Americans suffer from such smoking-related illnesses as coronary artery disease, lung cancer and low birth weight at greater rates than the overall population. However, these findings do not take into account important data showing that more than three times as many blacks smoke menthol cigarettes as whites a pattern which could result in additional physiological complications. These findings also do not explain the lower incidence of chronic obstructive pulmonary disease (COPD), another smoking-related disease, among African Americans as compared to the overall population (JAMA, op. cit.)

Scientists are also looking to DNA research to explain the higher incidence of prostate cancer among African Americans. Preliminary data are available that both support and refute this notion. The even higher incidence of prostate cancer reported among Jamaican men in 1992 (compared to African American men) suggests a genetic link. However, other findings reveal similar cell alterations among white and African American cancer patients (J. Urology 1998 Jun; 159(6):1984-6, Clin. Cancer Res. 1998 May; 4(5):1273-8). More light will undoubtedly be shed on this discussion once researchers at Howard University complete their work on the role of DNA in prostate cancer among African American men.

Challenges to the Genetic Explanation for Health Disparities

Notwithstanding the emergence of data suggesting genetic links, challengers also have evidence on their side. Research on hypertension for example is likely to be inconclusive. Onions et al. reported in a 1998 study that the leptin gene (OB) is not a major contributor to the phenotype of essential hypertension in African Americans (Hypertension 1998;

31:1230-1234). On the other hand, Cardillo et al., writing in the same edition of Hypertension, found that blacks have a reduced nitric oxide-dependent vascular response during mental stress, which may play some role in the greater prevalence of hypertension and its complications in this group.

Another explanation links a genetic explanation for hypertension with external stimuli associated with the slave trade. Grim and Wilson hypothesize that the harsh trans-Atlantic voyage eliminated those Africans who were not genetically equipped to conserve salt. These individuals survived and passed their efficient salt-retaining genes to subsequent generations. Their descendants retained therefore a capacity they no longer need to retain salt, and hence, suffer disproportionately from salt-sensitive hypertension (Pathophysiology of Hypertension in Blacks, Oxford University Press, 1993).

Asthma is also a health condition where genetics and external circumstances may intersect. In 1997, Nelson et al. concluded that black middle class children had twice the prevalence of asthma as white children in the same income group with similar access to medical care and in similar environmental conditions. The researchers called for further studies to evaluate biologic and environmental factors (including environmental pollution by toxic substances) in order to explain these differences (Annals of Allergy, Asthma, & Immunology: 78, pp. 21-26.)

The strongest challenges to the "genetics only" theory comes from those conducting cross-cultural studies. Feldman found that there are greater genetic variations within a racial

group than between racial groups (Cancer, Jan. 1, 1998, vol. 82, no.1). The work of David and Collins also weakens the genetic argument. In a comparison of the incidence of low birth weight babies among white, sub-Saharan African and African American women in Chicago, they found that white and sub-Saharan women had comparable rates of low birth weight babies (4.3 and 7.1 percent, respectively), while African American women eclipsed both groups (13.2 percent). (New Engl.J. Med 1997; 337:1209-14)

Focus on Culture and Life Style

More studies addressing risk factors associated with life style differences, such as obesity, physical inactivity and smoking, are also beginning to emerge. Researchers at Stanford University School of Medicine reported in July 1998, for example, on their analysis of NCHS data involving over 5,000 African American, Mexican American and white women. They concluded that cultural or even genetic differences among ethnic groups were more likely to explain variations in heart disease risk than was socioeconomic status. This is an area in which much more research is needed (The Washington Post, op.cit.)

Another important factor to be studied is the impact of the stress of living in an environment in which race remains a compelling reality. This is a dimension of the black experience which may well explain persistent health disparities unaccounted for by other factors. A critically important area for future research is the examination of psychological and physical responses among African Americans to the unique black/white connection in America an experience that no other racial/ethnic group shares.

Call to Action: A National Commitment

Historically, African Americans and other minorities have been underrepresented in all phases of health-related research. For example, blacks have not participated in numbers commensurate with their incidence in the total population in clinical trials as research investigators or subjects. Systems for data collection and reporting on utilization and outcomes by race and ethnicity are uneven and uncoordinated and with respect to managed care plans, nearly non-existent.

Given the complexity of these issues, funds must be allocated for research in all areas genetic, biological, behavioral, anthropological designed and conducted by African American researchers, historically black colleges and universities (HBCUs) and other black organizations involved in health care delivery and research. Systematic data collection by race and ethnicity is also a prerequisite if we are to determine whether discriminatory rationing of health care by health care providers and institutions is a myth or reality. (Editorial, New England Journal of Medicine 1996; 335:11).

