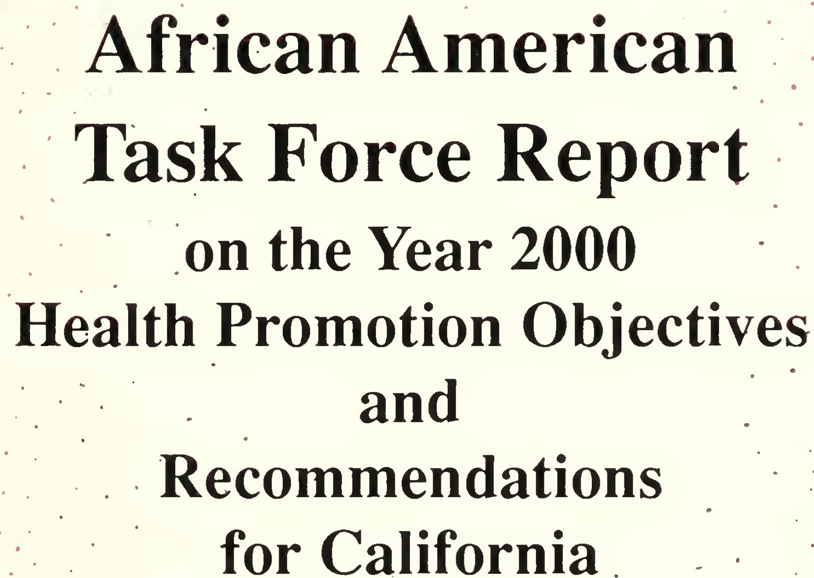

African American Task Force Report on the Year 2000 Health Promotion Objectives and Recommendations for California

May 1992

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Prepared by the African American Task Force for the
Unity in Health, Diversity in Culture Conference, sponsored by the
California Department of Health Services Health Promotion Section
in June 1991.

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African American Task Force Report

on the Year 2000 Health Promotion Objectives and Recommendations for California

May 1992

Prepared by the African American Task Force for the Unity in Health, Diversity in Culture Conference, sponsored by the California Department of Health Services Health Promotion Section in June 1991.

The comments and recommendations expressed in this report are of the African American Task Force and do not necessarily reflect the activities or plans of the California Department of Health Services. All four reports were presented by the Multi-Ethnic Steering Committee for Health Promotion to the California Department of Health Services in May 1992 in Sacramento, California.

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For more information on any of the Multi-Ethnic Health Promotion Task Force Reports, please contact the California Department of Health Services
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Forward

As a result of the astounding scientific and medical achievements of the 20th century, we now know that a fuller measure of health is within reach for all Californians. Yet, despite the overall achievements in health status, the burden of poor health all too often falls more heavily on some population groups than on others. The fact that this "gap" in health status occurs more frequently among people with low income and people belonging to racial/ethnic "minority" groups has been documented both nationally and in California. These groups are identified as African American, American Indian, Asian and Pacific Islander, and Hispanic/Latino. Rather than use the term "minority", the Steering Committee decided that the term "multi-ethnic" was more appropriate given the growth of these populations in California. Not only does this gap in the health status experienced by these racial/ethnic groups include consistently higher excess mortality and poorer overall health as measured by infant mortality rates and disability levels, it also involves disparities in health-related information and resources as well.

Confronting the gap in health status among the State's multi-ethnic groups began with a vision, followed by action, on the part of Lela Folkers, Barbara Marquez, Virginia Leung Jang, and other key staff of the California Department of Health Services' Health Promotion Section, which sponsored and coordinated the first Multi-Ethnic Health Promotion Conference in June 1991. As an integral part of that conference, four Ethnic Task Forces, under the leadership of Steering Committee members, were formed to identify critical areas of need with regard to health promotion within their respective communities and then worked one step further to develop health promotion objectives and recommendations for each area. This information was then assembled in the form of a series of discussion papers, which together served as the centerpiece of the conference's activities.

In addition to the information contained in the original discussion papers, the enclosed Ethnic Task Force Report now incorporates a wealth of additional information garnered from hundreds of conference participants and reviewers. The Task Force Report is prefaced by a summary and background which provides a description of the model used for the development of the ethnic-specific health promotion objectives, a summary of major recommendations, and a discussion of future directions and uses of the information.

The challenge of ensuring good health for all residents is of critical importance in California because our state is home to a large share of the nation's total racial/ethnic populations. It is projected to be the first mainland state with a majority of "minorities," an emerging majority if you will, possibly as early as the year 2005. California, as nowhere else in the United States, is a microcosm of multi-cultural living. Strategies to improve health must be based on the fullest possible knowledge of the influences on health and illness for a particular population group. But more often than not, strategies to improve the health of racial/ethnic groups are transplanted or adapted from interventions and research based on middle-income whites. Unfortunately, differences in culture, race, and language are all too often treated as a series of obstacles which must be overcome in providing health care services.

As a member of California's emerging majority, and on behalf of the Multi-Ethnic Health Promotion Conference Steering Committee and its four Ethnic Task Forces, we present the enclosed summary and information on ethnic-specific health promotion objectives and implementation strategies for the year 2000 for California. This report acknowledges the growing recognition by California's multi-ethnic communities of the importance of prevention and early detection of the major causes of excess mortality, illness, and disabilities rather than treatment of a disease after it has occurred. They also emphasize the overwhelming importance of cultural diversity as a guiding principle in the development of health promotion policies and practices.

As the product of one of the largest such undertakings ever brought to fruition in the United States, the Task Force Reports represent the product of many months of work by concerned individuals, health care providers, and educators from public health, academia, and most importantly, from the State's ethnic communities themselves. On behalf of all of us associated with the conference, I wish to take this opportunity to thank each Task Force member and conference participant for his/her contribution to this important effort. Continued cooperation and commitment from such groups and individuals across California will be needed if we are to move our multi-ethnic health promotion agenda forward.

Reaching the goal of equitable health status for all racial/ethnic groups will be one of the most important public health achievements of our time, not just for California, but for many other states as well. Good health and well-being is the greatest legacy we can leave our children and future generations. What we do now will influence the future for good or for bad. Therefore, I invite each of you to join in adapting and using the enclosed objectives and recommendations in your community.

Henry Montes, Chair
Steering Committee
Multi-Ethnic Health Promotion Conference

Acknowledgments

The development of each Task Force Report involved literally hundreds of individuals and organizations. These reports would not have been possible without their commitment and many hours of volunteer work. A special thanks also to the major sponsors of the Multi-Ethnic Health Promotion Conference:

-- The California Department of Health Services' Health Promotion Section
-- U.S. Public Health Service's Centers for Disease Control (U58/CCU900590-07)
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-- Federal Indian Health Services, California Area Office

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Summary and Background

Summary and Background for Advancing a Multi-Ethnic Health Promotion Agenda for California

The Multi-Ethnic Health Promotion Planning Model

Preliminary Planning Efforts

To better address the prevention and health promotion needs of the state's growing multi-ethnic groups, in 1987 the California Department of Health Services' (CDHS) Health Promotion Section coordinated and participated in a two-day workshop in Los Angeles. The purpose of the workshop was to identify emerging and critical issues germane to the state's ethnic groups. Participation was by invitation and the workgroups were largely comprised of representatives from the state's public health and social service organizations, voluntary health agencies, and academic institutions. Three major conclusions emerged from that workshop:

- There is a large unmet need for culturally appropriate and relevant health promotion and risk reduction services targeted toward the state's racial and ethnic population groups.
- There is a wealth of innovative community-based programs being undertaken throughout the state which have proven successful and which might serve as program models for other ethnic communities.
- There is currently no forum or structure for ongoing information exchange of innovations, successful strategies, and program models specifically for health promotion among multi-ethnic groups.

There were strong indications from workshop participants that the planning and direction for future "minority" health promotion efforts will be most successful if they originate from the racial and ethnic community. Since advocacy and information exchange were needed, the CDHS would play a critical role by: 1) directing funding and technical assistance to minority communities; 2) continuing to act as central focal point for data and technology transfer; and 3) creating forums for information exchange by the state's racial and ethnic minority groups. Since that time, the CDHS' Health Promotion Section incorporated most of the recommendations from the 1987 workshop into its state and local assistance programming. The consensus building model used for planning the first Multi-Ethnic Health Promotion Conference held in Sacramento in June 1991 represents one such collaborative effort on the part of many organizations, agencies, groups, and individuals to create the opportunity for communities to advance a multi-cultural health promotion agenda for California.

Planning Process

As depicted in Figure 1, "Model for the Development of California Ethnic-Specific Year 2000 Health Promotion/Disease Prevention Objectives," the Multi-Ethnic Health Promotion Conference was part of a larger planning and consensus-building process. The major elements of the model included the CDHS, a steering committee, four ethnic task force groups, and the community. Working together towards the common goal of creating a multi-ethnic agenda, the task force groups took the lead in (1) identifying health promotion priorities for their respective communities; (2) setting objectives; and (3) developing recommendations for strategies to be pursued to improve health promotion for the state's ethnic groups.

