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What is SIDS?

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age.

SIDS, sometimes known as crib death, is the major cause of death in babies from 1 month to 1 year of age. Most SIDS deaths occur when a baby is between 1 and 4 months old. More boys than girls are victims, and most deaths occur during the fall, winter and early spring months.

The death is sudden and unpredictable; in most cases, the baby seems healthy. Death occurs quickly, usually during a sleep time.

After 30 years of research, scientists still cannot find one definite cause or causes for SIDS. There is no way to predict or prevent SIDS. But, as this brochure describes, research has found some things that can help reduce the risk of SIDS.



Reduce the Risk of Sudden Infant Death Syndrome (SIDS)

This information is from the U.S. Public Health Service, American Academy of Pediatrics, SIDS Alliance, and Association of SIDS and Infant Mortality Programs.



¿Qué Es El SMIS?

El síndrome de muerte infantil súbita (SMIS) es la muerte repentina e inexplicable de un niño menor de un año de edad.

El SMIS, conocido a veces como muerte de cuna, es la causa principal de la muerte en bebés de 1 mes a 1 año de edad. La mayor parte de las muertes por SMIS ocurren cuando el bebé tiene entre 1 y 4 meses de edad. Mueren más varones que mujeres y la mayoría de las muertes ocurren durante los meses del otoño, el invierno y principios de la primavera.

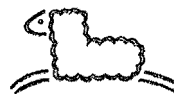
La muerte es repentina e imprevista; en la mayoría de los casos, el bebé parece estar sano. La muerte ocurre rápidamente, generalmente mientras duerme.

Después de 30 años de investigación, los científicos todavía no pueden encontrar una causa o causas definidas del SMIS. Pero, como explica este folleto, la investigación sí ha descubierto algunas cosas que pueden ayudar a proteger al bebé del SMIS.



*Proteja a su bebé
del síndrome de muerte
infantil súbita
(SMIS)*

Esta información viene del Servicio Salud Pública de los Estados Unidos, la Academia Americana de Pediatría, Alianza de SMIS, y la Asociación de Programas del SMIS y de la Muerte Infantil.



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FACTS ABOUT

Down Syndrome



U.S. DEPARTMENT
OF HEALTH
AND HUMAN SERVICES

Public Health Service
National Institutes of Health
National Institute of Child Health
and Human Development

NH Publication No. 97-3402
April 1997



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NICHD

National Institute
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El síndrome de Down



Departamento de Salud y
Servicios Humanos de los
Estados Unidos

Servicio de Salud
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Estados Unidos

Institutos
Nacionales
de Salud

INSTITUTO NACIONAL
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Y DESARROLLO HUMANO

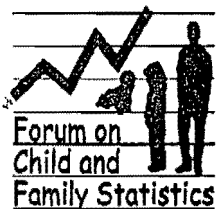
NIH Publicacion No. 98-3402 (S)
Junio 1998



NICHD

INSTITUTO NACIONAL
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Federal Interagency Forum on Child and Family Statistics

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Embargoed until 3 p.m. EDT July 8, 1999

Contact: Robert Bock
(301) 496-5133

Federal Agencies Report On Nation's Children

*Teen Smoking, Birth Rates Down
Children's and Youths' Diets Need Improvement*

America's children are, on average, doing better in several respects than they have in recent years, according to the third annual Federal report, *America's Children: Key National Indicators of Well-Being*.

The report, issued by the Federal Interagency Forum on Child and Family Statistics, represents a comprehensive look at such critical aspects of child well-being as family structure, economic security, health status, access to health care, behavior, social environment, and education.

"We're happy to report that the well-being of America's children has improved in several key areas," said Duane Alexander, M.D., Director of the National Institute of Child Health and Human Development (NICHD). "Infant, childhood, and adolescent death rates are down, as are teen smoking, teen crime, and teen birth rates."

Statistics in the Forum report show other trends regarding America's children. For example, preschool enrollment rates are up. Most children and adolescents have a diet that is poor or needs improvement. In addition, 12 percent of America's children have difficulty performing everyday activities, most of whom have a learning disability or a limitation in the ability to communicate.

Infant, child, and adolescent mortality have declined, noted Edward Sondik, Ph.D., Director of the National Center for Health Statistics.

"The findings on mortality represent a true success story," Dr. Sondik said. "Fewer children die during infancy and the mortality rate for all children has continued to fall."

The infant mortality rate has dropped since 1983, from 10.9 deaths per 1,000 live births, to 7.2 deaths per 1,000 live births in 1997.*

Although the death rate for almost all groups of children has declined, the drop was greatest for black children from ages 1 to 4. From 1996 to 1997, the death rate for black children fell from 67.6 to 59.2 per 100,000. This rate, however, remained at almost twice the rate for whites, which was 31.6 in 1997.*

In 1996, the death rate for adolescents ages 15 to 19 was 78.6 deaths per 100,000. The death rate for this age group reached a peak of 89 per 100,000 in 1991. Among black males from ages 15 to 19, the death rate from firearms dropped, from 120.3 per 100,000 in 1995, to 108.7 per

*The mortality statistics for 1997 published in the Forum report are preliminary, as the final statistics were not yet available at the time of publication. The updated mortality statistics appearing in this release are available from the *National Vital Statistics Report*, Volume 47. "Deaths: Final Data for 1997," at <http://www.cdc.gov/nchswww/products/pubs/pubd/nvsr/47-pre/47-pre.htm>.

100,000 in 1996. Firearm deaths for white males ages 15 to 19 were much lower than for black males, and also declined during the same period, from 27.9 per 100,000 to 23.1 per 100,000.

A new indicator [page 17] measures the quality of children's diets. From 1994 through 1996, most children and adolescents had a diet that was poor or needed improvement. Moreover, older children had poorer diets. For example, in 1996, for children ages 2 to 5, 24 percent had a good diet and 8 percent had a poor diet. The remainder had a diet that needed improvement. For those ages 13 to 18, only 6 percent had a good diet, while 20 percent had a poor diet. The Forum report explains that the lower quality diets of older children are linked to declines in their fruit and milk consumption. (For more information on this topic, see the accompanying backgrounder, "Healthy Eating Index Shows Most Children and Adolescents Have a Diet That is Poor or Needs Improvement.")

The 1999 Forum report also includes a special indicator [page 56] that shows 12.3 percent of America's children from ages 5 to 17 have difficulty performing everyday activities, such as understanding schoolwork, communicating, eating, or dressing. (For more information on this indicator, see the accompanying backgrounder, "Special Indicator Shows More Than 12 Percent of Children Have Difficulty Performing Everyday Activities.")

Although still high, smoking rates also declined among teenagers, the Forum report says. The percentage of 10th and 12th graders who smoked daily dropped in 1998 after having gradually increased since 1992. For 10th graders, the percentage dropped from 18 percent in 1997 to 16 percent in 1998. Among 12th graders, it dropped from its recent high of 25 percent in 1997 to 22 percent in 1998.

Another area to show improvement was the birth rate for teenagers from ages 15 to 17, which dropped from 38.7 live births per 1,000 females in 1991 to 32.1 in 1997.

Regarding education, a higher percentage of children ages 3 to 4 were enrolled in preschool in 1997 than in 1996--48 percent, compared to 45 percent. Preschool enrollment increased most among black, non-Hispanic children, from 45 to 55 percent.

Other education indicators have remained stable, however. High school completion and college completion rates have not improved, and disparities exist between whites, blacks, and Hispanics. For example, the high school completion rate for blacks was 82 percent in 1997, and for whites, 91 percent. The high school completion rate for Hispanics in 1997 was much lower than for either blacks or whites, at 67 percent.

The percentage of high school graduates ages 25 to 29 who earned a bachelor's degree or higher remained relatively stable since 1996, at 31 percent. Again, whites (35 percent) were more likely to attain a bachelor's or higher level degree than were blacks (18 percent) or Hispanics (17 percent).