Whether they point to genetics, behaviors, environmental factors or institutional racism, nearly all studies underscore one fact. Race has profound effects on the health of African Americans. As Dr. Martin Luther King once said: "Racism is a sickness unto death". Nothing less than a national commitment, commensurate with the challenge, will lead to a cure.

National Immunization Program

PROJECT TITLE

“Give Your Child A Shot At Life” Pre-school Immunization Project

Description of the Project

The principal goal of “Give Your Child A Shot At Life” is to target low immunization levels in constituent children so that they receive complete and timely vaccination by two years of age. Through its National Health Program, the Congress of National Black Churches (CNBC) provides technical assistance to clergy, auxiliary, and lay leadership within its affiliates and denomination churches. Training and technical assistance are designed to inform and enable Pastors along with the leaders of their various church auxiliaries and youth departments to provide the critical leadership needed to affect the vaccination status of their constituent preschoolers (birth to two years of age). CNBC represents eight historically black denominations which constitute 65,000 congregations and 19 million members. The Project sustained a network of 200 churches in each site during the first three years.

The project' principal goals to:

- Provide technical assistance to improve the organizational capacity of the member affiliates and their participating congregations to organize and engage their churches in the national immunization effort;
- Improve programmatic immunization efforts implemented by each of the affiliates and member congregations in previous years;
- Enhance and disseminating easily understandable information on church-based prevention efforts designed to reduce immunization rates among African-Americans;

Types of Services Provided

The CNBC has implemented program activities based on three concepts: sustainability, focused training, and coalition-building. The CNBC participates in selected national coalitions and conferences and distributes immunization education materials to

organizations and groups nationwide. At the local level, close collaboration between church members, health departments, and hospitals is a crucial component of this project as is continuous communication and training for

church volunteers.

Specific activities vary by geographic area. For example, the Los Angeles Affiliate conducts Immunization Caravans. Church Nurses Units and Health Ministries host church immunization screens, review the immunization records of church member children, provide referrals and assist program participants in understanding and interpreting their children's immunization records. Participants are also encouraged to keep their children's immunizations up to date.

The Atlanta Affiliate has identified "Youth Ambassadors for Health." This youth group has developed skits and rap songs to share the immunization message with their peers. These are used at vacation bible schools, youth groups, and schools. Youth also disseminate information door-to-door in the community.

The Washington, D.C. affiliate has implemented the "CNBC Adopt-A-Family" initiative. The purpose of "CNBC Adopt-A-Family" is two-fold: 1) to provide adequate and timely immunizations to children from birth to age two and 2) to provide other health and family services to families in the Washington Metropolitan Area. During the second year of the project the 1995 First Ladies Luncheon was held to kick off the implementation of "CNBC Adopt-A-Family." This program has been well received by the community. Two churches have been designated as immunization sites where monthly services are available with the assistance of local health departments. The Project recently expanded its activities into McDowell County, West Virginia. The CNBC also develops promotional and educational materials geared towards the church community.

From CNBC's National office, the Project Director and Expansion Coordinator provide technical assistance to the Health Education Coordinator at each site. The Health Education Coordinators then provide training on developing and implementing program activities in their affiliate churches and/or communities. The First Ladies (Pastors' wives) have been instrumental in conducting follow-up activities with participating community churches through a train-the-trainer model.

Project staff participate in immunization coalitions including the California Coalition for childhood Immunization, the South central Immunization coalition and the Washington, D.C. Immunization Coalition. Project staff continuously assist health departments nationwide to identify churches with whom they may partner to implement immunization activities in selected African-American communities.

Population Expertise

Leadership (clergy and church auxiliaries) of CNBC affiliates nationwide, to

influenza vaccination coverage levels of constituent preschool children. Specific target geographic areas include Los Angeles, CA; Atlanta, GA; Washington, DC metropolitan area; Baltimore, MD; and McDowell County, WV.

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National Immunization Program

PROJECT TITLE

National Immunization Outreach Effort (NIOE)

Description of the Project

The principal goal of the National Medical Association's (NMA) National Immunization Outreach Effort (NIOE) is to ensure that children 19 to 35 months of age are adequately immunized against vaccine preventable diseases.

The project carries out the goal by encouraging physicians to decrease missed opportunities and contribute to increased immunization rates. The immunization project collaborates with established immunizations coalition/advisory groups in each of the target areas.

Types of Services Provided

In collaboration with NMA constituent and component societies and other national, state and local entities that focus on immunization issues, NIOE implements the following activities:

- Conducts or assists agencies that conduct provider immunization training sessions, and develops a provider "how to manual" on immunizing the urban and minority child.;
- Creates and distributes culturally sensitive educational materials and maintains a clearinghouse of appropriate materials developed by other organizations;
- Develops immunization checklist for NMA physicians to simplify the immunization assessment process;
- Develops linkages with established coalition/advisory groups who focus on urban and minority children;
- Recruits eligible physicians to participate in the Vaccines for Children Program; and,
- Solicits and publishes immunization articles in the NMA Scientific Journal and NMA Newsletter, and distributes an NIOE newsletter highlighting activities in geographic target areas.