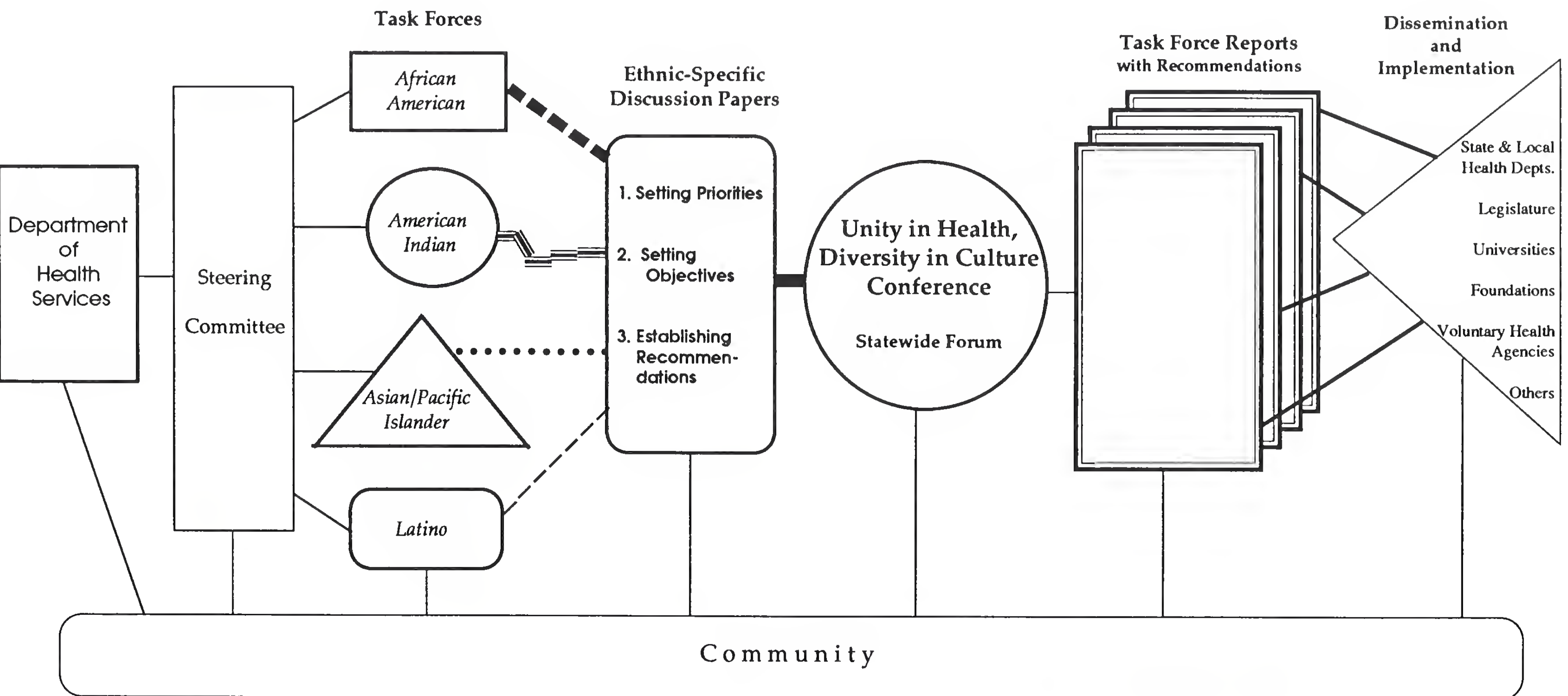
The methods employed by the task force groups to gain community involvement and to develop the initial discussion papers included: identifying key individuals and groups involved in service delivery, research, training or who otherwise have health promotion knowledge and experience; conducting community assessments through surveys or interviews; and reviewing existing data and key pieces of literature. Once the priority areas were selected and the discussion papers were developed, they were circulated for review and then presented during the conference. Finally, feedback from conference participants concerning priorities, objectives, and recommendations was consolidated into the final task force reports, which together serve as a framework for advancing a multi-ethnic health promotion agenda in California. As shown by the model, community involvement was a key ingredient at each juncture in the development of health promotion objectives, from the initial conceptualization of the project by the CDHS to the dissemination and implementation of the objectives by community groups. This latter activity is described in the "Future Directions" section.

Developing the California Multi-Ethnic Health Promotion Agenda was a one-year consensus-building project that involved a number of resources, key groups, and individuals. The Multi-Ethnic Health Promotion Agenda was conceptualized in response to and as an outcome of earlier planning and program implementation activities of the Health Promotion Section. To ensure that the new health promotion agenda reflected the needs of California's increasingly diverse population, in November 1990 the CDHS' Health Promotion Section organized, through internal and external nominations, a steering committee of 15 public health leaders who represented ethnic community-based organizations, academia, and federal and county governments. The steering committee, chaired by Mr. Henry Montes, provided overall guidance for the conference and its members were instrumental in forming and providing leadership for each of the ethnic task forces.

Convened in January 1991, the ethnic task forces were charged with setting health priorities, establishing objectives, and developing recommendations for four key ethnic groups: African Americans, American Indians, Asians and Pacific Islanders, and Latinos. Each group met separately over a six-month period and developed unique working arrangements in accordance with its own infrastructure, resources, and cultural norms. Continuity was provided by the members of the steering committee who provided leadership on the various task forces. The CDHS provided staff support and was able to reimburse the costs of some expenses. However, it should be noted that the majority of the necessary resources were supplied by the steering committee and the task force members on a voluntary basis.

Figure 1

Model for the Development of California Ethnic-Specific Year 2000 Health Promotion/Disease Prevention Objectives



The resource documents used in the task force deliberations were Healthy People 2000: National Health Promotion and Disease Prevention Objectives, published by the U.S. Department of Health and Human Services[1] and the Summary of Healthy People 2000, prepared by the American Public Health Association[2]. Due to the time constraints inherent in preparing for the June 1991 conference and the fact that the major topic of concern was health promotion and the prevention of chronic disease, the task force groups were asked to limit their deliberations to 10 of the 22 topic areas (see Table 1) listed in these two documents. Within these areas, task force groups were asked:

- To prioritize topic areas and provide a rationale statement concerning the importance, in terms of the health status of the ethnic population.
- To review and comment upon the relevance to the ethnic group of the Year 2000 health status, risk reduction, and service and protection objectives. Each task force was thus able to accept the objectives as written, modify the objectives to make them more relevant, or prepare completely new objectives.
- To make recommendations on three levels -- policy, community interventions, and resource development -- for achieving the objectives.

More than 100 task force members participated in the development of the initial discussion papers. As described more fully in each of the Task Force reports, during the months preceding the conference, each task force employed several activities for prioritizing topics, establishing objectives, and formulating recommendations. For example, some groups formed subcommittees and held regional meetings, while other groups conducted statewide surveys, examined available state and national data bases, and solicited written comments from knowledgeable reviewers.

The Conference Objectives, Process, and Participants

The 1991 Multi-Ethnic Health Promotion Conference played a central role in the development of a multi-ethnic health promotion agenda. It provided a statewide forum to:

- Build public and private partnerships for resource development to expand and enhance health promotion programs and services for multi-ethnic communities.
- Identify and disseminate culturally appropriate and sensitive health promotion and chronic disease programs and models for the African American, American Indian, Asian/Pacific Islander, and Latino communities.
- Create a forum for participants to contribute to the development of a California Multi-Ethnic Health Promotion Agenda based upon the Year 2000 Objectives.
- Explore existing educational and community-based programs and surveillance and data systems and identify gaps in these systems related to multi-ethnic communities and their health status.

In June 1991, the discussion papers were debated at the statewide conference referred to as the Multi-Ethnic Health Promotion Conference, but officially titled "Unity in Health, Diversity in Culture, Advancing a Multi-Ethnic Health Promotion Agenda for California." Although an attendance of approximately 150 conference participants was initially expected, pre-conference registration had to be closed once the number of participants reached 550 people.

The first day of the conference was reserved for discussion groups on data and surveillance systems, and for seminars on chronic diseases and risk factors, including those related to unintentional injuries and violent and abusive behavior. On the morning of the second day, conference participants were able to attend workshops to learn first hand about successful community interventions, policy strategies, and ways to develop resources. The ethnic-specific breakout sessions were held the remainder of the day. During the breakout sessions, participants had an opportunity to discuss and comment upon the papers they had received earlier as part of the conference materials.

Each breakout session had a facilitator and a recorder. As previously mentioned, community input from conference participants was used to then revise the papers and to draft the final task force reports. The conference steering committee, in conjunction with the task force groups, compiled the final recommendations between June and December of 1991. However, the major changes or new recommendations garnered as part of this working conference were reported to all participants during the plenary session held at the end of the conference. At that time, participants were invited to comment informally (and formally through the written conference evaluation) on the proceedings. There was one final review of the post-conference revised reports by conference participants in August 1991.

Health Promotion Priorities

As stated earlier, in preparing the discussion papers, the task force groups were limited to ten of the twenty-two topic areas in Healthy People 2000. These topics (listed in Table 1) were selected because they fall within the parameters of the Health Promotion and Tobacco Control Sections and their closely allied programs within the CDHS. The Task Force groups selected those areas which members felt to be highly significant to promoting good health within their respective communities. The details of the selection or priority topic areas are shown in Table 1. The rationale for their selection is contained in the individual task force reports. The four groups viewed the areas differently and some of the groups went on to set priority areas while others did not.

Table 1
Priority Health Promotion Topic Areas Selected by each Task Force

	African American	American Indian	Asian/Pacific Islander	Latino
• Physical Activity & Fitness	✓			✓
• Nutrition	✓	✓	✓	✓
• Tobacco	✓		✓	✓
• Violent & Abusive Behavior	✓			✓
• Educational & Community-Based Programs	✓			✓
• Unintentional Injuries				✓
• Heart Disease & Stroke	✓	✓	✓	✓
• Cancer	✓	✓	✓	✓
• Diabetes & Chronic Disabling Conditions	✓	✓	✓	✓
• Surveillance & Data Systems				✓

Source: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. D.H.H.S., 1990. Topic areas in Table 1 are listed in the order in which they appear in Healthy People 2000.

New/Modified Objectives

Once they had identified priority areas for their respective community, each task force was then asked to review the objectives already developed by the Federal Public Health Service and contained in Healthy People 2000. For the most part, the task force groups accepted Healthy People 2000 as a working document which could be adapted to reflect more accurately the most significant needs of specific populations. During the review of existing information, each Task Force could reject, accept as is, or modify the Healthy People 2000 objectives, or develop new objectives for any topic area. Therefore, the objectives listed in each ethnic Task Force Report represent those objectives which, after a review of existing information, were found to be of importance to meet the health promotion needs for that particular ethnic community.