Serious crimes against children and adolescents are also down. For example, youth from ages 12 to 17 were the victims of violent crime at a rate of 27 per 1,000 in 1997, down from 44 per 1,000 in 1993. (More information on this topic is contained in the accompanying backgrounder, "Indicators of Youth Violent Crime and Victimization Show Continuing Declines.")

In some areas of children's lives, economic disparities have decreased. The percentage of children in families living in poverty who have received the combined series of vaccines has increased between 1996 and 1997, from 69 to 71 percent. In addition, the percentage of children living with their parents who had at least one parent working full time all year increased 5 percentage points to 76 percent from 1993 to 1997. A large share of this increase was due to the increase in the percentage of children living with employed single mothers, which increased from

33 percent in 1993 to 41 percent in 1997. Moreover, preschool enrollment increased among children living in poverty, from 34 percent to 40 percent.

However, while these areas show improvement, significant disparities in child well-being still exist, principally along economic lines.

There has been little change in the percentage of children living in poverty, about 19 percent, roughly the same as it was in 1980. Compared to children above the poverty level, children in poverty are more likely to be at a disadvantage. For example, poor children are more likely to have a significant disability, to live in substandard housing, and to receive inadequate nutrition. Children below the poverty level are also less likely to receive the complete set of childhood immunizations and are more likely to have difficulties in school.

There has been a growing income disparity reflecting a higher proportion of children in extreme poverty as well as in high-income families. Since 1980, the percentage of children living in families with medium income has fallen from 41 percent to 34 percent in 1997, while the percentage of children living in families with high income and the percentage of children in extreme poverty have risen, from 17 to 25 percent, and from 7 to 8 percent, respectively.

The Federal Interagency Forum was entrusted with creating the America's Children Report by Presidential Order 13045. The National Center for Education Statistics played a lead role in producing the final report.

Members of the public may obtain single copies of the Forum report through the National Maternal and Child Health Clearinghouse (while supplies last) at 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182; telephone (703) 356-1964. The report is also available from the Forum's website at <http://childstats.gov>.

Pre-release distribution:

Members of the news media *only* may access the report at <http://156.40.88.8/childindicators/>. Type in the account name, cipaccess, and the password, cip2ja. Access will not be granted until you check the prompt indicating that you will abide by the news embargo of 3 p.m. Eastern Daylight Time, July 8, 1999.

Satellite information

SLUG: Report on America's Children

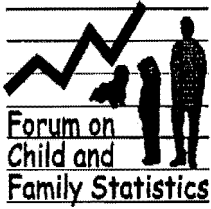
FIRST DISTRIBUTION

DATE: Wednesday, July 7, 1999
FEED TIME: 1:00 to 1:30 p.m. EDT (fed in rotation)
FEED COORDINATES: (C) Galaxy 6/Transponder 9/audio 6.2 & 6.8

SECOND DISTRIBUTION

RE-FEED DATE: Thursday, July 8, 1999
RE-FEED TIME: 10:00-10:30 a.m. EDT (fed in rotation)
FEED COORDINATES: (C) Telstar 4/Transponder 20/ audio 6.2 & 6.8

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**The forum
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produce data
about children.**

Embargoed until 3 p.m. EDT July 8, 1999

**Contact: Sandy Smith
301-436-7551**

Special Indicator Shows More Than 12 Percent of Children Have Difficulty Performing Everyday Activities

A special indicator of child well-being from the *America's Children* report shows that 12.3 percent of America's children from ages 5 through 17 have difficulty performing everyday activities, such as communicating, understanding school work, eating, dressing, and walking (see page 56 of the report).

At 10.6 percent, learning disabilities were the most common of these limitations. This indicator also shows that 5.5 percent of America's children had a limitation in the ability to communicate. These two categories overlap to some degree, since many children with a learning disability also have difficulty communicating, and vice versa.

In addition, about 1.3 percent had limitations in mobility, and 0.9 percent had difficulty with such self-care activities as eating and dressing.

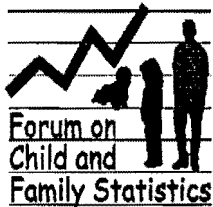
Overall, boys (16 percent) are more likely than girls (9 percent) to have one of these four activity limitations.

The Report noted that children who have such limitations have a very high use of the health care system, and many of them receive special services at school. Activity limitations may be due to childhood illnesses, injuries, and low birthweight.

Moreover, improved methods for detecting activity limitations have allowed service providers to identify larger numbers of children with special needs. Medical treatment, rehabilitation, and other services may remove barriers that determine whether children with a specific activity limitation can perform everyday tasks.

The new indicator measures whether children have difficulty performing specific activities, such as bathing, eating, communicating, or understanding school materials. For this reason, a child with a specific activity limitation, such as attention deficit disorder, may have difficulty with a specific task, such as concentration, but may be able to carry out a more general activity, such as going to school, if he or she receives proper medical treatment.

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**Contact: Adam Spector
(202) 307-3912**

Indicators of Youth Violent Crime and Victimization Show Continuing Declines

By 1997, the rate of serious violent crime involving juvenile offenders had dropped significantly from its peak in 1993.

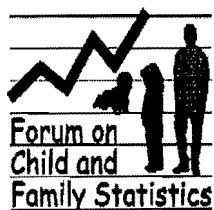
This finding is from the Bureau of Justice Statistics' National Crime Victimization Survey (NCVS), summarized in the 1999 *America's Children* report, which provides a key measure on the level of violence committed by youth, as well as the number of youth age 12 through 17 years old who were crime victims. The serious violent crime measures include the crimes of rape, robbery and aggravated assault from the NCVS, along with data on juvenile-related homicides from the FBI's Uniform Crime Reporting Program.

In 1997, according to victims' reports, 70,000 serious violent crimes involved one or more juvenile offenders between the ages of 12 and 17. The 1997 juvenile violent crime rate of 31 crimes per 1,000 youth in the general population dropped from a high of 52 per 1,000 in 1993 and is the lowest rate since 1986. When compared to the number of violent crimes nationwide, violent crimes committed by juveniles comprise about 1 in 4 of all violent crimes.

Juvenile violence (particularly juvenile homicide) is geographically concentrated, and not a phenomenon experienced by most communities in the U.S. In fact, nearly 9 out of every 10 counties nationwide did not have a juvenile murderer and 1 out of every 4 juvenile murderers were located in eight counties.

Overall, violence rates against youth have also experienced declines nationwide. More than 600,000 serious violent crimes were committed against juveniles in 1997, or nearly 3 such crimes for every 100 youth aged 12-17 in the population. This rate also reflects a steady drop since the 1993 peak of 4 per 100. Significant declines occurred in all age, race and sex groups.

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**Contact: Phil Shanholtzer
(703-305-2286)**

Healthy Eating Index Shows Most Children and Adolescents Have a Diet That Is Poor Or Needs Improvement

A new indicator of child well-being shows that most children and adolescents have a diet that is poor or needs improvement and that as children get older the quality of their diet declines. In 1996, 76 percent of children ages 2 to 5, 88 percent of children ages 6 to 12, and 94 percent of children ages 13 to 18 had a diet that was poor or needed improvement. One out of five children ages 13 to 18 had a poor diet.

This indicator of diet quality is assessed by the Healthy Eating Index (HEI). The HEI, developed by the U.S. Department of Agriculture's Center for Nutrition Policy and Promotion, consists of 10 components, each representing different aspects of a healthful diet. Components 1 to 5 measure the degree to which a person's diet conforms to the Department of Agriculture's Food Guide Pyramid serving recommendations for the five major food groups: grains, vegetables, fruits, milk products, and meat/meat alternates. Components 6 and 7 measure fat and saturated fat consumption. Components 8 and 9 measure cholesterol intake and sodium intake. And component 10 measures the degree of variety in a person's diet.