Population Expertise

NIOE focuses upon member physicians who administer immunizations and NMA constituent and component societies to address the vaccination needs of children in Detroit, MI; Los Angeles, CA; St. Croix, VI; and Washington, D.C.

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The Healthy Start Initiative

The Healthy Start Initiative, which began as a demonstration program in 1991, has made achievement in the area of integrating the perinatal system of care for many communities with high infant mortality rates. These communities are predominantly African American and are rich in racial and ethnic diversity. Programs and strategies have been implemented, which address those diverse cultures and provide opportunities for women of childbearing age, pregnant women, their infants and their families to have access to comprehensive health and social support services which are critical to improved birth outcomes.

Achievements of the demonstration phase as reported by the Healthy Start projects include:

- Success in building community-based coalitions;
- Establishment of community-wide service system integration;
- Improved care coordination;
- Expanded level and range of services;
- Alleviation of barriers to care; and
- Promotion of healthy behaviors.

Within the next year, HRSA will complete a cross-site analysis that will chronicle some of the results at the community level. Measuring the impact of these programs has proven difficult, as researchers must rely heavily on providers to share data.

Despite the lack of systematic data on the impact of the program, anecdotal case studies clearly demonstrate the potential for improvement in the health of women and infants residing within these communities.

Positive program outcomes have resulted from reducing low birthweight through promotion of healthy behaviors such as prenatal care visit compliance, smoking cessation and substance abuse treatment. The **Baltimore City Healthy Start** program utilized a case management approach which utilized special teams for high-risk perinatal and substance abusing women. Each team consisted of a case manager and perinatal monitoring specialists who operated out of two local community centers, providing a variety of services to high-risk women, including education, peer support groups, nutrition and food preparation, life skills (including family planning), men's service, child care, and transportation. (Men's services are included because local officials found that males become more interested in caring for the mother and child if they are included in the program.)

The project reported a 56% lower very low birthweight rate among clients enrolled during pregnancy than those enrolled post-partum. Similarly, the low birthweight rate was 23% less. Substance abusing clients enrolled during pregnancy had significantly

lower low birthweight and very low birthweight rates than substance abusing clients enrolled post-partum.

With the implementation of case management and home visiting, the **Florida Panhandle Healthy Start** reported a significant drop in the project area very low birthweight rate (2.4% in 1995 to 1.7% in 1996). Women of Hispanic origin in the project area experienced a drop in low birthweight rate (from 10.9% to 7.8%) and a dramatic fall in very low birthweight rates (from 3.3% to 1.9%) between 1994 and 1996. The rates for black women also fell from 3.2% to 2.2% between 1994 and 1996.

Boston Healthy Start provided GED/ESL and adult education services to pregnant and parenting women in the project area. The benefits offered by these programs are immense in non-English-speaking communities. The education and training have allowed project area women to obtain the skills necessary to access care and advocate for themselves, as well as to comprehend prenatal care, pediatric care, and parenting health education. The GED classes improve the employment potential of women without a high school degree, with the added benefit of building sufficient confidence for them to advocate for appropriate health services.

The **Chicago Healthy Start** project has realized and embraced the differences inherent in its project area. Its four Healthy Start Family Centers have involved the community in the design of each center's programs and in turn, created a sense of community ownership and responsibility. The Family Centers provide far more than increased capacity of the primary health care system. They are also vital links between community-based case management and their primary health care providers.

OBRA 89 mandated the implementation of toll-free information lines by each State under Title V funding. As part of the Healthy Start national public information and education campaign to increase public awareness of the problems of infant mortality and promote prenatal care and other healthy behaviors, in 1997, HRSA launched a new set of public service announcements (PSAs) via television, radio, print and other media. The PSAs also released two Healthy Start Prenatal Care call-for-action toll-free resource lines, one for English-speaking callers, and one for Spanish-speaking callers. The English language line would route the calls to the State maternal and child health offices or a local Healthy Start site. Spanish-speaking calls would reach the new National Hispanic Prenatal Hotline. For the period February 1997, frequency of calls ranged from 2400 to 4300 per month, combined English and Spanish lines. This demonstrated the concerns of the public and prenatal care.

Due to the success of the previously described grantees and others involved in the Demonstration Phase of the Healthy Start Initiative, there is currently a Replication Phase of the program in which an additional 55 communities have the opportunity of being mentored on adapting Healthy Start strategies for their communities and have access to useful materials available from the National Healthy Start Resource Center.