In preparing the early drafts of the discussion papers, several task force and steering committee members had raised the issue that a number of pressing areas of concern, such as HIV infection, alcohol and drug use, maternal and child health issues, immunizations, and infectious diseases, to ethnic communities were not addressed through the chosen process . These limitations were also noted by some conference participants. As discussed in the "Future Directions" section, the activities being planned by task force groups is to use the initial 10 areas as a starting point and to continue planning for the other 12 health promotion and disease prevention objectives which were not addressed in the initial process.

Recommendations for Intervention Strategies

The Process for Developing Recommendations for Intervention Strategies

A major portion of the Multi-Ethnic Health Promotion Conference was devoted to identifying activities and developing strategies for accomplishing the health promotion objectives. The task force groups had completed their prioritization of topics and had reviewed and quantified ethnic-specific objectives through the various processes described above. The conference participants, who were predominantly community representatives, were asked to review and comment on the work of the task forces. After a review of this information, conference workshop participants were asked to develop three levels of recommendations for each topic area. These levels were:

- Policy
- Resource Development
- Community Intervention

Participants were encouraged by the facilitators of each workshop to gear their recommendations to those activities which can make the greatest improvements in health and which will assist the public, health professionals, and decision makers in both public and private sectors in adopting an agenda for advancing multi-ethnic health promotion.

Overall Recommendations

The following recommendations were developed through several methodologies (e.g., community surveys, literature review, interviews, and the iterative group processes used by facilitators and moderators at the conference). These methods culminated in an extensive listing of recommendations and activities for future action, which were compiled and reviewed separately by each of the four Ethnic Task Force Groups.

The following recommendations are presented from the broadest level of intervention at the policy level to the most focused level of implementation at the community level and represent a distillation of those issues and concepts which cut across diverse program areas and interests. They were formulated in response to the following general perceptions:

- Although there is an overall gap in health status between whites and non-whites in California, a wide range of differences exist across ethnic population subgroups.

- The use of averaged white health data as the normative standard or optimal reference point may not necessarily adequately reflect needs for many ethnic populations:

- Health promotion programs for multi-ethnic populations are characterized by insufficient ongoing funding and inadequate manpower resources at all levels (research, training, community intervention). This, in turn, often results in fragmented services and program activities which cannot comprehensively address individual personal health needs nor adequately address the important social/economic/community antecedents to poor health.

- There is a need for effective culturally and linguistically appropriate health promotion educational materials and methods, as well as trained staff.

Recommendations which target discrete agencies or entities appear within each of the individual Ethnic Task Force Reports. However, overall, the recommendations were made with an understanding that no one agency can or should be responsible for addressing the plethora of health promotion issues brought to light by the task force members and conference participants. Rather, at each level of recommendations being offered, a multitude of agencies will need to be actively involved and partnerships formed to achieve results.

An overriding recommendation made by each Task Force on the final day of the conference was to continue the work of the Steering Committee and the conference. Repeatedly, it was recommended that the conference become an annual event.

Summary of Major Policy Recommendations

1. An Office of Minority Health Affairs should be created within State government, either within the Health and Welfare Agency or the Department of Health Services, to: act as or coordinate the activities of an existing agency acting as a central clearinghouse for health-related information and interventions specific to California's multi-cultural communities; coordinate the activities of multiple state programs; provide technical assistance to communities on program planning, implementation, and evaluation; monitor the progress of State agencies and programs whose activities have an impact on the health of California's ethnic populations; and advocate for necessary resources to address emerging problems.

2. State and federal agencies which routinely collect data or which fund programs which collect data should require the use of ethnic-specific identifying information. Where appropriate, these agencies should make a concerted effort to collect the following:

   - Multiple types of information for specific ethnic subgroups, including non-health information which can contribute to the development of health models for ethnic subgroups.

   - Descriptive epidemiologic data to better understand how and when disease occurs among ethnic groups.

   - Anecdotal information from health and service practitioners on interventions and approaches that are effective.

3. All agencies, organizations, and groups concerned with health promotion and disease prevention should advocate for the creation of a legislative multi-ethnic health promotion agenda in California. This advocacy should emphasize the growing importance of prevention and its integration with other services and such integration should take place at the community, regional, and statewide levels.

4. Health promotion should be emphasized in all programs/program areas funded or implemented by the California Department of Health Services and the California Department of Education. The importance of health promotion should be stressed for all participants in entitlement programs administered by the California Department of Social Services, the California Department of Health Services, and the California Department of Mental Health.

Summary of Major Resource Development Recommendations

1. Institutions of higher education in the health sciences should initiate mandatory cross-cultural, bilingual education and training programs for health and social service providers to increase the number of providers who are able to provide high-quality, appropriate multi-cultural services.

2. All educational institutions and voluntary health agencies in California involved in health professional, patient education, public awareness, and public school education should be encouraged to develop and implement culturally appropriate and relevant health promotion, health protection, and disease prevention curricula, and to implement and promote such education and training programs within their jurisdictions.

3. The California Department of Health Services and local health jurisdictions should actively provide technical assistance to community organizations serving ethnic populations on the availability of funding, grant writing, and community organization/mobilization, effective state-of-the-art education and outreach programs for ethnic populations, and the institutionalization of prevention activities in other existing services.

4. Public-private partnerships should be forged between providers of education and medical services to fund pilot programs which increase access to high-quality, comprehensive chronic disease prevention programs for high-risk ethnic populations.

5. Coverage for health promotion and preventive health services should be increased under existing health care financing and social service programs; targeted tax initiatives and tax incentives should be sought to develop stable, long-term funding for ethnic health promotion programs.

Summary of Major Recommendations for Community Intervention

1. Community health promotion interventions should be comprehensive, well-coordinated, accessible, acceptable, and appropriate for the ethnic population(s) they intend to serve. Programs are more likely to be effective if they build upon existing efforts and expertise, use multiple community channels, and involve community constituency groups in all program phases from community assessment and program planning through implementation and evaluation.

2. Community organizations and groups providing or interested in providing health promotion and disease prevention services should create broad-based support through the creation of public-private partnerships and the development of community coalitions.

3. Broad-based community interventions aimed at long-term change in community norms should use a variety of approaches and have multiple targets, such as:

    - individuals (all age/gender groups)
    - organizational (worksites, churches, schools)
    - environmental (local policies and regulations)
    - education (all levels)
    - community organization (coalitions, consortia)
    - regulatory (federal, state, local)

4. Multi-ethnic health promotion is jeopardized by unstable and decreased resources for programs and trained staff. Federal, state, and local health jurisdictions and voluntary agencies should earmark a portion of their resources/activities for multi-ethnic health promotion; those agencies which make grant funding available should earmark a portion of these funds to address the health promotion needs of ethnic groups.

Future Directions

Intent and Distribution of the Task Force Reports

The task force reports provide a framework for efforts to improve health of a large and growing segment of the California population over the present decade. They are intended to serve as a tool for decision makers in public and private agencies in planning and implementing programs. To that end, the conference steering committee has developed a plan for the dissemination of the task force reports. Each conference participant and task force member will receive a copy of each report. The task force groups have developed listings of agencies and individuals who will also receive the Task Force Reports.

To make these reports true working documents, the steering committee has created a list of high and low intensity organizations. The low intensity organizations (e.g., minority organizations, community clinics, community-based organizations) will receive the full set of reports along with the summary information. In addition to this information, the organizations identified as high intensity (e.g., the major voluntary health organizations in California, foundations, hospitals, and health maintenance organizations, professional groups) will receive follow-up contact and technical assistance.

Building Momentum

As a result of the planning process used in the development of the Task Force Reports, hundreds of community organizations, groups, and individuals have now become familiar with Healthy People 2000 and its objectives for health promotion and disease prevention. Healthy People 2000, along with the Task Force Reports, have become important, highly visible working documents.

To continue the forward momentum, the African American Task Force has already distributed a working paper version of its report and in September and October of 1991 initiated training to its members on ways to present the report and how to provide technical assistance on its use. The conference steering committee, which itself is evolving into an ad hoc advisory body and advocacy group, is reviewing this training format and design for possible use by the other task force groups. As part of its new role and in recognition of the importance of ethnic-specific information in policy formation, the chair and members of the steering committee wrote letters of support for the CDHS' application to the Robert Woods Foundation to fund an "Information and State Health Policy Program" which at the time of this writing is being considered for funding.

The task force recommendations are now being actively used by programs within the CDHS, academic institutions, and legislative bodies. The CDHS' Health Education-Risk Reduction Program used the task force recommendations in setting priorities for local funding in its Fiscal Year 1992-93 Request for Applications, issued in November 1991. The CDHS' Special Projects Section used information from the initial discussion papers in the development of its funding

proposal to the Centers for Disease Control for a statewide breast and cervical cancer control program for low-income women. This program was funded in July 1991 and is now in operation. The new Breast and Cervical Cancer Program, in turn, initiated a local assistance funding program incorporating many recommendations. The CDHS' Preventive Medical Services' Target Population Committee is currently using the task force reports in the identification of priority areas and strategies for its chronic disease and injury control activities. The CDHS' Tobacco Control Section, which is responsible for implementing Proposition 99, the Tobacco Tax Initiative, has formed four ethnic networks. These networks are also using the recommendations in their planning of future tobacco prevention and cessation programs.

The planning model and the recommendations are also being used to pattern other similar efforts. For example, in November 1991, the Riverside Health Department presented a series of in-service training sessions for its medical and health education staff modelled after the Multi-Ethnic Health Promotion Conference. The California State University at San Francisco has received a health education grant award and in April of 1992 is presenting a "Multi-Cultural Health Challenges" Career Opportunities Workshop. The Steering Committee members, Task Force leadership, and CDHS staff have been invited to participate. It is also the intent of the Steering Committee to advocate that the planning model be utilized by the Department of Health Services in addressing the other twelve health promotion topics of Healthy People 2000 not addressed at the Unity in Health, Diversity in Culture Conference.