The decline in children's diet as they get older is linked to declines in their fruit and milk component scores of the HEI. The average fruit score falls from 7.0 (out of a maximum score of 10.0), for children ages 2 to 3, to 3.1 for females and 2.8 for males ages 15 to 18. Only 11 to 12 percent of these older children meet the dietary recommendation for fruit. The milk score declines after age 10. Females ages 15 to 18 have a particularly low milk score--4.2. Only 12 percent of these girls meet the dietary recommendation for milk servings.

Whereas children in poor families may have access to various forms of nutrition assistance programs, they are still more likely than children in nonpoor families to have a diet rated as poor or needs improvement. For children ages 2 to 5, 19 percent of those in poor households had a good diet, compared with 28 percent of those in nonpoor households.

###

Some \$s

Not some

\$s as healthy

people 2000?

Need to check.

GOAL 1 - Eliminate disparities in infant mortality rates.

Infant mortality is an important measure of a nation's health and a worldwide indicator of health status. Although infant mortality in the United States has declined steadily over the past several decades and is at a record low of 7.2 per 1,000 live births (1996 data), the United States still ranks 24th in infant mortality compared with other industrialized nations.

Infant mortality rates (IMR's) vary substantially among and within racial and ethnic groups. Infant death rates among blacks, American Indians and Alaska Natives, and Hispanics in 1995 or 1996 were all above the national average of 7.2 deaths per 1,000 live births. The greatest disparity exists for blacks, whose infant death rate (14.2 per 1,000 in 1996) is nearly 2 times that of white infants (6.0 per 1,000 in 1996). The overall American Indian rate (9.0 per 1,000 live births in 1995) does not reflect the diversity among Indian communities, some of which have infant mortality rates approaching twice the national rate. Similarly, the overall Hispanic rate (7.6 per 1,000 live births in 1995) does not reflect the diversity among this group which had a rate of 8.9 per 1,000 live births among Puerto Ricans in 1995.

To achieve further reductions in infant mortality and morbidity, the public health community, health care providers, and individuals must focus on modifying the behaviors, lifestyles, and conditions that affect birth outcomes, such as smoking, substance abuse, poor nutrition, other psychosocial problems (e.g., stress, domestic violence), lack of prenatal care, medical problems, and chronic illness.

Women who receive prenatal care in the first trimester have better pregnancy outcomes than women who receive little or no prenatal care. For example, the likelihood of delivering a very low birthweight (VLBW) infant (less than 1,500 grams or 3 lb. 4 oz.) is 40 percent higher among women who receive late or no prenatal care compared with women entering prenatal care in the first trimester. Approximately 95 percent of VLBW infants are born preterm (less than 37 weeks gestation). The risk of early death for VLBW infants is about 65 times that of infants who weigh at least 1,500 grams.

In 1996, the proportion of pregnant women across the Nation receiving prenatal care in the first trimester reached 81.8 percent--a consistent improvement for the seventh consecutive year and up from 75.5 percent in 1989. Yet, one in five pregnant women, or three-quarters of a million women, still did *not* receive timely prenatal care; almost 47,000 women received *no* prenatal care at all. In addition, there are substantial racial disparities in the timely receipt of prenatal care. In 1996, 84 percent of white pregnant women, compared with approximately 71 percent of black and Hispanic pregnant women, received early prenatal care. Eliminating these disparities requires the removal of financial, educational, social, and logistical barriers to care.

Among the leading causes of death in infants, the racial and ethnic disparity (expressed as the ratio of the infant mortality rate for black infants to that for white infants, representing the greatest disparity) is greatest in the following: disorders relating to short gestation (preterm birth [PTB]) and unspecified low birthweight (4.1), respiratory distress syndrome (2.8), infections specific to the perinatal period and newborns affected by maternal complications of pregnancy (2.7), and sudden infant death syndrome (SIDS) (2.6). Overall, 13 percent of infants die from disorders relating to short gestation. A much higher incidence of PTB's occurs among black mothers than among white mothers (17.7 compared with 9.7 percent). Underlying factors, such as chronic hypertension and bacterial vaginosis, which have higher incidences among blacks, play a role in PTB's.

SIDS accounts for approximately 10 percent of all infant deaths in the first year of life. Minority populations are at greater risk for SIDS. In addition to the greater risk among blacks, the rates are three

to four times as high for some American Indian and Alaska Native populations.

We will have a significant impact on infant mortality by increasing our efforts to address the racial disparities that exist in both PTB and SIDS rates. Racial and ethnic differences in PTB's and SIDS most likely reflect variations in the prevalence of risk factors, including socioeconomic and demographic factors, certain medical conditions, quality of and access to health care, and practices such as placing babies on their backs to sleep to prevent SIDS. We can work toward addressing all of these issues and measure their impact on reducing the rates of infant deaths due to PTB and SIDS.

Our goal is to continue progress in reducing overall infant mortality rates and to eventually eliminate disparities among groups. As a major step toward that end, we have set a near-term goal to reduce infant mortality among blacks (the group with the greatest disparity in terms of infant death rates) by at least 22 percent from the 1996 rate by the year 2000--or from 14.2 per 1,000 to 11.0 per 1,000 live births. We also will work to reduce infant mortality rates among American Indian and Alaska Natives, and Puerto Ricans, whose rates also are above the national average. In addition, we will continue to monitor progress in reducing the SIDS rates for all racial and ethnic groups as an indicator of our progress toward reducing the national infant mortality rate.

Near-Term Goal

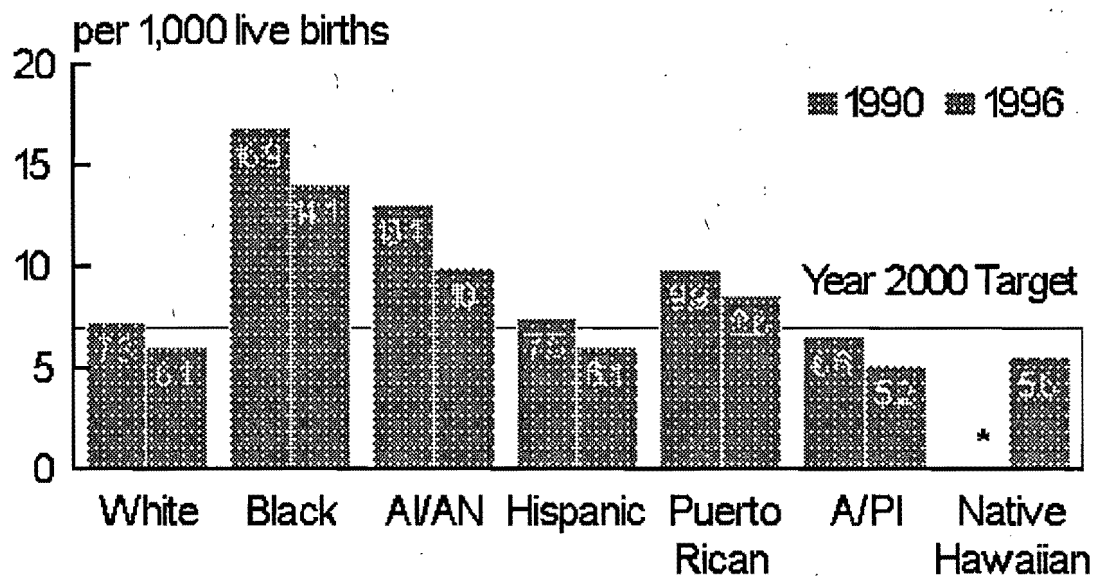
Reduce infant mortality among blacks by at least 22 percent.

Link to Related Charts

[\[ASPE Home Page\]](#) [\[HHS Home Page\]](#) [\[Site Home Page\]](#) [\[Top of Page\]](#)

Please send comments or suggestions to:
HealthDisparities@osaspe.dhhs.gov

Infant Mortality Rates by Race and Hispanic Ethnicity, United States, 1990 and 1996



*Rates based on fewer than 10,000 births are considered unreliable.

NOTE: AI/AN is American Indian or Alaska Native; A/PI is Asian American or Pacific Islander. Y2000 denotes National Year 2000 Target.