Centers for Disease Control and Prevention Division of Cancer Prevention and Control

PROJECT TITLE

“Circle of Friends” -- The National Caucus and Center on Black Aged (NCBA)

Description of the Project

The *Circle of Friends* project, described as Women Telling Women About Health Issues, is a culturally appropriate breast and cervical cancer education and early detection program for low-income, mature African American women, especially those who live in public housing. This project is in its 6 year of continuing support and collaboration with the Centers for Disease Control and Prevention and has evolved from a developmental, education and outreach project into a second phase of successful replication and dissemination of their strategies.

The principle goals are to:

The goals have evolved from, “providing breast and cervical cancer information and opportunities for screening to low-income women, 50 years of age and older, living in public and assisted housing” to “engaging state and local health departments and representatives to replicate an expanded model and conduct outreach to the general population of African American women over 40 years of age to promote early detection of breast cancer.”

The project carries out the goals by:

In the first phase of the project the grantee developed specialized processes for garnering support in the form of work agreements with National Partners, culturally relevant principles that guide the messages, resource materials and strategies for outreach, specialized outreach to recruit program participants, educational sessions, distribution of materials, and linking program participants to screening opportunities. The current methods for carrying out the program goals include: maintaining prior methods with added features to include professional education for representatives of the health departments regarding strategies to replicate the program and successful outreach for African American women; utilizing NCBA’s employment program to work with the health departments; conducting national public awareness campaigns; utilizing media conferences, formal press packages, videos, advertisements, and promotional events.

Types of Services Provided

In the first five years, this project concentrated on conducting focus groups with the target population, a series of educational programs, Afro-centric designed low-literacy materials, a resource distribution campaign, outreach volunteer training, replication training for four State Health Departments and referring women for mammograms. The current project builds on the success of the original activities through replication/ dissemination strategies. Specifically, seeking to train staff from 20 State Health Departments and 40 local health organizations on successful outreach strategies for reaching the target populations and how to replicate the *Circle of Friends* program.

Population Expertise

Low-income, 40+ African American women, especially those who live in public and assisted housing.

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Centers for Disease Control and Prevention Division of Cancer Prevention and Control

PROJECT TITLE

“The Witness Project” --Replication & Dissemination of Effective Breast & Cervical Cancer Health Education Intervention, University of Arkansas for Medical Sciences

Description of the Project

The Witness Project was designed in 1990 and is a community-based cancer education program designed to meet the specific cultural, educational, knowledge, and learning style levels of underserved African American women. Under the cooperative agreement with the Centers for Disease Control and Prevention, the Witness Project will replicate, disseminate, implement, and evaluate its model in institutions and communities over a 4 year period. Two sites were selected from 14 applications for piloting this replication project.

The principle goals are to:

The Witness Projects goals have not changed since 1990 and include, increasing awareness and early detection of breast and cervical cancer in the African American community.

The project carries out the goals by:

Providing culturally appropriate role models who promote behaviors that detect cancer early. Working as teams in the community, the women provide educational messages and empowerment with African American churches and community groups to increase the practice of breast self-examination, clinical breast examination, mammography, and Pap test screening.

Types of Services Provided

The Witness Project will: 1) explain the Witness Project model, its goals and the background and research that supports it; 2) provide information about African American women and the cultural barriers and issues as they relate to the early detection of cancer; 3) define and guide the collaboration and staffing needs to implement their program; 4) explain the recruitment and selection of Witness Role Model and Lay Health Advisor team members; 5) provide guidelines, agendas, slides, curriculum, and resources for training team members; 6) provide resources for promoting and enhancing the program efforts, and for

troubleshooting as necessary; 8) provide videotapes that illustrate the spirit of the program and enhance the enthusiasm and probability of success; 9) provide technologies to link the network of Witness Project programs for the purpose of increasing communications and technical assistance; and 10) provide personal assistance and an *esprit de corp* from an experienced staff of leaders, trainers, and volunteers as necessary.

Population Expertise

African American women, especially those in small rural communities.

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National Center for Injury Prevention and Control Center for Disease Control and Prevention

PROJECT TITLE

Richmond, Virginia--Richmond Youth Violence Prevention Program

Description of the Project

The Richmond Youth Violence Prevention Program is a 3-year school-based project to reduce aggressive behaviors among 6th grade students. The program consists of a 16-session curriculum that teaches students the use of alternative methods for dealing with violence and adaptive methods for dealing with anger. The program also has a peer mediation program that uses a problem-solving approach to reinforce the skills students learn in the curriculum. The intervention is administered by facilitators from the Richmond Community Services Board.

Evaluation of the Project

During the first year, the program was implemented in eight middle schools in the Richmond public school system and administered to approximately 1,800 students. Satisfaction and suggestions for change were elicited with surveys and focus groups of students, teachers, and facilitators. The revised program was implemented and evaluated in the second year with three schools. The program was initially evaluated using an index of aggression based upon self-reported behavior and attitudes toward the use of violence and nonviolent methods for dealing with conflict.