Several exciting activities are also happening on the legislative front. On September 27, 1991, Senators Diane Watson, Art Torres, and Lieutenant Governor Leo McCarthy held a forum on Asian/Pacific Islander Health Issues during which the recommendations from the reports were shared. Information and recommendations from the African American Task Force Report were used at the October 11, 1991 meeting of the California Legislature's Subcommittee on Minority Health Affairs, chaired by Assemblyman Curtis Tucker, Jr.

Later that same month, a Steering Committee member, George Flores, M.D., presented information and an overview of lessons learned from the planning process to the California Conference of Local Health Officers at their October 31, 1991 meeting. Finally, information from the reports were presented at a senate hearing on Youth, Health, and Fitness convened on December 2, 1991 by Senator Charles Calderon at California Polytechnic State University in Pomona.

References

1. U.S. Department of Health and Human Services: Healthy People 2000: National Health Promotion and Disease Prevention Objectives. U.S. Government Printing Office, Washington DC., September 1990.

2. Professional Affairs Division, American Public Health Association: Summary of Healthy People 2000: National Health Promotion and Disease Prevention Objectives. (Abridged) American Public Health Association, Washington DC.

Year 2000 Health Promotion Objectives and Recommendations for African Americans in California

Year 2000
Health Promotion Objectives and Recommendations for African Americans in California

Summary on the Preparation of the African American Task Force Report

Introduction

Regional task forces were coordinated by the staff of the Health Promotion Section of the California Department of Health Services to gain input in determining regional appropriateness, and selecting and defining priorities within the four major ethnic/racial communities in California from ten health promotion topics from Healthy People 2000. This particular strategy was part of the planning process for the Multi-Ethnic Health Promotion Conference held in J une 1991. The physical size of the State of California also necessitated a regional approach to accomplishing the task of producing a statewide conference truly reflective of the needs of the multi-ethnic communities of California.

In order to simplify some of the work of the regional task forces, members of the conference Steering Committee met to discuss establishing four priority topics most relevant to the African American community. The Steering Committee members also provided leadership for the three African American Task Forces formed to represent three geographical regions in California: San Diego - southern; Los Angeles - southern/central; and San Francisco - northern. After some discussion, the four topics selected for consideration were violent and abusive behavior, physical fitness and exercise, nutrition, and tobacco. Although there was not complete consensus on each of the topics, there was agreement that the four topics would be brought back to the regions for discussion. There was as much discussion about the process for getting regional input as there was further discussion about what topics were most relevant to the African American community. At issue was a unique combination of process, philosophy, and local resources, coupled with indicators for regional differences identified by the public health leadership in the African American community.

Violent and abusive behavior was a topic for which there was consensus. The remaining three topics were debated along the lines of morbidity and mortality in the African American community due to cardiovascular disease, cancer, and diabetes versus risk reduction and prevention of illness through exercise and nutrition. The topic of tobacco was discussed in relationship to the existence of massive funding for tobacco control in California financed via the state tobacco tax, some of which is specifically directed to the African American community. The debate centered around the level of funding already present in statewide tobacco control activities versus the correlation of tobacco consumption with the incidence and prevalence of site-specific cancers and cardiovascular diseases in African Americans. The resolution reached

called for obtaining regional input based on the four initial topics discussed and on the premise that the topics selected held the greatest potential to reduce the risk of disease. However, the process for obtaining input from African American communities in the three regions was a function of regional differences in leadership style. The outcomes were also a reflection of those regional differences.

The leadership in the southernmost part of the state chose to work through the African American physician and nurses associations to get community input by sponsoring community forums. Southern/central Californians worked through a university-based medical center utilizing staff experts from various disciplines, and the northern part of the State solicited regional experts in the four topic areas. The southernmost most region defined as priorities three different topics from the original four, specifically, heart disease, cancer, and diabetes, with violent and abusive behavior remaining. The southern/central region consolidated topics, i.e., physical fitness and nutrition, cancer and tobacco, added educational/community based programs and retained violent and abusive behavior. The northern region obtained consensus on the original four topics from its regional task forces.

Negotiations took place among the three regions to consolidate the regional priorities in order to develop a cohesive position paper that was representative of the health promotion needs of California African Americans.

The Northern California task force developed a preliminary document containing the four topics, each with objectives selected from Healthy People 2000. They were modified and expanded, some with additional objectives that reflected cultural specificity. Program development strategies, public policy recommendations, strategies for community-based advocacy and resource development were included for each topic, emphasizing an Afro-centric focus. The document was developed over a three-month period and was immediately shared with the other two regions via FAX machines during its various stages of development. The document become the vehicle around which the negotiations took place for consolidating differing regional priorities. By way of several teleconferences and consultation from the CDHS Health Promotion Section, agreement was reached with the document as the focal point.

Both the southern and southern/central regions adopted the work of the Northern Task Force. The additional priority topics, educational/community-based programs, cancer, diabetes, heart disease and stroke were developed by their respective regional task forces using the same format as the northern California document. The consolidated document became the basis for the draft position paper for health promotions/mandates for African American communities in California.

A draft document was given to each conference participant. At the African American breakout session, the participants ranked the health promotion objectives in order of priority and their recommendations for community and policy interventions and resources development for each of the topic areas. Additional recommendations proposed to the group were adopted. With additions and modifications incorporated into the draft, it was reported to the general conference and adopted as the Health Promotion Agenda in the African American Communities of California.

The overriding policy recommendation of the task force was to endorse Assembly Bill 136 proposed by California Assemblyman Curtis Tucker, Jr.: To establish a centralized office within the State Health and Welfare Agency that will coordinate activities, provide technical assistance, and monitor progress of State and local agencies and programs that impact on the health status of African Americans.

The Task Force is proceeding to introduce and present the agenda to community, professional and voluntary organizations, foundations and interested others. The agenda has been included as part of California State Assemblyman Curtis Tucker's hearings on the status of African American health in California and in the testimony of several presenters.

The Task Force is conducting training sessions on presenting the health promotion agenda. The goal is to use the document to assist communities in identifying and defining their health promotion concerns and to raise awareness about the extent of the problems identified and the preventive strategies outlined in the document. It is hoped that organizations and individuals will be motivated to take action in developing coalitions to address the issues. The task force plans to record and track those activities.

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Violent and Abusive Behavior

Priority I. Violent and Abusive Behavior

Introduction

The consensus reached in selecting violent and abusive behavior apart from others in the Healthy People 2000 document reflects its significance and impact upon the African American community. The issue is of paramount concern to the African American (AA) Task Force and is deemed to have similar importance for African Americans in California. It carries significant emotional charge in this society. This is particularly so for African Americans because of the historical context of being an enslaved people and the continuing legacy of violent and abusive behavior toward African Americans as individuals and as members of a community.

What follows are the objectives selected by the AA Task Force from the national document. Objectives have been modified where the Task Force saw the need to to expand the scope of an objective. Modifications are identified as REV., indicating a revision of the original objective; the letter A indicates the expansion of the scope of an objective. Modified objectives are bulleted (•); all revisions are underlined. New indicates the addition of a new objective to the original document. Reference to specific Healthy People 2000 Objectives appear in parenthesis.

Rationale

Homicide is the leading cause of death for young African Americans;
Violence as a social health issue affects the family structure, support systems, and vitality of the community;
Violence is a mental health aberration with either social or intrapsychic antecedents;
The impact of child abuse in early childhood development contributes to adult violent behavior;
Negative role stereotyping of women contributes to male aggressive behavior toward women;
There are alternatives to violent behavior as a means to resolve conflict;
There is need to expand the perspective of violence from law enforcement and criminal justice to public and mental health and other social systems;
Much violence is associated with factors of unemployment, illegal drug use, and the availability and accessibility of guns.

A. Health Status Objectives

1.3 Reduce weapon-related violent deaths to no more than 12.6 per 100,000 people from major causes.

(Age-adjusted baseline: 12.9 per 100,000 by firearms; 1.9 per 100,000 by knives in 1987) (Healthy People 2000, Objective 7.3)

• 1.3A Reduce to no greater than 18.1 percent weapon-related violent deaths for African American males, aged 18-34.

(There is a need for ethnic-age/specific data.)

1.4 Reverse to less than 25.2 per 1,000 children the rising incidence of maltreatment of children younger than age 18.

(Baseline: 25.2 per 1,000 in 1986.) (Ibid., Objective 7.4)

Type-Specific Targets

Incidence of Types of Maltreatment	1986 Baseline	2000 Target
1.4a Physical abuse	5.7/1,000	<5.7/1,000
1.4b Sexual abuse	2.5/1,000	<2.5/1,000
1.4c Emotional abuse	3.4/1,000	<3.4/1,000
1.4d Neglect	15.9/1,000	<15.9/1,000

1.6 Reduce assault injuries among people aged 12 and older to no more than 10 per 1,000 people.

(Baseline: 11.1 per 1,000 in 1986) (Ibid., Objective 7.6)

1.8 Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14 through 17.

(Baseline data available from national agencies in 1991.) (Ibid., Objective 7.8)

• 1.8A Reduce the physical, sexual, and emotional abuse of women and female adolescents.

(Data is needed; reporting mechanisms need to be clarified.)

B. Risk Reduction Objectives

1.9 Reduce by 20 percent the incidence of physical fighting among adolescents aged 14 through 17.

(Baseline data available in 1991.) (Ibid., Objective 7.9)

- 1.9Rev. Reduce by 20 percent the incidence of physical fighting among children and adolescents under age 18.

  (Baseline data available in 1991.)

C. Services and Protection Objectives

1.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of quality school health education.

(Baseline data available in 1991.) (Ibid., Objective 7.16)

- 1.16Rev. Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of quality school health education and through the activities of community-based organizations.

  (Baseline data available in 1991.)

1.18 Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent suicide of jail inmates.

(Baseline data available in 1991.) (Ibid., Objective 7.18)

- 1.18Rev. Increase to 50 the number of States with officially established protocols that engage mental health, alcohol and drug, and public health authorities with corrections authorities to facilitate identification and appropriate intervention to prevent violent and abusive behavior.