SOURCE: CDC/NCHS National Vital Statistics System, Linked Birth and Infant Death data set.

GOAL 2 - Eliminate disparities in cancer screening and management.

Cancer is the second leading cause of death in the United States, accounting for more than 544,000 deaths each year. About 1.4 million new cases of cancer are expected to be diagnosed in 1997, and approximately 7.4 million Americans have or have had cancer. The chances of developing cancer in a lifetime are nearly 50 percent for men and nearly 40 percent for women. About half of those who develop the disease will die from it.

Many minority groups suffer disproportionately from cancer. Disparities exist in both mortality and incidence rates. For men and women combined, blacks have a cancer death rate about 35 percent higher than that for whites (171.6 vs. 127.0 per 100,000). The death rate for cancer for black men is about 50 percent higher than it is for white men (226.8 vs. 151.8 per 100,000). The death rate for lung cancer is about 27 percent higher for blacks than for whites (49.9 vs. 39.3 per 100,000). The prostate cancer mortality rate for black men is more than twice that of white men (55.5 vs 23.8 per 100,000).

Paralleling the death rate, the incidence rate for lung cancer in black men is about 50 percent higher than in white men (110.7 vs. 72.6 per 100,000). Native Hawaiian men also have elevated rates of lung cancer compared with white men. Alaska Native men and women suffer disproportionately higher rates of cancers of the colon and rectum than do whites. Vietnamese women in the United States have a cervical cancer incidence rate more than five times greater than white women (47.3 vs. 8.7 per 100,000). Hispanic women also suffer elevated rates of cervical cancer.

Much can be done to reduce the burden of cancer in the United States through prevention. Lifestyles can be modified to greatly reduce an individual's risk for cancer. Tobacco use is responsible for nearly one-third of all cancer deaths. Evidence suggests that diet and nutrition may be related to 30 to 40 percent of cancer deaths. Additionally, many of the estimated 900,000 skin cancer cases diagnosed each year could be prevented by reducing sun exposure.

For some cancers that we do not yet know how to prevent, early detection can dramatically reduce the risk of death. Regular mammography screening and appropriate follow-up can reduce deaths from breast cancer by about 30 percent for women 50 years of age and older. Screening by Pap test for cervical cancer along with appropriate follow-up care can virtually eliminate the risk of developing this disease.

The purpose of goal 2 is to improve screening and management of cancer. Although colorectal cancer screening is now recommended, few data on screening rates exist. Screening for prostate cancer remains controversial, and for this cancer as well, few data on screening rates exist. Indeed, there is a significant need for public education about what is known, what is not known, and what is believed about prostate cancer screening and treatment. Breast and cervical cancers, however, have proven screening modalities for which screening data, both baseline and continuing, are available. For this reason, the strategy for achieving goal 2 focuses on breast and cervical cancers.

Despite the considerable gains in screening in the black community, the mortality rate from breast cancer for black women is greater than for white women. Some of the reasons for this disparity include the fact that many women have not yet had a mammogram or a Pap smear, many more are not screened regularly, and still others are screened but have limited follow-up and treatment services available to them. Hispanic, American Indian and Alaska Native, and Asian and Pacific Islander women also have low rates of screening and treatment, limited access to health facilities and physicians, and barriers related to language, culture, and negative provider attitudes, which negatively affect their health status. Eliminating

these differences is critical and will be the focus of attention for the HHS initiative to help identify and understand approaches that have proven successful in some communities. Our focus on tracking breast and cervical cancer will serve as an indicator for assessing our overall efforts to reduce and eventually eliminate disparities in the prevention and management of all cancers.

Breast Cancer

Our goal for the year 2000 for breast cancer screening is to increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and a mammogram within the preceding 2 years.

Near-Term Goal

Increase to at least 60 percent those women of all racial or ethnic groups, aged 50 and older, who have received a clinical breast exam and mammogram within the preceding two years.

Cervical Cancer

Our goal for the year 2000 for cervical cancer is to increase to at least 85 percent the proportion of all women aged 18 and older who have received a Pap test within the preceding 3 years.

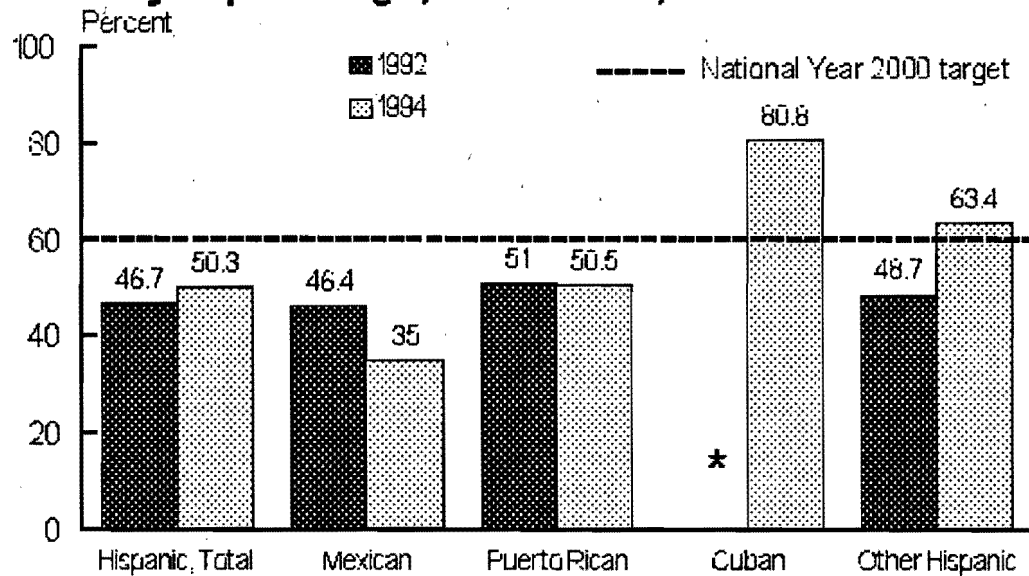
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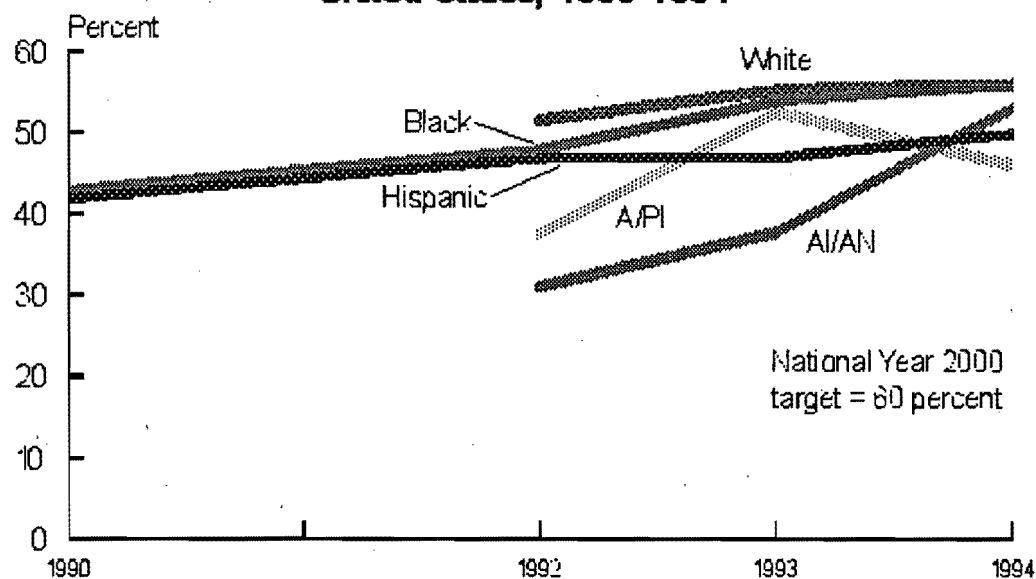
Women 50 Years and Over Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding 2 Years by Hispanic Origin, United States, 1992 and 1994



* Relative standard error greater than 30 percent.