Pre- and post-intervention self-report data obtained from both RIPP participants and non participants indicate that the initial intervention (the 6th grade curriculum) achieved behavioral improvement in the target group. Self-reported quantitative data from the children participating in the RIPP program show significantly greater reductions in fight-related injuries requiring medical attention compared with non-participating children. Boys in RIPP also reported a lower frequency of threatening to hurt a teacher. RIPP participants reported significantly greater reductions in fight-related injuries that require medical treatment; significant improvements in self-esteem, greater increases in their knowledge of the curriculum content, and increased use of violence prevention resources within their school. School disciplinary data showed differences between RIPP participants and non participants. Participants had fewer suspensions for fighting, bringing weapons to school, disruptive behavior, and

defiance of school authority.

Partners

Virginia Commonwealth University in collaboration with the Richmond Community Services Board (City of Richmond)

Target Group

Students in 6th grade

Setting

Schools

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PROJECT TITLE

Portland, Oregon--RMC Research Corporation

Description of the Project

Students were be provided with adult mentors and programs that included training in conflict resolution and social skills, peer education in violence prevention, recreational opportunities, and academic tutoring. Students spent at least 1 hour per month interacting with their mentor. Services were provided about 13 hours per week during the school year and 25 hours per week during the summer months. The training drew extensively upon unique African-American cultural foundations and experiences.

The proposed evaluation has two major goals: 1) to assess the sustained, long term effects of the SEI intervention, and; 2) to determine the most salient characteristics of students and program participation that are associated with the most positive and lasting effects of the SEI violence prevention program. Objectives for goal one address the impact of differences in program participation and different student characteristics on long-term effects. Goal two has five specific objectives pertaining to aspects of the family environment, the surrounding community, the school environment, peer-individual factors, and specific aspects of the SEI program most strongly associated with long-term, positive effects of the program.

Evaluation of the Project

Approximately 120 students from four schools (three middle and one high school) were enrolled in the program. Approximately 200 other students from the same school and with similar school performance, behavioral problems, and peer relationships served as the comparison group. Differences between groups have been assessed by comparing school records and self-reported information on key psychosocial factors and violence-related risk behaviors. Information on how the program is being conducted will be collected quarterly; data on how behavior has been affected is collected once yearly.

After two years, a 12% reduction in physical fighting and 21% reduction in weapon carrying was observed in the intervention group and no significant decreases in these behaviors were noted in the control group. The applicant proposes to continue to follow these two groups, re-using the previously administered instruments and previously deployed analytic strategy to compare risk and protective factors, health risk behaviors, and pro-social outcomes.

The initial evaluation also yielded some interesting and unexpected, interrelationships among risk and protective factors. Reported use of marijuana

increased significantly for both groups. As a result, illicit drug use has become a priority of the SEI program. An unexpected finding was that weapon carrying was higher in students who had their father living at home.

The applicant's evaluation plan includes both quantitative and qualitative methods in the data analyses. Process data collection will include interviews, student surveys, and case studies. Outcome data collection will assess the same battery of risk and protective factors, health risk behaviors, and pro-social measures using the same standardized instruments and methods as in the initial evaluation. The following additional data sources will be utilized: school records, the Gang Task Force (gang involvement information), juvenile justice records, and a survey of employers, universities, vocational schools, or other organizations where participants are located following high school.

Partners

Self Enhancement, Inc., and the Portland Public Schools.

Target group

Students in grade 7-9 from low-income, high-crime neighborhoods

Setting

Schools

Contact Person

Roy M. Gabriel, Ph.D.
(503) 223-8248

National Center for Chronic Disease Prevention and Health Promotion

Tobacco **PROJECT TITLE**

Uptown Campaign

Description of the Project

The principal goals are to block the release of a cigarette aimed at the African American market.

The project carried out these goals by intense community organizing. In mid-December, 1989, members of Philadelphia's African American community were alerted to the arrival of Uptown, a mentholated cigarette brand targeted to African Americans, scheduled to be test marketed in the city starting on February 5, the beginning of 1990's Black History Month. On January 4, 1990, the local American Cancer Society's (ACS) Committee on Cancer and the Poor met to discuss possible strategies to address the imminent Uptown introduction.

At this meeting the community determined that the ACS would not take the lead and that a coalition approach was preferred. The coalition was organized under the leadership of the local Committee to Prevent Cancer Among Blacks, headed by Reverend Jesse Brown.

Types of Services Provided

On January 11, 1990, the Coalition Against Uptown Cigarettes held its first meeting. The next day the Coalition's media committee held its first meeting. The Uptown Coalition worked strategically to mobilize the African American community, smokers and nonsmokers alike, to oppose the introduction of Uptown to the community. Specifically, the Coalition focused on getting African American smokers to refuse to participate in the planned test market. The Coalition did not polarize the community and made it impossible for the tobacco industry to form its usual alliances with smokers and business owners against individuals working for tobacco control.