  (Baseline data available in 1992.)

Recommendations:

Community Priorities

A. Promote a climate of social change.

1. Campaign for a forum or series of forums to initiate dialogue on the use of physical punishment of children; re-examine the history of discipline in African American communities beginning with slavery to promote positive disciplinary models; emphasize parenting skills; and set goals for self-esteem. Create community awareness of violence and abusive behavior and their implications. Stimulate a media campaign focused on violence prevention. Increase employment opportunities to address the underlying causes of violence.

2. Direct local health departments and mental health systems to address violence as a public health issue and as a predictable and preventable social phenomenon. Include the factor of recidivism in approaches to violence prevention.

3. Promote peer education for parents and youth on nonviolent behavior. Stress positive role models for nonviolent redefinitions of "power" and "strength", i.e., what it means to be powerful, what it means to be a man or a woman in the context of the African American culture.

4. Promote a change of social climate in African American communities making violence an unacceptable behavior.

Activities:

1. Educate child protective services workers, social services workers, and teachers to encourage a multi-cultural awareness stressing the different manner in which African American children may learn (storytelling, parables).

2. Refocus education of child protective services workers, social services workers and teachers directed toward unlearning racism.

3. Stimulate unlearning sexism in K-12 education.

4. Reinforce a system of reporting, preventing and responding to hate violence against African Americans that includes new policetraining efforts and a broader range of sanctions against perpetrators.

5. Encourage institutions of higher learning to research the effects of racism on the social development and self-esteem of African American communities and individuals.

6. Institute community forums emphasizing community strengths: utilize dialogue as an approach to community building and as an appropriate skill.

7. Institute codes or ratings to identify violence in films, TV programming, and music.

8. Increase employment opportunities and address other core problems associated with violence.

B. Initiate training

1. Integrate and initiate self-defense and assertiveness training for girls and women into ongoing programs. Violence is a symbiotic relationship. Non-violent and conflict resolution skills are needed by males and by females.

2. Train parents and teachers to identify and prevent violence and abuse.

Activity: 1. Integrate martial arts instruction into physical education programs in schools (K-12).

C. Reduce institutional and cultural racism

1. Promote an examination of the effects of institutional and cultural racism upon African Americans and within their communities.

Activities: 1. Institute community forums emphasizing community strengths; utilize in dialogue as an approach to community building and as an appropriate skill.

2. Institute codes or ratings to identify violence in films, TV programming, and music.

3. Increase employment opportunities and address other core problems associated with violence.

4. Reinforce a system of reporting, preventing and responding to hate violence against African Americans that includes new police training efforts and a broader range of sanctions against perpetrators.

5. Encourage institutions of higher learning to research the effects of racism on the social development and self-esteem of African American communities and individuals.

Policy Priorities

A. Address the acceptance of violence in the society.

1. With violence prevention project funds and initiate media campaign addressing sexist, racist and violent imagery.
TARGET: CALIFORNIA DEPARTMENT OF HEALTH SERVICES

2. Develop handgun-control initiatives as part of a broader agenda for achieving nonviolent communities.
TARGET: STATE LEGISLATURE AND LOCAL COMMUNITIES

B. Establish partnerships and participation of social and professional groups including the media.

1. Institute a rating index for violence in films.
TARGET: CALIFORNIA DEPARTMENT OF HEALTH SERVICES
LOCAL FILM REVIEW BOARDS
ENTERTAINMENT INDUSTRY

2. Enlist community support for stricter regulation and monitoring of violence in television programming.
TARGET: FEDERAL COMMUNICATIONS COMMISSION
STATE & LOCAL REGULATORY BODIES

C. Advocate legislation/improve data collection

1. Reinstate Community Action Programs (CAP) funding.
TARGET: FEDERAL & STATE LEGISLATURES

2. Develop evaluation and data and surveillance systems to determine an accurate incidence of violence and abuse-related injuries.
TARGET: CALIFORNIA DEPARTMENT OF HEALTH SERVICES
LAW ENFORCEMENT AGENCIES

3. Develop a legislative agenda that explores the underlying causes of violence and abusive behavior, i.e., unemployment, housing, education.
TARGET: FEDERAL & STATE LEGISLATURES

D. Increase advocacy/funding

1. Develop legislation that taxes gun sales. A percentage of these taxes would be directed for use in violence prevention projects.
   TARGET: STATE LEGISLATURE

2. Enlist the cooperation of health departments in addressing violence as a public health issue.
   TARGET: STATE & LOCAL HEALTH DEPARTMENTS

Resource Development Priorities

A. Enhance personal skills development

1. Develop culturally-specific curricula that address conflict resolution, "unlearning sexism", handgun-violence prevention, and cultural pride within community agencies and schools.

2. Develop leadership building in communities to address the problem of inter-personal violence, and to support/foster community monitoring of racism/ sexism in the media andlocal institutions.

3. Reinstate Community Action Programs (CAP) funding.

4. Educate and empower African American communities on how to obtain funds to implement the priorities.

B. Address needs/establish partnerships

1. Inform foundations of the need to deal with violence as an issue in African American communities.

2. Develop a Speakers Bureau to inform foundations of the perceived needs of African Americans and their communities with regard to violence reduction. Utilize role models.

3. Develop a slide show on violence as a public health issue for use as an awareness tool.

4. Enlist churches, fraternities, sororities and other African American social organizations to act as partners in violence control.

5. Develop a coalition to establish linkages with networks that focus on violence as a public health issue.

C. Apply research findings

1. Develop a core of interdisciplinary trained people with violence prevention expertise to plan and implement an intervention.

2. Develop indigenous community review boards to review and monitor violence-related research done in African American communities.

Physical Activity and Fitness

Priority II. Physical Activity and Fitness

Introduction

The selection of this topic indicates the AA Task Force's desire to choose objectives that have the potential for making the greatest impact on improving the health status of African Americans. Physical Activity and Fitness focus attention on risk factors that address major diseases and conditions that affect African Americans: coronary heart disease, hypertension, cancer, diabetes, and obesity.

Rationale

Physical fitness can be a factor in reducing risks for Type II diabetes, cardiovascular diseases, and some cancers;
There is a lack of emphasis on fitness in African American communities that needs to be addressed;
Fitness programs need to reflect community sensitivity;
Physical fitness makes a major contribution to the overall well-being of the person;
Physical fitness is a stress reducer; and
Physical fitness is an aid in weight control.

A. Health Status Objectives

2.1 Reduce coronary heart disease deaths to no more than 100 per 100,000 people.

(Age-adjusted baseline: 135 per 100,000 in 1987.) (Healthy People 2000, Objective 15.1)

• 2.1A Reduce coronary heart disease deaths among African Americans to no more than 115 per 100,000 people.

(Age-adjusted baseline: 135 per 100,000 in 1987.)

B. Risk Reduction Objectives

2.3 Increase to at least 30 percent the proportion of people aged 6 and older who engage regularly, preferably daily, in light to moderate physical activity for at least 30 minutes per day. (Ibid., Objective 1.3)

2.4 Increase to at least 20 percent the proportion of people aged 18 and older and to at least 75 percent the proportion of children and adolescents aged 6 through 17 who engage in vigorous physical activity that promotes the development and maintenance of cardio-respiratory fitness 3 or more days per week for 20 or more minutes per occasion. (Ibid., Objective 1.4)

2.8 Increase to at least 50 percent the proportion of children and adolescents in 1st through 12th grade who participate in daily school physical education.

(Baseline: 36 percent in 1984-86.) (Ibid., Objective 1.8)

2.10 Increase the proportion of worksites offering employer-sponsored physical activity and fitness programs as follows:

Worksite Size	1985 Baseline	2000 Target
50-90 employees	14%	20%
100-249 employees	23%	35%
250-749 employees	32%	50%
>750 employees	54%	80%

2.11 Increase community availability and accessibility of physical activity and fitness facilities. (Ibid., Objective 1.11)

- 2.11Rev. Increase community availability and accessibility of physical activity and fitness facilities to community-based, family-centered programming as follows:

Facility	1986 Baseline	2000 Target
Hiking, biking, gyms & fitness trail miles	1 per 71,000 people	1 per 10,000 people
Public swimming pools	1 per 53,000 people	1 per 25,000 people
Acres of park & recreation open space	1.8 per 1,000 people (250 people per managed acre)	4 per 1,000 people (553 people per managed acre)

Recommendations:

Community Priorities

A. Increase fitness awareness & assessment activities

1. Develop an awareness of fitness as a community issue. Encourage and promote the comunity as a place for fitness to occur by identifying walks, scenic aspects, and encouraging group fitness activities. Utilize the media to address this priority.

2. Acknowledge fitness activities already taking place; relate to media campaign.

3. Develop intergenerational fitness groups.

4. Establish public/private partnerships that promote fitness.

B. Encourage wider program implementation

1. Encourage community groups to incorporate fitness as an ongoing activity.

2. Encourage social clubs and community organizations to sponsor women's sports activities.

3. Encourage church-sponsored walking/exercise activities and groups.

C. Orient attitude to enhance fitness

1. Begin childhood education on the importance of health and its relationship in a lifelong program of fitness.

2. Target young girls, broadening the concept of beauty to include well-functioning bodies, self-esteem, etc.; encourage a sense of community; and provide needed support.