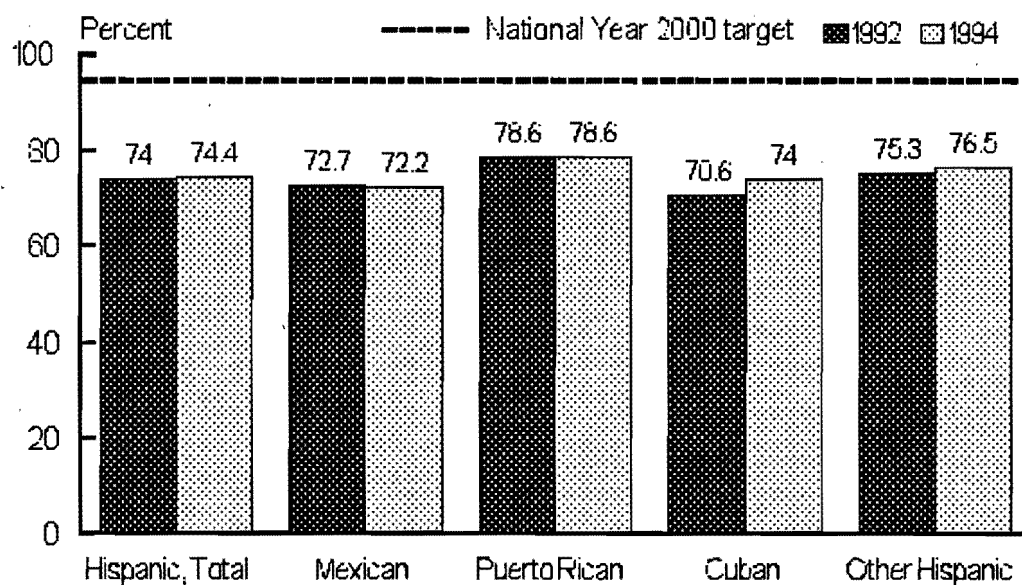
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Women 50 Years and Over Who Have Received a Clinical Breast Examination and a Mammogram Within the Preceding 2 Years, United States, 1990-1994



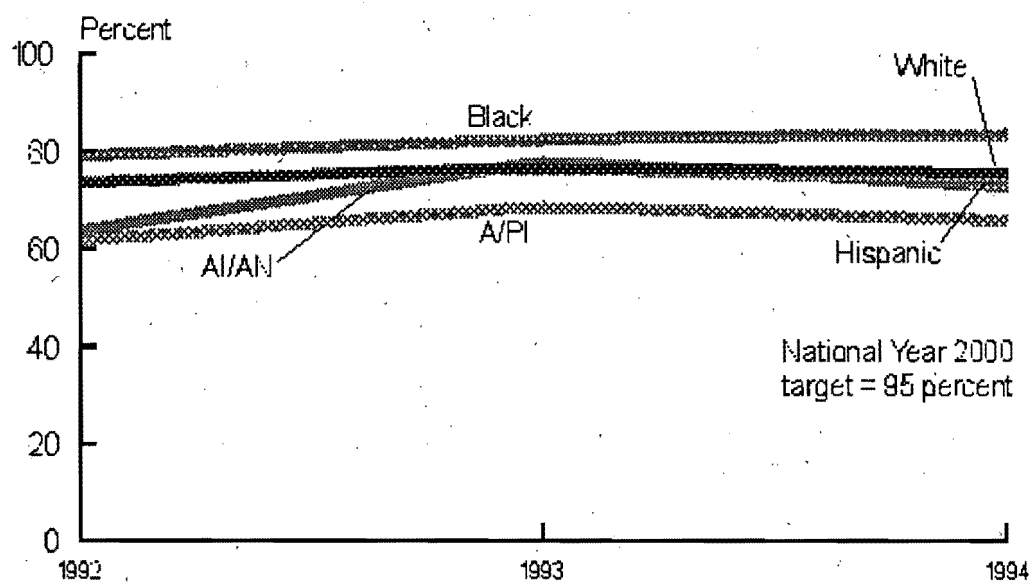
NOTE: AI/AN is American Indian or Alaska Native; A/PI is Asian American or Pacific Islander.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Women 18 Years and Over Who Have Received a Pap Test Within the Preceding 3 Years by Hispanic Origin, United States, 1992 and 1994



SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Women 18 Years and Over Who Have Received a Pap Test Within the Preceding 3 Years, United States, 1992-1994



NOTE: A/AN is American Indian or Alaska Native; A/PI is Asian American or Pacific Islander.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

GOAL 3 - Eliminate disparities in cardiovascular disease.

Cardiovascular disease, primarily coronary heart disease and stroke, kills nearly as many Americans as all other diseases combined and is among the leading causes of disability in the United States. Cardiovascular disease is the leading cause of death for all racial and ethnic groups. The impact of premature morbidity from cardiovascular disease on the ability of affected individuals to function independently or to participate fully in everyday life is devastating in terms of personal loss, pain, suffering, and effects on families and loved ones. The annual national economic impact of cardiovascular disease is estimated at \$259 billion as measured in health care expenditures, medications, and lost productivity due to disability and death.

The major modifiable risk factors for cardiovascular disease are high blood pressure, high blood cholesterol, cigarette smoking, excessive body weight, and physical inactivity. The greatest potential for reducing coronary heart disease morbidity, disability, and mortality appears to be in prevention, by addressing these risk factors.

- Some people with **high blood pressure** have three to four times the risk of developing coronary heart disease and may have as much as seven times the risk of a stroke as do those with normal blood pressure. Clinical trials show that blood pressure reduction significantly reduces stroke mortality and can help to reduce deaths from coronary heart disease.
- Each 1 percent reduction in serum **cholesterol** level has been associated with a greater than 1 percent reduction in risk of coronary heart disease death.
- Prospective epidemiologic studies have documented a rapid and substantial reduction in coronary heart disease rates following **smoking** cessation. Reducing the proportion of youth who start to smoke and encouraging smoking cessation among current smokers are important preventive measures for reducing coronary heart disease incidence and mortality.
- A reduction in the proportion of Americans who are **overweight** and **physically inactive** can help lower coronary heart disease incidence and mortality. Risks of nonfatal myocardial infarction and coronary heart disease death increase with increasing levels of body mass index (BMI) (weight in kg divided by height in meter²) and with weight gain. Risks are lowest in men and women with BMI's of 22 or less and increase with modest elevations of BMI. Persons who are physically active have one-half the risk of both coronary heart disease incidence and mortality compared to persons who are sedentary.

Major disparities exist among population groups, with a disproportionate burden of death and disability from cardiovascular disease in minority and low-income populations. The age-adjusted death rate for coronary heart disease for the total population declined by 20 percent from 1987 to 1995; for blacks, the overall decrease was only 13 percent. Compared with rates for whites, coronary heart disease mortality was 40 percent lower for Asian Americans but 40 percent higher for blacks in 1995. Stroke is the only leading cause of death for which mortality is higher for Asian-American males than for white males.

Disparities also exist in the prevalence of risk factors for cardiovascular disease. Racial and ethnic minorities have higher rates of hypertension, tend to develop hypertension at an earlier age, and are less likely to undergo treatment to control their high blood pressure. For example, from 1988 to 1994, 35 percent of black males ages 20 to 74 had hypertension compared with 25 percent of all men. When age differences are taken into account, Mexican-American men and women also have elevated blood pressure rates. Among adult women, the age-adjusted prevalence of overweight continues to be higher for black women (53 percent) and Mexican-American women (52 percent) than for white women (34 percent). Furthermore, the rates for regular screening for cholesterol show disparities for certain racial and ethnic

minorities--only 50 percent of American Indians/Alaska Natives, 44 percent of Asian Americans, and 38 percent of Mexican-Americans have had their cholesterol checked within the past 2 years.