In the week after the first Coalition meeting, the Uptown campaign received a great deal of local and national press. The Coalition held its second meeting on January 18. On the same day, Secretary of Health and Human Services Louis Sullivan spoke at the University of Pennsylvania Medical School and denounced the Uptown marketing campaign plans.

Consequently, RJR publicly announced the cancellation of test marketing of

Uptown in Philadelphia and later announced that it would not market Uptown anywhere in the country. Extensive media coverage of Uptown and the effects of targeted marketing continued after these announcements.

The Uptown Coalition success has served as a catalyst for communities around the country to mobilize against targeted marketing to African Americans by tobacco and alcohol companies. Lessons learned from the Uptown success played a role in the decision by the CDC to fund national organizations to mobilize communities and develop leadership around tobacco control. To this end, CDC recently funded nine organizations to conduct tobacco control activities.

Specific Target Population

Initially, African Americans in Philadelphia and then, African Americans throughout the country.

Contact information

Dr. Robert Robinson, Office of Smoking and Health, Centers for Disease Control and Prevention, (404) 488-5701.

National Heart, Lung, and Blood Institute

Association of Black Cardiologists (ABC) National Medical Association (NMA) National Black Nurses' Association (NBNA)

PROJECT TITLE

The National Physicians' Network

Description of the Project

The National Physicians' Network is a national strategy designed to mobilize, train, and equip physicians and other health providers who provide care to African Americans to become more actively involved in prevention, and education activities in the African American community. Since 1995, a total of 140 physicians have been trained and are presently part of the network. Based on the lessons learned to date, the Web-based activities will help to ensure more immediate access to updated information in the prevention, diagnosis, treatment, and management of cardiovascular and pulmonary disease in African Americans. The Web site will provide a series of self-study continuing education programs for health care providers and electronic versions of the NHLBI's patient/public education publications. In addition, the National Physicians' Network will use the Web site to facilitate activities and stimulate communication among Network members.

Specific Target Population

Health professionals and the African American community

Public Health Impact

The Web-based continuing education and training for health professionals will provide state-of-the-art information in the clinical management and treatment of heart, lung, and blood diseases. In addition, it will help facilitate patients/public education opportunities regarding prevention and control of heart disease, stroke, and asthma. The Web site will also provide a mechanism to strengthen and maintain the Physicians' Network through an incentive system (continuing education credits) as well as networking opportunities among health professionals.

TIME PERIOD

September 1998 - September 2000

BUDGET

\$200,000 FY 98

Contact Person

Glen Bennett, M.P.H., National Heart, Lung, and Blood Institute, (301) 496-0554

National Heart, Lung, and Blood Institute

PROJECT TITLE

Historically Black Colleges and Universities (HBCUs) Professional and Community Education Outreach

Description of the Project

To increase knowledge, skills, and practice behavior of health professionals who provide care to African American patients, the NHLBI and the NIH, ORMH sponsored forums in collaboration with two HBCUs and the Harlem Hospital. The forums aimed to: 1) share the latest research and treatment information to prevent and control cardiovascular (CVD) risk factors; 2) forge linkages and partnerships among medical and public health organizations, community coalitions, churches, and social and civic organizations to undertake activities; 3) promote the adoption and maintenance of health lifestyle behaviors; and 4) stimulate environmental change activities on HBCU campuses as well as the surrounding community to improve cardiovascular health of African Americans.

Types of Services Provided

Forum at Howard University. “Forum on the Status of CHD in Black Americans: A Blueprint of Forging Linkages to Improve Medical Management and to Enhance Public Health Action” was held at Howard University in Washington, D.C. The forum was held in conjunction with the NHBPEP Coordinating Committee composed of organizations such as the American Medical Association, the American Public Health Association, and the American Heart Association, providing opportunities for establishing linkages with majority organizations. The ABC, NMA, and National Black Nurses’ Association are represented on the NHBPEP Coordinating Committee as well.

Proceedings of the Howard University forum were published in the Journal of the National Medical Association and distributed to more than 32,000 physicians and other health care providers who serve the African American population.

Forum at Meharry Medical College. “Issues of the Heart: Prevention, Management, and Control of Cardiovascular Risk Factors in African Americans” focused on CVD prevention and control in African Americans. The Meharry Medical College, Tennessee State Health Department, and representatives from local coalitions and nonprofit groups within the greater Nashville area were cosponsors of the forum. The forum provided opportunities to stimulate CVD activities on several HBCU campuses (Tennessee State

University and Fisk University) and promote linkages with church-based groups and community coalitions. Proceedings from this forum were published in the Journal of Health Care for the Poor and Underserved and has been distributed widely to NHLBI constituents, HBCUs and other professional groups.