D. Focus on the family

1. Develop culturally specific fitness programs focusing on family-centered activities.

E. Utilize the media

1. Use public service announcements to promote fitness as a community issue.

Policy Priorities

A. Initiate a compulsory requirement for physical and health education in elementary and secondary schools (K-12). Stress the importance of physical education throughout their lives.
TARGET: CALIFORNIA DEPARTMENT OF EDUCATION
LOCAL BOARDS OF EDUCATION

B. Establish public/private partnerships that promote fitness.
TARGET: MUNICIPAL GOVERNMENTS
CHAMBERS OF COMMERCE
EMPLOYER ASSOCIATIONS
HEALTH ASSOCIATIONS
LABOR UNIONS

C. Sponsor worksite exercise programs.
TARGET: MAYORS, CITY COUNCILS
MUNICIPAL GOVERNMENTS
CHAMBERS OF COMMERCE
BUSINESS ASSOCIATIONS
LABOR UNIONS

D. Establish linkages with local parks & recreation departments.
TARGET: COMMUNITY ORGANIZATIONS

E. Enlist African American Chambers of Commerce and shoe manufacturers in sponsoring fitness programs and activities.
TARGET: AFRICAN AMERICAN CHAMBERS OF COMMERCE
SHOE MANUFACTURERS
ATHLETIC EQUIPMENT & CLOTHING MANUFACTURERS

Resource Development Priorities

A. Encourage community organizations to focus on fitness.

B. Promote funding of research to examine motivational issues related to fitness.

C. Encourage existing fitness organizations to conduct outreach activities to African American communities.

D. Encourage state and local health departments to provide technical assistance to communities in organizing and establishing fitness programs.

E. Encourage resource development skills in African American communities.

F. Establish linkages with African American athletes and dancers as possible role models.

Nutrition

Priority III. Nutrition

Introduction

Nutrition is another significant risk factor that has impact on major diseases and conditions: cancer, coronary heart disease, diabetes, low birth weight and growth retardation. It is a topic of rapid change and controversy. The basic food groups have been challenged for their absolute value in promoting wellness for African Americans. African Americans question the current height/body weight standardizations. For example, do they allow for denser bone mass? How does an emphasis on weight address the cultural acceptance of obesity? How much weight is too much?

Rationale

"...what we eat may affect our risk for several of the leading causes of death for African Americans, notably coronary heart disease, stroke, atherosclerosis, diabetes and some types of cancer. These disorders together now account for more than two-thirds of all deaths in the U.S." - Surgeon General's Report, Nutrition and Health, 1989.

Current knowledge in nutrition indicates that specific types of food reduce risks for some kinds of diseases and it is important to examine how the traditional African American diet increases the risks for disease;

The overfed, but undernourished condition, is prevalent in African American communities;

The cultural connection of African Americans and food choices needs is unique; and

The quality of food available in African American communities is often poor and accessibility varies widely among communities.

A. Health Status Objectives

3.1 Reduce coronary heart disease deaths to no more than 100 per 100,000 people.

(Age-adjusted baseline: 135 per 100,000 in 1987.) (Healthy People 2000, Objective 15.1)

Special Population Target		
Coronary Deaths per 100,000	**1987 Baseline**	**2000 Target**
3.1a Blacks	163	115

3.2 Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people.

(Age-adjusted baseline: 133 per 100,000 in 1987.) (Ibid., Objective 16.1)

3.3 Reduce overweight to a prevalence of no more than 20 percent among people aged 20 and older and no more than 15 percent among adolescents aged 12 through 19.

(Baseline: 26 percent for people aged 20 through 74 in 1976-80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-80.) (Ibid., Objective 2.3)

• 3.3 Rev. Reduce overweight to a prevalence of no more than 30 percent among African American families.

(Baseline: 26 percent for people aged 20 through 74 in 1976-80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12 through 19 in 1976-80.)

3.4 Reduce growth retardation among low-income African American children younger than age one to less than 10 percent.

(Baseline: Up to 16 percent among low-income children in 1988, depending on age and race/ethnicity.) (Ibid., Objective 2.4)

• 3.4A Reduce low birth weight among low-income black infants to less than 10 percent.

B. Risk Reduction Objectives

3.5 Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older.

(Baseline: 36 percent of calories from total fat and 13 percent from saturated fat for people aged 20 through 74 in 1976-80; 36 percent and 13 percent for women aged 19 through 50 in 1985.) (Ibid., Objective 2.5)

3.6 Increase complex carbohydrate and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including legumes and fruits) and to six or more daily servings for grain products.

(Baseline: 2 1/2 servings of vegetables and fruits and 3 servings of grain products for women aged 19 through 50 in 1985.) (Ibid., Objective 2.6)

3.7 Increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted sound dietary practices combined with regular physical activity to attain an appropriate body weight.

(Baseline: 30 percent of overweight women and 25 percent of overweight men for people aged 18 and older in 1985.) (Ibid., Objective 2.7)

• 3.7Rev. Increase to at least 50 percent the proportion of overweight people aged 12 and older who have adopted the following sound dietary practices:

Reduce dietary fat intake to an average of 30 percent of calories or less and average saturated fat intake to less than 10 percent of calories among people aged 2 and older; increased complex carbohydrate and fiber-containing foods in the diets of adults to five or more daily servings for vegetables (including and fruits, and to six or more daily servings for grain products); increase calcium intake so at least 50 percent of youth aged 12 through 24 and 50 percent of pregnant and lactating women consume three or more servings daily of foods rich in calcium, and at least 50 percent of people aged 25 and older consume two or more servings daily; decrease salt and sodium intake so at least 65 percent of home meal preparers prepare foods without adding salt, at least 80 percent of people avoid using salt at the table, and at least 40 percent of adults regularly purchase foods modified or lower in sodium, combined with regular physical activity to attain an appropriate body weight.

(Baseline: 30 percent of overweight women and 25 percent of overweight men for people aged 18 and older in 1985.) (Combines 3.5, 3.6, 3.8, 3.9)

3.8 Increase calcium intake so at least 50 percent of youth aged 12 through 24 and 50 percent of pregnant and lactating women consume three or more servings daily of foods rich in calcium, and at least 50 percent of people aged 25 and older consume two or more servings daily.

(Baseline: 7 percent of women and 14 percent of men aged 19 through 24 and 24 percent of pregnant women and lactating women consumed three or more servings, and 15 percent of women and 23 percent of men aged 25 through 50 consume two or more servings in 1985-86.) (Ibid., Objective 2.8)

3.9 Decrease salt and sodium intake so at least 65 percent of home meal preparers prepare foods without adding salt, at least 80 percent of people avoid using salt at the table, and at least 40 percent of adults regularly purchase foods modified or lower in sodium.

(Baseline: 54 percent of women aged 19 through 50 who served as the main meal preparer did not use salt in food preparation, and 68 percent of women aged 19 through 50 did not use salt at the table in 1985; 20 percent of all people aged 18 and older regularly purchased foods with reduced salt and sodium content in 1988.) (Ibid., Objective 2.9)

3.13 Increase to at least 85 percent the proportion of people aged 8 and older who use food labels to make nutritious food selections.

(Baseline: 74 percent used labels to make food selections in 1988.) (Ibid., Objective 2.13)

C. Services and Protection Objectives

3.18 Increase to at least 80 percent the receipt of home food services by people aged 65 and older who have difficulty in preparing their own meals or are otherwise in need of home-delivered meals.

(Baseline data available in 1991.) (Ibid., Objective 2.18)

3.20 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer nutrition education and/or weight management programs for employees.

(Baseline: 17 percent offered nutrition education activities and 15 percent offered weight control activities in 1986.) (Ibid., Objective 2.20)

• 3.20Rev.. Increase to at least 50 percent the proportion of worksites with 50 or more employees and community-based organizations that offer nutrition education and/or weight management programs.

(Baseline: 17 percent offered nutrition education activities and 15 percent offered weight control activities in 1985.)

3.21 Increase to at least 75 percent the proportion of primary care providers who provide nutrition assessment and counseling and/or referral to qualified nutritionists or dietitians.

(Baseline: Physicians provided diet counseling for an estimated 40 to 50 percent of patients in 1988.) (Ibid., Objective 2.21)

• 3.21New Increase by 50 percent the enrollment in Women, Infant, and Children (W.I.C.) Supplemental Food Program.

Recommendations:

Community Priorities

A. Improve education/awareness

1. Create community awareness campaigns on the relationship of nutrition and lifestyle to health from an African American perspective.

    a. Examine and educate on the emotional, psychological, and psychosocial effects of food: what it does, how it contributes to well being; apply a culturally relevant approach to nutrition education. What is important to the individual? Is it losing weight or feeling better?

    b. Develop an awareness campaign, "It's not just your body." Connect the individual with the group. Identify the disparity between how African Americans eat and healthy eating.

    c. Address the relationship between behavior and mood in response to food.

    d. Emphasize developing an awareness of African and African American cuisine. Educate on the basis of "soul food" as having roots in slavery and survival needs.

2. Encourage culturally specific weight loss programs for African Americans to be located in those communities.

Activities:
1. Support weight loss groups in social clubs and churches.
2. Conduct classes for teenage mothers, focusing on "urban survival."

B. Increase access and quality

1. Increase access to healthy foods in African American communities.
2. Encourage grocery and convenience stores to improve the selection and quality of healthy foods and merchandise sold.
3. Utilize Project SHARE.
4. Encourage the development and use of community gardens.
5. Encourage the development of minority-owned businesses that grow, produce, package, and cook food by and for the African American community.

C. Focus on "Back to Basics"

1. Encourage breast feeding for at least three months.

2. Utilize University of California Extension Program—Expanded Food, Nutrition and Education Program (EFNEP).

3. Encourage African American churches to implement a program aimed at getting individuals to make nutritionally sound food choices.