Our goal is to continue progress in reducing the overall death rates from heart disease and stroke and eventually to eliminate disparities among all racial and ethnic groups. To have the greatest impact toward that end, we have set near-term goals of reducing the heart disease and stroke mortality rates among blacks by 25 and 40 percent, respectively, from their 1995 level by the year 2000. Although age-adjusted death rates for cardiovascular disease among other minority groups are lower than the national average, there are subgroups within these populations that have high mortality rates from heart disease and stroke. We will develop strategies to reduce these mortality rates as well.

Near-Term Goals

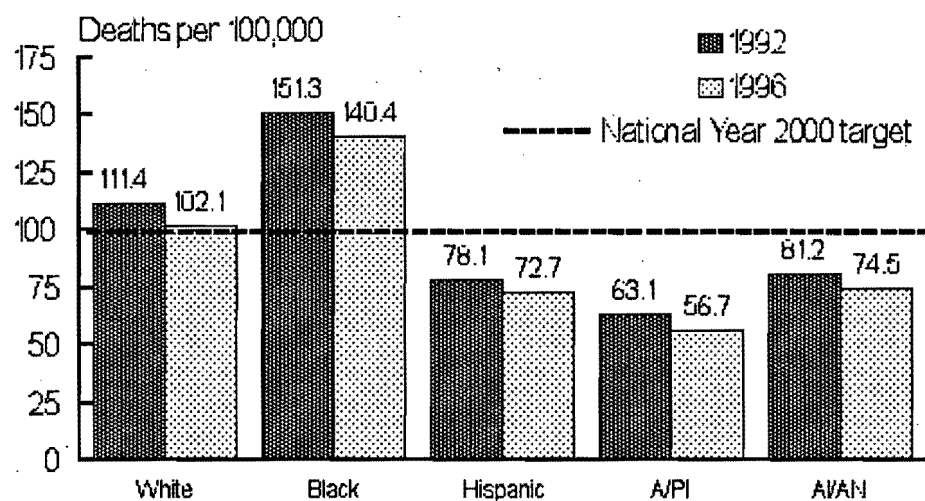
- Reduce the heart disease mortality rate among blacks by 25 percent
- Reduce the stroke mortality rate among blacks by 40 percent

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Coronary Heart Disease (CHD) Deaths by Race and Hispanic Ethnicity, United States, 1992 and 1996



NOTES: Death rates are age-adjusted to 1940 standard million age distribution.

A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

GOAL 4 - Eliminate disparities in diabetes.

Diabetes, the seventh leading cause of death in the United States, is a serious public health problem affecting nearly 16 million Americans. The estimated total direct and indirect costs of diabetes for the United States in 1993 was \$98 billion.

The prevalence of diabetes in blacks is approximately 70 percent higher than whites and the prevalence in Hispanics is nearly double that of whites. The prevalence rate of diabetes among American Indians and Alaska Natives is more than twice that for the total population and at least one tribe, the Pimas of Arizona, have the highest known prevalence of diabetes of any population in the world.

Cardiovascular disease is the leading cause of death among people with diabetes, accounting for over one-half of all deaths. Achieving mortality reduction among high-risk populations will require targeted efforts to reduce cardiovascular risk factors among these groups, which is a focus of our goal on eliminating disparities in cardiovascular disease. Individuals with diabetes, however, face not only a shortened life span, but also the probability of multiple acute and chronic complications, including end-stage renal disease (ESRD), blindness, and lower extremity amputations. All of these complications have the potential to be prevented.

- If uncontrolled hypertension among people with diabetes were reduced by half, about one-quarter of *ESRD* due to diabetes could be prevented.
- **Diabetic retinopathy** is the leading cause of new cases of blindness among people 20 to 44 years of age. Clinical trials have demonstrated that approximately 60 percent of diabetes-related blindness can be prevented with good blood glucose control or by early detection and laser photocoagulation treatment, which is widely available but underused.
- One half of all **lower extremity amputations** can be prevented through proper foot care and by reducing risk factors such as hyperglycemia (abnormally high blood sugar), cigarette smoking, and high blood pressure.

Preventive interventions should target high-risk groups. Rates for diabetes-related complications such as ESRD and amputations are higher among blacks and American Indians compared to the total population. Even among similarly insured populations, such as Medicare recipients, blacks are more likely than whites to be hospitalized for septicemia, debridement, and amputations -- signs of poor diabetic control. Scientists are concerned that a number of people in these minority groups develop type 2 (non-insulin-dependent) diabetes in adolescence, and therefore face a lifetime of diabetes and its potential complications. Undiagnosed and poorly controlled diabetes increases the likelihood of serious complications; for every two persons who are aware of their illness, there is one person who remains undiagnosed.

Although the increasing burden of diabetes is alarming, the good news is that much of this major public health problem can be prevented with early detection, improved care, and diabetes self-management education. Diabetes presents both a challenge and an opportunity for public policy makers, health care providers, community leaders, and individuals with diabetes to apply prevention strategies known to make a significant impact. Recent studies in diabetes have confirmed that careful control of blood glucose levels is a strategy that works for preventing the complications of diabetes. The challenge is to make proper diabetes management part of daily clinical and public health practice.

Therefore, our goal is to monitor progress in reducing diabetes by reducing the overall rate of diabetic complications among all individuals with diabetes and eventually to eliminate disparities among groups.

As a major step toward that end, we have set two near-term goals: (1) reducing the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent from their 1995 levels by the year 2000, and (2) reducing lower extremity amputation rates from diabetes among blacks by 40 percent from their 1995 levels. Rates of diabetic complications among Hispanics are also high; however, current data do not permit us to monitor diabetic complications among this group. We will develop strategies to reduce diabetes-related complications among all minority groups and to improve data collection.

Near-Term Goals

- Reduce the rate of ESRD from diabetes among blacks and American Indians/Alaska Natives by 65 percent.
- Reduce lower extremity amputation rates from diabetes among blacks by 40 percent.

The rates of diabetes-related complications used as outcome measures are crude indicators of progress in eliminating disparities; however, they are the only outcome measures available consistently on a national basis. We also will monitor behavioral practices and health care access issues as indicators of success. Examples of these indicators include diabetes-specific preventive care such as self-monitoring of blood glucose levels, clinic visits, diabetic foot care, and dilated-eye exams.

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GOAL 5 - Eliminate disparities in HIV Infection/AIDS.

HIV infection/AIDS is a leading cause of death for all persons 25 to 44 years of age. Between 650,000 and 900,000 Americans are estimated to be living with HIV infection. Approximately 62 percent (375,000) of the 604,200 adults and adolescents reported with AIDS in the United States have died from the disease.

AIDS has disproportionately affected minority populations. Racial and ethnic minorities constitute approximately 25 percent of the total U.S. population, yet they account for nearly 54 percent of all AIDS cases. While the epidemic is decreasing in some populations, the *number* of new AIDS cases among blacks is now greater than the number of new AIDS cases among whites.

There are several different HIV epidemics occurring simultaneously in the United States, each of which must address the specific population affected and their associated risk factors. For example, although the number of AIDS diagnoses among gay and bisexual men has decreased dramatically among white men since 1989, the number of AIDS diagnoses among black men who have sex with men have increased. In addition, AIDS cases and new infections related to injecting drug use appear to be increasingly concentrated in minorities; of these cases, almost 75 percent were among minority populations (56 percent black and 20 percent Hispanic). Of cases reported among women and children, more than 75 percent are among racial and ethnic minorities.

During 1995 and 1996, AIDS death rates declined 23 percent for the total U.S. population while declining only 13 percent for blacks and 20 percent for Hispanics. Contributing factors for these mortality disparities include late identification of disease and lack of health insurance to pay for drug therapies. The cost of efficacious treatment, between \$10,000 and \$12,000 per patient per year, is a major hurdle in the effort to ensure equitable access to available drug therapies.