Forum at Harlem Hospital. A forum was conducted at Harlem Hospital that focused on both CVD and asthma among African Americans, a major problem in the New York City area. The goal of the forum was to: 1) bring together experts from a variety of disciplines and perspectives to discuss multiple approaches to promote cardiopulmonary health; 2) heighten awareness in the African American community about the major burden of CVD, stroke, and pulmonary conditions such as asthma; and 3) forge linkages to initiate steps to increase activities to improve prevention, detection, and treatment of cardiopulmonary disease and its contributing risk factors. The forum provided opportunities for interactive sharing of the latest guidelines to help health professionals enhance their practice management skills related to the prevention and control of CVD risk factors and the effective management of asthma in inner-city and high-risk populations.

Specific Target Population

Health professionals, medical students as well as the black community

Collaborating Agencies/Organizations

Office of Research on Minority Health (ORMH), National Institutes of Health (NIH)
Association of Black Cardiologists (ABC)
National Medical Association (NMA)
Howard University
Meharry Medical College
Tennessee State Health Department
Harlem Hospital
Columbia University
National High Blood Pressure Education Program (NHBPEP) Coordinating Committee

Public Health Impact

The forums drew a large number of health professionals, program planners, community leaders, and students involved in providing health care and/or health information to African Americans as well as underserved populations. The provided opportunities to educate health professionals on the latest treatment and management of diseases that impact on the African American community. The forum also provided an opportunity to dialogue and network with other

multidisciplinary groups in an effort to find solutions to public health problems affecting the community.

TIME PERIOD

March 1995 - October 1997

BUDGET

\$195,600 FYs 95-97

Contact Person

Matilda Alvarado, R.N., M.S.N., National Heart, Lung, and Blood Institute,
(301) 496-1051

National Heart, Lung, and Blood Institute

PROJECT TITLE

Working with Religious Congregations: A Guide for Health Professionals

Description of the Project

NHLBI has a long history of promoting CVD health education programs in churches. The church serves as an important avenue to reach special populations who may have fewer contacts with the health care system than the general population. Therefore, church sites offer unique opportunities to conduct a variety of heart-health activities including screening for hypertension, counseling for reduction of saturated fat, cholesterol, and sodium, staying physically active, quitting smoking, and limiting the use of alcohol.

In 1987, *Churches As an Avenue to High Blood Pressure Control*, was developed by the NHLBI to provide information on the development and implementation of high blood pressure programs. In 1997, *Working with Religious Congregations: A Guide for Health Professionals* was developed in collaboration with the State health departments that had participated in the NHLBI Stroke Belt Projects. The guide is designed to help professionals in health agencies reach out to religious congregations and work with them to implement programs to reduce the risk of CVD. This guide provides information about how to: contact and recruit congregation members, train volunteer teams within congregations, implement effective CVD prevention programs, sustain momentum for continued activity, and monitor and evaluate congregation-based programs. In addition to this guide, the CHD and Blacks, east-to-read set of booklets and recipe book are also being distributed to religious groups.

Public Health Impact

Church-based programs are important for reaching populations who have less access to the medical care system. The guide is designed to help congregations get their programs started. Such programs can help to raise community awareness about CVD and associated risk factors and stimulate action to change lifestyles behavior community wide.

Collaboration Organizations

State Health Departments
Private Sector Organizations

Specific Target Population

African Americans

TIME PERIOD

1994 - 1997

BUDGET

\$53,000 FYs 95-97

Contact Person

Glen Bennett, M.P.H., National Heart, Lung, and Blood Institute, (301) 496-0554

National Center for Chronic Disease Prevention and Health Promotion

PROJECT TITLE

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Specific Target Population

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Contact Person

Dr. Robert Robinson, Office of Smoking and Health, Centers for Disease Control and Prevention, (404) 488-5701

Administration on Aging

PROJECT TITLE

A Church-based Health Promotion Project for Elderly Blacks

Description of the Project

This project is designed to enhance the well-being of black elders who reside in Tallahassee, Florida through the development of church-based health promotion programs. These programs will provide various health services, such as health education and physical fitness initiatives. Currently, two black churches have been selected as project sites to serve approximately 5400 elderly persons.

The goals are to:

Conduct a needs assessment survey that will identify and prioritize health risk factors among the black aged.

Increase the awareness of health risks, and increase participation in health promotion activities.

Train local church leaders in the development of new church-based health programs; and

Evaluate the effectiveness of health promotion programs by analyzing pre and post test results to health improvement and healthy lifestyles.

Florida A&M University, aging and health care networks, and local churches are working cooperatively on this project. This collaborative working relationship is coordinated through the Community Health Advisory Council and Church Committee, which are products of this project.