4. Encourage food chains to donate the fresh food they discard to the community food banks, etc.

D. Boycott food companies and products owned and distributed by tobacco companies.

Policy Priorities

A. Increase qualified staff

1. Increase funding for public health nutritionists who are culturally sensitive or African American.
TARGET: FEDERAL LEGISLATURE
STATE LEGISLATURE

2. Ensure that quality, culturally sensitive community nutrition programs staffed by African American nutritionists, and access to food programs are sufficient to meet the community identified needs. Each local health jurisdiction should employ a public health nutritionist.
TARGET: STATE LEGISLATURE
CALIFORNIA DEPARTMENT OF AGRICULTURE

B. Advocate for legislation

1. Initiate legislation to ensure that all eligible low-income women, infants and children can receive assistance through the Women, Infant, and Children (WIC) Supplemental Food Program.
TARGET: STATE LEGISLATURE

2. Urge passage of the "Freedom from Want Act"/Mickey Leland Bill.
TARGET: FEDERAL LEGISLATURE

3. Include a nutrition education component to food labeling legislation at the State level.
   TARGET: STATE LEGISLATURE
   CALIFORNIA DEPARTMENT OF AGRICULTURE

4. Increase the tax on candy and snack foods to benefit school nutrition programs.
   TARGET: STATE LEGISLATURE

C. Increase funding and program participation

1. Increase funding for the Expanded Food, Nutrition, and Education Program (EFNEP).
   TARGET: STATE LEGISLATURE

2. Increase participation in all categories of food assistance, i.e., W.I.C. vouchers, food stamps.
   TARGET: FEDERAL LEGISLATURE
   STATE LEGISLATURE

3. Implement the WIC Supplemental Food Program throughout California.
   TARGET: CALIFORNIA DEPARTMENT OF AGRICULTURE
   LOCAL HEALTH DEPARTMENTS

D. Strategies

1. Utilize "Madison Avenue" approach to get messages across. Apply social marketing techniques to programs and activities.
   TARGET: LOCAL HEALTH DEPARTMENTS
   COMMUNITY-BASED ORGANIZATIONS
   CHURCHES, CIVIC AND SOCIAL ORGANIZATIONS

2. Implement an early nutrition education program for children.
   TARGET: CALIFORNIA DEPARTMENT OF EDUCATION

3. Encourage community-based programs that combine nutrition programs for the elderly with those for youth, i.e., Child & Adult Day Care Food Program.
   TARGET: CALIFORNIA DEPARTMENT OF AGING
   CALIFORNIA DEPARTMENT OF AGRICULTURE
   COMMUNITY-BASED ORGANIZATIONS
   CHURCHES, CIVIC AND SOCIAL ORGANIZATIONS

Resource Development Priorities

A. Develop a resource bank/clearinghouse to inform the community of what is taking place, make referrals, and establish linkages.

B. Utilize community knowledge in the development of programs to ensure that program design matches community need.

C. Develop a Speaker's Bureau on nutritional issues specific to African American communities.

D. Seek corporate funding from food manufacturers for nutrition programs and activities.

Tobacco

Priority IV. Tobacco

Introduction

Although tobacco cessation and prevention have been targeted for action by California voters (Proposition 99) and the California Department of Health Services (Assembly Bill 75), the continuation of this funding is uncertain. The significance and impact of tobacco use to African American communities warrants continued emphasis on its eradication.

Because of the preventive efforts that are occurring through tobacco tax funding in California, the AA Task Force felt it could be even more proactive in setting objectives and making recommendations.

Rationale

Tobacco use significantly affects morbidity and mortality in African-American communities;
Tobacco use prevention addresses cardiovascular diseases and their impact;
There are "mega-bucks" advertising campaigns targeting African American communities by the tobacco industry; and
The high prevalence of smoking is a significant problem in African American communities.

A. Health Status Objectives

4.1 Reduce coronary heart disease deaths to no more than 100 per 100,000 people.

(Age-adjusted baseline: 135 per 100,000 in 1987.) (Healthy People 2000, Objective 15.1)

Special Population Target		
Coronary Deaths per 100,000	**1987 Baseline**	**2000 Target**
4.1a Blacks	163	115

4.2 Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people.

(Age-adjusted baseline: 37.9 per 100,000 in 1987.) (Ibid., Objective 16.2)

4.3 Slow the rise in deaths from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000 people.

(Age-adjusted baseline: 18.7 per 100,000 in 1987.) (Ibid., Objective 3.3)

B. Risk Reduction Objectives

4.4 Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 20 and older.

(Baseline: 29 percent in 1987, 32 percent for men and 27 percent for women.) (Ibid., Objective 3.4)

Special Population Targets

Cigarette Smoking Prevalence		1987 Baseline	2000 Target
4.4a	People w/high school education or less aged 20 & older	34%	20%
4.4b	Blue-collar workers aged 20 & older	36%	20%
4.4c	Military personnel	42%	20%
4.4d	Blacks aged 20 & older	34%	18%
4.4h	Women of reproductive age	29%	12%
4.4i	Pregnant women	25%	10%
4.4j	Women who use oral contraceptives	36%	10%

4.5 Reduce the initiation of cigarette smoking by children and youth so that no more than 15 percent have become regular cigarette smokers by age 20.

(Baseline: 30 percent of youth had become regular cigarette smokers by ages 20 through 24 in 1987.) (Ibid., Objective 3.5)

• 4.5Rev. Reduce the initiation of cigarette smoking by children and youth so that no more than 10 percent have become regular cigarette smokers by age 20.

(Baseline: 30 percent of youth had become regular cigarette smokers by ages 20 through 24 in 1987.)

Special Population Target

Initiation of Smoking		1987 Baseline	2000 Target
4.5a	Lower socioeconomic status youth	40%	18%

4.7 Increase smoking cessation during pregnancy so that at least 60 percent of women who are cigarette smokers at the time they become pregnant quit smoking early in pregnancy and maintain abstinence for the remainder of their pregnancy.

(Baseline: 39 percent of White women aged 20 through 44 quit at any time during pregnancy in 1985.)(Ibid., Objective 3.7)

Special Population Target		
Cessation & Abstinence During Pregnancy	**1985 Baseline**	**2000 Target**
4.7a Women w/less than a high school education	28%	45%

4.8 Reduce to no more than 20 percent the proportion of children aged 6 and younger who are regularly exposed to environmental tobacco smoke at home.

(Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 7 or younger had a cigarette smoker in the household.) (Ibid., Objective 3.8)

- 4.8Rev. Reduce to no more than 20 percent the proportion of children of any age who are regularly exposed to environmental tobacco smoke at home.

  (Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 7 or younger had a cigarette smoker in the household.)

C. Service and Protection Objectives

4.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of quality school health education.

(Baseline: 17 percent of school districts totally banned smoking on school premises or at school functions in 1988; anti-smoking education was provided by 78 percent of school districts at the high school level, 81 percent at the middle school level, and 75 percent at the elementary school level in 1988.) (Ibid., Objective 3.10)

4.11 Increase to at least 75 percent the proportion of worksites with a formal smoking policy that prohibits or severely restricts smoking at the workplace.

(Baseline: 27 percent of worksites with 50 or more employees in 1985; 54 percent of medium and large companies in 1987.) (Ibid., Objective 3.11)

4.12 Enact in 50 states comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places (including health care facilities, schools, and public transportation).

(Baseline: 42 States and D.C. had, but rarely enforced, laws regulating the sale and/or distribution of cigarettes or tobacco productsto minors in 1990; only 3 set the age of majority at 19 and only 6 prohibited cigarette vending machines accessible to minors.) (Ibid., Objective 3.12)

• 4.12Rev. Enact in 50 states comprehensive laws on clean indoor air that prohibit or strictly limit smoking in the workplace and enclosed public places (including health care facilities, schools, and public transportation and institutional settings).

(Baseline: 42 States and D. C. had laws restricting smoking in public places; 31 States restricted smoking in public workplaces; but only 13 States had comprehensive laws regulating smoking in private as well as public worksites and at least 4 public places, including restaurants, as of 1988.)

4.13 Enact and enforce in 50 States laws prohibiting the sale and distribution of tobacco products to youth younger than age 19.

(Baseline: 44 States and DC had, but rarely enforced, laws regulating the sale and/or distribution of cigarettes or tobacco products to minors in 1990; only 3 set the age of majority at 19 and only 6 prohibited cigarette vending machines accessible to minors.)
(Ibid., Objective 3.13)

• 4.13A Enact and enforce in 50 States laws authorizing the sale and distribution of tobacco products similar to those enacted for alcohol beverage sale and distribution.

4.15 Eliminate or severely restrict all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed.

(Baseline: Radio and television advertising of tobacco products were prohibited, but other restrictions on advertising and promotion to which youth may be exposed were minimal in 1990.) (Ibid., Objective 3.15)

• 4.15Rev. Eliminate or severely restrict all forms of tobacco product advertising and promotion to which youth younger than age 18 are likely to be exposed, particularly billboards and advertising in close proximity to schools.

(Baseline: Radio and television advertising of tobacco products were prohibited, but other restrictions on advertising and promotion to which youth may be exposed were minimal in 1990.)

Recommendations:

Community Priorities

A. Increase awareness and education

1. Focus education on the concept of the tobacco industry as the purveyor of genocide.

2. Include the message on nicotine as a drug in education and health programs of community-based organizations.

3. Include the concept of the genocidal effect of nicotine on the African American community in education and health projects of community-based programs. Focus on nicotine as a gateway drug in education and health programs of community-based programs .

4. Include education of the physiological effects of smoking in education and health programs of community-based programs.

5. Promote complementary parent education that reinforces non-smoking behavior as a positive role model.

6. Promote other activities/behaviors that prevent starting tobacco use or help individuals stop. Focus on relapse prevention.

B. Improve community leadership and increase advocacy

1. Promote community gatherings as smoke-free.

2. Promote peer education non-smoking efforts. Employ youth peer educators.

3. Engage African American Chambers of Commerce, physician groups, and other professional associations in examining the marketing of alcohol and tobacco and other forms of legal drug use in African American communities. Encourage professional partnerships with the generalAfrican American community in promoting the health of the community.

Activities:

1. Develop mentor role models.
2. Convene community task forces.
3. Strengthen existing task forces.
4. Include community organizations, medical organizations, and churches.

C. Utilize promotions, advertisements, media, etc.

1. Counteract tobacco advertising with a billboard campaign that is culturally-relevant, emphasizing cultural pride. Use positive advertisements. Address placement of billboards near schools and the sale of candy cigarettes.

2. Promote positive non-smoking role models (i.e., singers, rap groups, athletes).

3. Promote the unacceptability of smoking through social marketing techniques.

4. Utilize the American Lung and Heart Associations' lists of magazines that do not use cigarette advertising and direct them to medical providers for use in their offices.