Inadequate recognition of risk, detection of infection, and referral to follow-up care are major issues for high-risk populations. About one-third of persons who are at risk of HIV/AIDS have never been tested. Better prevention strategies are needed that are acceptable to the target community (i.e., they must be culturally and linguistically appropriate), and the capability of organizations serving at-risk populations to develop, implement, evaluate, and fund prevention and treatment programs must be improved. Efforts should include risk reduction counseling, street and community outreach, prevention case management services, and help for individuals at risk in gaining access to HIV testing, treatment, and related services.

At this moment, there are many causes for optimism in the fight against HIV/AIDS. HIV prevention efforts have contributed to slowing the spread of the disease. For the first 6 months of 1996, there was an overall decrease in deaths among persons with AIDS, attributed primarily to the effect of antiretroviral therapies on the survival of persons with HIV infection. The decrease in the growth of AIDS cases in minority populations, however, has not been so strong.

To enable HIV-infected persons to benefit from treatment advances, HIV counseling and testing programs in screening and health care settings must better facilitate early diagnosis of HIV infection and ensure that HIV-infected persons have access to care and treatment services. Continued emphasis on behavioral risk reduction and other prevention strategies targeted to these populations is still the most effective way to reduce HIV infections.

Although advances in prevention and treatment are improving the quality of life for individuals living with HIV/AIDS, not everyone is benefiting equally from this progress. Concerns regarding education about

the benefits of knowing one's serostatus, access to counseling and testing, and referral and access to medical services, including efficacious therapies, will continue to guide the development and administration of Federal initiatives to prevent HIV transmission and improve access to care for individuals living with HIV/AIDS.

Our goal is to continue progress in increasing the overall availability of early diagnosis of HIV infection and ensuring access to appropriate health services for all and to eventually eliminate disparities among groups. By the year 2000, the combined efforts of Medicaid, Medicare, and HRSA's Ryan White CARE Act will ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS. We will establish educational outreach to all major medical providers to promote the current standard of clinical care for all persons living with HIV/AIDS, including Medicaid-eligible women and children with HIV infection.

Near-Term Goal

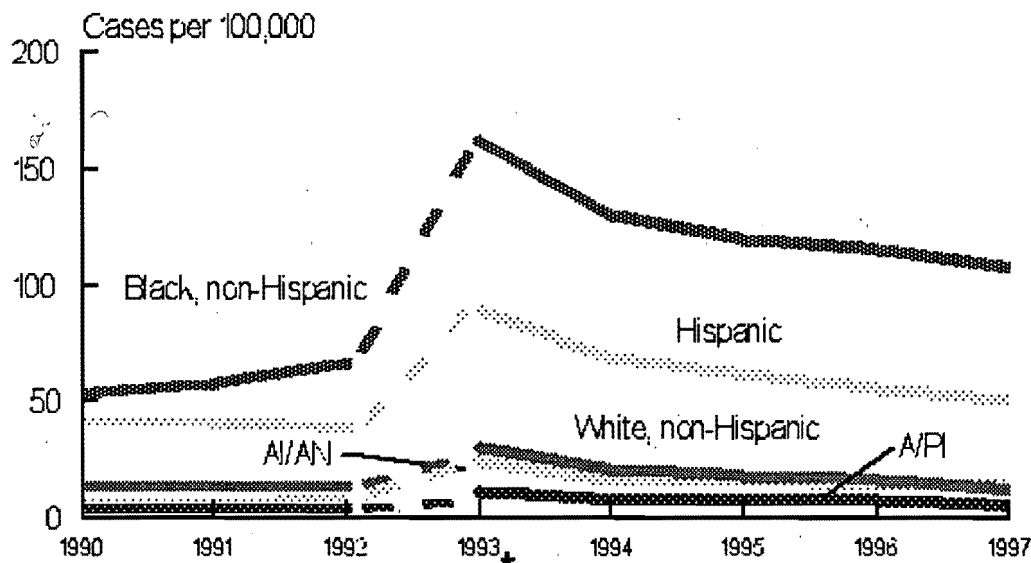
Ensure early and equal access to life-enhancing health care and appropriate drug therapies for at least 75 percent of low-income persons living with HIV/AIDS.

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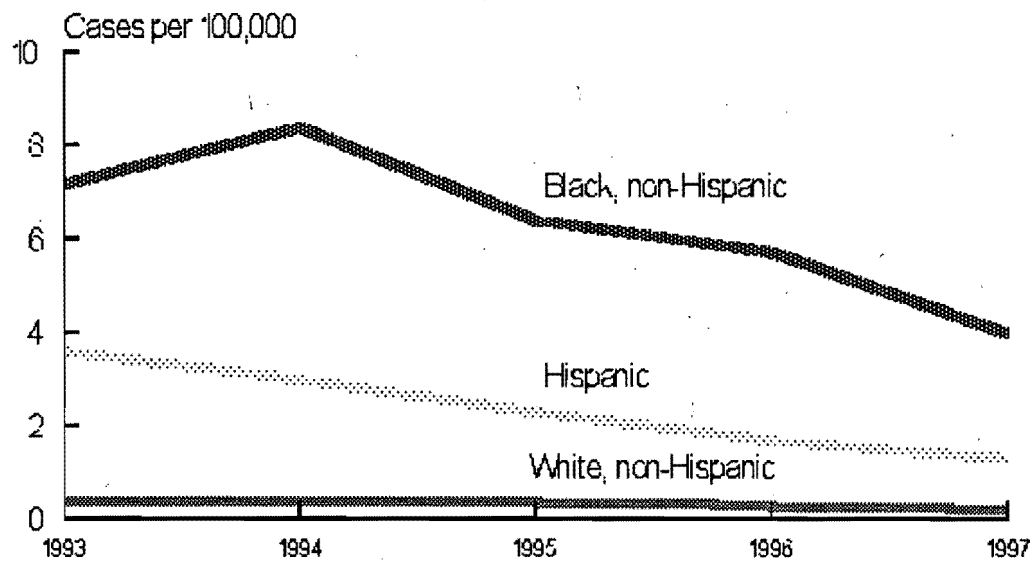
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AIDS Case Rates in Persons 13 years and over by Race and Hispanic Ethnicity, United States, 1990-1997



NOTES: Case definition changed in 1993. A/PI is Asian American or Pacific Islander; A/AN is American Indian or Alaska Native. SOURCE: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Adult/Adolescent AIDS Reporting System.

AIDS Case Rates in Children under 13 years by Race and Hispanic Ethnicity, United States, 1993-1997



NOTES: Asian American or Pacific Islander and American Indian or Alaska Native populations had fewer than 10 cases annually. SOURCE: Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Pediatric AIDS Reporting System.

GOAL 6 - Eliminate disparities in child and adult immunization rates.

The reduction in incidence of vaccine-preventable diseases is one of the most significant public health achievements of the past 100 years. This success is best illustrated by the global eradication of smallpox, achieved in 1977. The major factor in this success is the development and widespread use of vaccines, which are among the safest and most effective preventive measures. Billions of dollars are saved each year through the use of vaccines.

Childhood immunization rates are at an all-time high, with the most critical vaccine doses reflecting coverage rates of over 90 percent. The 1996 immunization coverage targets for all five vaccines (measles, mumps, and rubella [MMR]; polio; diphtheria, tetanus, and pertussis [DTP]; *Haemophilus influenza* type B [Hib]; and hepatitis b [Hep B]) were exceeded. Although immunization rates have been lower in minority populations compared with the white population, minority rates have been increasing at a more rapid rate, thus significantly narrowing the gap. For example, four of the five 1996 coverage targets were met for blacks. Current efforts must be sustained in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations.

Although coverage for preschool immunization is high in almost all States, pockets of need, or areas within each State and major city where substantial numbers of underimmunized children reside, continue to exist. These areas are of great concern because, particularly in large urban areas with traditionally underserved populations, there is a potential for outbreaks of vaccine-preventable diseases.