Target Group

African American Elderly

Contact Person

James Y. Koh, Ph.D.
Project Director
Florida A&M University
Department of Social Work
Tallahassee, FL 32307
(904) 561-2254

Administration of Aging

PROJECT TITLE

Health Promotion Among Minority Elderly In Southwest Mississippi

Description of the Project

The purpose of this project is to improve the quality of health promotion behaviors among minority elderly in Southwest Mississippi. The project provides services to blacks 65 years and older who reside in the Adams County area of Mississippi.

The goals are to:

- Deliver health screening, health education, and health counseling to minority elderly at four rural citizen sites in Adams County, Mississippi with the assistance of a mobile nursing center and rural transportation network;
- Provide supportive health education for families and/or caregivers of minority elderly;
- Establish supportive health referral mechanisms and resource system; and
- Collect, analyze and interpret data from minority elderly in a 13-county target area that will identify perception of their health status, health beliefs, and self-care practices.

Alcorn State University, a land grant institution, is conducting this project in collaboration with Area and State Agencies on Aging through its Division of Nursing, using interdisciplinary project staff.

Target Group

African American Elderly

Contact Person

Francis C. Henderson, Ed.D.
Director, Division of Nursing and Project Director
Alcorn State University, Division of Nursing
P.O. Box 18399
Natchez, Mississippi 39122
(601) 442-3901

Administration on Aging

PROJECT TITLE

Health Promotion for Minority Elderly

Description of the Project

This program serves as the focus for health promotion activities which are designed for minority elderly residing in Southeastern Virginia.

The goals are to:

- Develop, implement and evaluate, through an established research process, a health promotion model which is aimed at minority elders;
- Design, utilize and disseminate learning modules, which relate to health promotion and risk reduction strategies, that can be used by health care providers to encourage good health practices among minority elderly;
- Provide affordable primary health care services to minority elderly residing in underserved and unserved urban and rural communities in Virginia, with the assistance of a mobile van; and
- Design and disseminate health promotion education materials to minority elderly.

This project is a collaborative effort which includes Hampton University School of Nursing faculty, students, health care resources, and minority elderly volunteers.

Target Group

Minority Elderly

Contact Person

Patricia Sloan, Ph.D., Professor
Hampton University
School of Nursing
Hampton, VA 23668
(804) 727-5673

Administration on Aging

PROJECT TITLE

Health Promotion/Disease Prevention for Low-Income Elderly Blacks

Description of the Project

The purpose of this project is to encourage the reduction of risk factors associated with disability and death from preventable diseases. This health promotion and disease prevention model accomplishes this objective through the use of lay people who serve as peer counselors. The target population is low-income elderly blacks living in inner-cities and rural areas in Georgia.

The goals are to:

- Identify strategies, which are culturally sensitive and educationally appropriate for the target group, that encourage the reduction of risk factors;
- Generate and disseminate health education materials, concentrating on those inner-city areas where the health problems of low-income black elderly are identified as most severe; and
- Develop a comprehensive training curriculum for peer counselors, which will serve as a model program that can be replicated in similar communities in other states.

This project is a collaborative effort involving the Morehouse School of Medicine, Area Agencies on Aging, volunteer community groups, Fort Valley State College, and the Cooperative Extension Service of the U.S. Department of Agriculture.

Target Group

African American Elderly

Contact Person

Mary Williams, Ph.D.
Project Director
Morehouse School of Medicine
720 Westview Drive
Atlanta, GA 30310
(404) 752-1626

Administration on Aging

PROJECT TITLE

Health Education Maintenance Program

Description of the Project

The primary objective of this project is to improve the health status of minority elderly, using an interdisciplinary educational model. A total of five educational sessions have been designed to stimulate and motivate more minority elders and their service providers to take better care of themselves, in order to control diseases and other debilitating conditions. Educational intervention is directed at a target population that frequent senior citizen programs located in urban and rural areas, minority elderly 60 years of age and above, and their service providers. A special effort is being made to recruit male participants through churches, barber shops, and neighborhood organizations in five different cities/counties in the Baltimore Metropolitan Area.

The goals are to:

- Administer a "Health Style Self Test," which addresses such issues as stress control, nutrition, exercise and fitness, to each participant at the outset of each of the five sessions;
- Engage the project's Advisory board, which consists of an interdisciplinary team of health professionals and consumer members, in the approval of the curriculum and monitoring of session activities;
- Use Lay Trainers for the coordination and administration of the project sessions; and
- Utilize students as assistance to Lay Trainers in the administration of the project sessions.

This project is being conducted with the cooperation of the National Caucus and Center on the Black Aged, various Baltimore social services agencies, and agencies in Anne Arundel and Prince Georges Counties.

Target Group

African American Elderly

Contact Person

Willamae Kilkenny Ph.D.
Project Director
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Cold Spring Lane and Hillen Road
Baltimore, MD 21239
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