In addition to the very young, older adults are at increased risk for many vaccine-preventable diseases. Approximately 90 percent of all influenza-associated deaths in the United States occur in people aged 65 and older, the fastest growing age group of the population. Reduction of deaths in this age group has been hindered in part by relatively low vaccine utilization. Immunization is one of the most cost-effective strategies to prevent needless morbidity and mortality. Each year, however, an estimated 45,000 adults die of infections related to influenza, pneumococcal infections, and hepatitis B despite the availability of safe and effective vaccines to prevent these conditions and their complications. In addition, the overall cost to society for vaccine-preventable diseases exceeds \$10 billion each year.

There is a disproportionate burden of these diseases in minority and underserved populations. Although vaccination levels against pneumococcal infections and influenza among people 65 years and over have increased slightly for blacks and Hispanics, the coverage in these groups remains substantially below the general population and the year 2000 targets.

Childhood Immunization

Our goal is to enhance current immunization efforts in order to achieve and maintain at least 90 percent coverage for all recommended vaccines in all populations and to eliminate remaining disparities among groups.

Near-Term Goal

Achieve and maintain at least 90 percent coverage for all recommended childhood vaccines in all populations

Adult Immunization

Our goal is to increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent and eventually to eliminate disparities among groups. To reach this goal by the year 2000, we need to nearly *double* the 1994 influenza immunization rates among blacks, Hispanics, and Asians and Pacific Islanders and *quadruple* the 1994 pneumococcal immunization rates among these groups.

Near-Term Goal

Increase pneumococcal and influenza immunizations among all adults aged 65 years and older to 60 percent

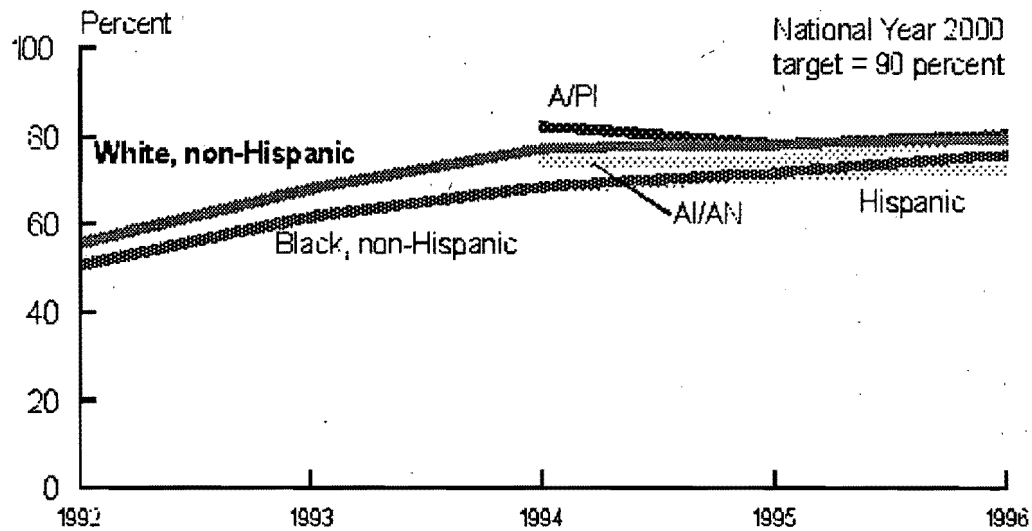
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Childhood Immunization Rates* by Race and Hispanic Ethnicity, United States, 1992-1996

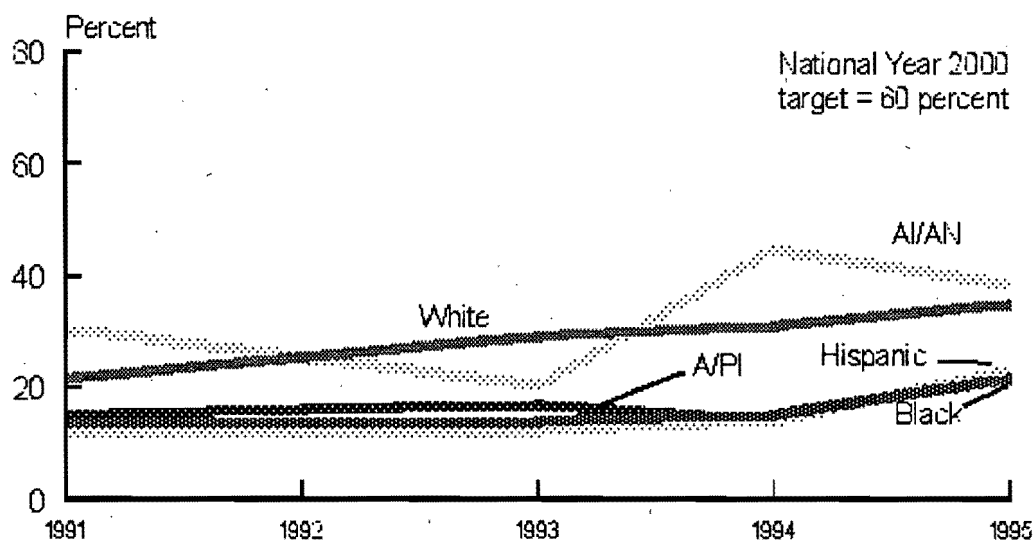


*Immunization rates reflect those children ages 19-35 months who have received 4 doses of DTP (diphtheria, tetanus, pertussis), 3 polio, and 1 MMR (measles, mumps, rubella).

NOTE: A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.

SOURCES: Centers for Disease Control and Prevention, National Immunization Survey (1994-1996), and National Health Interview Survey (1992-1993).

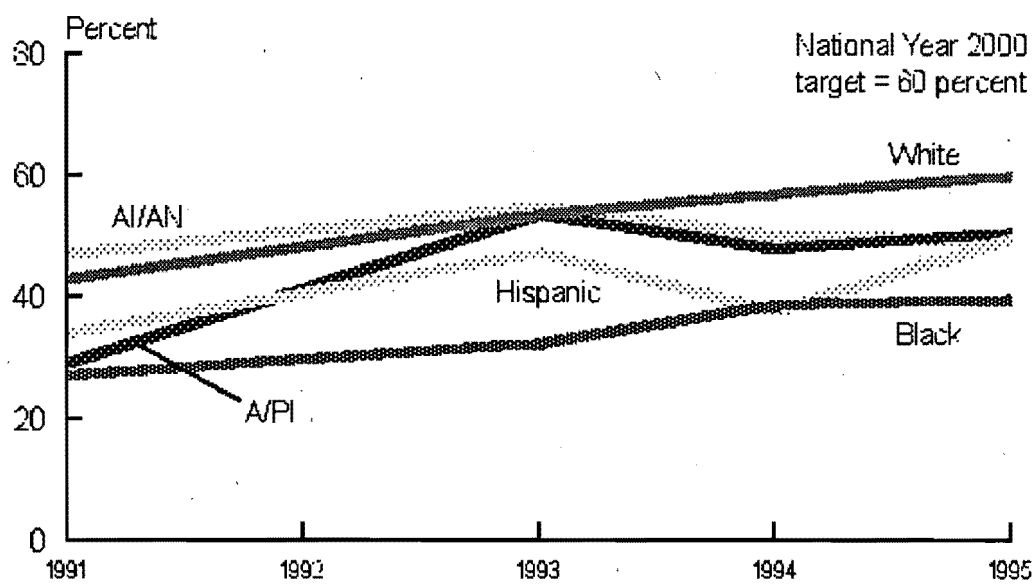
Pneumococcal Immunization Rates for Persons 65 Years and Over by Race and Hispanic Ethnicity, United States, 1991-1995



NOTES: A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Influenza Immunization Rates for Persons 65 Years and Over by Race and Hispanic Ethnicity, United States, 1991-1995



NOTES: A/PI is Asian American or Pacific Islander; AI/AN is American Indian or Alaska Native.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics,
National Health Interview Survey.