Policy Priorities

A. Focus on prevention

1. Emphasize the prevention of smoking in all funded programs of the California Departments of Education and Health Services where there are prevention components.
   TARGET: LOCAL AND STATE LEGISLATURES.

2. Mandate the prevention of smoking in school curricula from K-12.
   TARGET: STATE LEGISLATURE
   CALIFORNIA DEPARTMENT OF EDUCATION

3. Emphasize the continuation of existing funding of the health education account of Assembly Bill 75.
   TARGET: STATE LEGISLATURE

4. Focus prevention efforts on younger aged individuals (24 years & under). Increase the funding of school-based clinics with emphasis on prevention.
   TARGET: STATE LEGISLATURE
   CALIFORNIA DEPARTMENT OF EDUCATION

5. Directed funding for cessation during pregnancy and continued abstinence. Funding should be directed to maternal and child health programs. Special emphasis should be placed on cessation using the categorical programs: Child Health Disability Prevention (CHDP), Comprehensive Perinatal Services Program (CPSP), WIC, Infant Mortality projects, etc.
   TARGET: FEDERAL & STATE LEGISLATURES

B. Increase advocacy

1. Enlist endorsement, participation, and support of community organizations in creating a non-smoking environment in African American communities: school environments, specifically, and national conferences (NAACP, Urban League, church, and social/civic organizations). The endorsement of community-based organizations should be sought and the approved recommendation placed on their letterhead.
   TARGET: ORGANIZATIONS LISTED ABOVE
   SUPPORTED BY TOBACCO CONTROL SECTION AND HEALTH PROMOTION SECTION OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES

2. Restrict the sale of gum and candy cigarettes. Ban the sale of symbolic candy tobacco products. Write companies to request they make their product using another symbol. Use "sting operations" to uncover the sale of these items to minors. Advocate that community-based organizations, sororities, fraternities, and civic clubs taking on this activity as their project.
   TARGET: ORGANIZATIONS LISTED ABOVE

3. License the sale of tobacco products as with alcoholic beverages. Recommend the state treat tobacco as a controlled substance.
   TARGET: STATE LEGISLATURE

4. Develop legislation to eliminate the sale of single cigarettes and ban cigarette vending machines. As this is an enforcement issue, it is recommended that directives be given to local health departments for health department inspectors to monitor. Where sales to minors do occur, "sting operations" are suggested; vending machines would then be confiscated.
   TARGET: STATE LEGISLATURE

5. Promote the divestiture of tobacco producing/manufacturing companies to a less harmful product line. Recommend that the tobacco industry cease and desist. Establish liaisons with watchdog groups: American Cancer Society, Heart and Lung Organizations, Action On Smoking and Health regarding "targeted markets" (i.e., young women, blue collar workers) of the tobacco industry.
   TARGET: FEDERAL LEGISLATION THROUGH STATE REPRESENTATIVES
   ORGANIZATIONS LISTED ABOVE

6. Encourage physicians to place "DOC" (Doctors Ought to Care) stickers on covers of current magazines that contain cigarette advertising. Information on stickers may be obtained by calling Baylor University, Houston, Texas, (713) 798-7729.

Resource Development Priorities

A. Educate public agencies and foundations to create a more accurate awareness of African American community needs relating to tobacco control.

B. Coordinate programs to maximize community services on local, regional, and national bases.

C. Promote community review boards for local input on research studies conducted in African American communities to ensure cultural appropriateness and to determine ultimate impact on the community.

D. Assess the extent to which existing curricula are culturally relevant and establish guidelines for evaluating cultural relevancy and quality.

E. Lobby foundations to identify school-based clinics as priorities for funding.

Educational and Community-Based Programs

Priority V. Educational and Community-Based Programs

Introduction

The attainment of Healthy People 2000 objectives will depend on educational and community-based programs designed to promote health and prevent disease. Promoting health in low-income African American families is very challenging. They often differ from members of the dominant culture in their conceptual models of illness, values, health habits, level of compliance, and need to cope with stressful social and economic conditions. Many may have limited resources for maintaining their personal health and the health of family members. This topic examines issues related to health-oriented behavior change and the community-based intervention models that may be employed to impact the African American population in California.

Rationale

Implementation of educational interventions requires effective community organization as well as a complete community assessment. In order to assess high-risk populations who have been socialized into apathy and inaction, the strategy must be to demonstrate that the solution to health problems lies in the hands of the residents in interdependent relations and activities with professionals and agencies within their own communities. Many community organization models support the notion that increasing the power of the individual consumer is the key to quality health care and the elimination of access and delivery barriers. This empowerment can be reached through effective participation in education and community-based programs.

Educational and Community-Based Programs are a most important component as they are the first line of contact with the community. Their purpose is to organize, plan and educate community organizations in order to encourage and facilitate citizen participation. By so doing, the credibility of the programs and approach suggested is established. In developing effective rapport and communication, acceptance of the multi-ethnic health promotion concept can take place.

A. Health Status Objectives

5.1 Increase years of healthy life to at least 65 years.

(Baseline: An estimated 62 years in 1980.) (Healthy People 2000, Objective 8.1)

• 5.1Rev. Increase years of healthy life among African Americans to at least 60 years.

(Baseline: An estimated 56 years in 1980.)

Special Population Targets		
Years of Healthy Life	**1980 Baseline**	**2000 Target**
5.1a Blacks	56	60
5.1b Hispanics	62	65
5.1c People 65 & Older	12	14

B. Risk Reduction Objectives

5.2 Increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health.

(Baseline: 79 percent of people aged 20 through 21 had graduated from high school with a regular diploma in 1989.) (Ibid., Objective 8.2)

• 5.2A Increase the proportion of black families who have adopted healthy lifestyles, thereby reducing risks for multiple problem behaviors and poor mental and physical health.

C. Services and Protection Objectives

5.3 Achieve for all disadvantaged children and children with disabilities access to high quality and developmentally appropriate preschool programs that help prepare children for school, thereby improving their prospects with regard to school performance, problem behaviors, and mental and physical health.

(Baseline: 47 percent of eligible children aged 4 were afforded the opportunity to enroll in Head Start in 1990.) (Ibid., Objective 8.3)

• 5.3A Improve school achievement of African American children to reduce the prevalence of mental and physical health problems, as measured by an increase to at least 80 percent of the proportion of African American elementary and secondary school children participating in health promotion activities.

5.5 Increase to at least 50 percent the proportion of postsecondary institutions with institution-wide health promotion programs for students, faculty, and staff.

(Baseline: At least 20 percent of higher education institutions offered health promotion activities for students in 1989-90.) (Ibid., Objective 8.5)

5.6 Increase to at least 85 percent the proportion of workplaces with 50 or more employees that offer health promotion activities for their employees, preferably as part of a comprehensive employee health promotion program.

(Baseline: 65 percent of worksites with 50 or more employees offered at least one health promotion activity in 1985; 64 percent of medium and large companies had a wellness program in 1987.) (Ibid., Objective 8.6)

5.7 Increase to at least 20 percent the proportion of hourly workers who participate regularly in employer-sponsored health promotion activities.

(Baseline data available in 1992.) (Ibid., Objective 8.7)

5.8 Increase to at least 90 percent the proportion of people aged 65 and older who had the opportunity to participate during the preceding year in at least one organized health promotion program through a senior center, lifecare facility, or other community-based setting that served older adults.

(Baseline data available in 1992.) (Ibid., Objective 8.8)

5.9 Increase to at least 75 percent the proportion of people aged 10 and older who have discussed issues related to nutrition, physical activity, sexual behavior, tobacco, alcohol, other drugs, or safety with family members on at least one occasion during the preceding month.

(Baseline data available in 1991.) (Ibid., Objective 8.9)

5.10 Establish community health promotion programs that separately or together address at least three of the priorities and reach at least 40 percent of each state's population.

(Baseline data available in 1992.) (Ibid., Objective 8.10)

5.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations.

(Baseline data available in 1992.) (Ibid., Objective 8.11)

5.12 Increase to at least 90 percent the proportion of hospitals, health maintenance organizations, and large group practices that provide patient education programs, and to at least 90 percent the proportion of community hospitals that offer community health promotion programs addressing the priority health needs of their communities.

(Baseline: 66 percent of 6,821 registered hospitals provided patient education services in 1987; 60 percent of 5,677 community hospitals offered community health promotion programs in 1987.) (Ibid., Objective 8.12)

• 5.15New Increase to at least 50 percent the proportion of counties where a racial/ethnic minority group constitutes more than 10 percent of the population which has established culturally and linguistically appropriate community health promotion programs for these populations.

(Baseline data unavailable.)

Recommendations:

Community Priorities

A. Assess community needs

1. Conduct community assessment to determine community health problems and resources.

2. Encourage citizen participation from all segments of the community: government, education, business, religion, health care, media, voluntary agencies.

B. Implement comprehensive community-based programs

1. Implement comprehensive, multi-faceted, culturally relevant interventions that have multiple targets and approaches for change:

- individual (all age/gender groups)
- organizational (worksites, churches, schools)
- environmental (local policies/regulations)
- education (all levels)
- community organization
- regulatory environment (federal, state, local)

Policy Priorities

A. Mandate training in health promotion/disease prevention at all levels of the education system. Focus on comprehensive health programs in schools to address teachers' concern for the number of categorical programs.
TARGET: CALIFORNIA DEPARTMENT OF EDUCATION
CALIFORNIA DEPARTMENT OF HEALTH SERVICES
LOCAL SCHOOL DISTRICTS/BOARDS OF EDUCATION
LOCAL HEALTH DEPARTMENTS

B. Emphasize health promotion in all California Department of Health Services and Department of Education programs.
TARGET: CALIFORNIA DEPARTMENT OF HEALTH SERVICES
CALIFORNIA DEPARTMENT OF EDUCATION

C. Emphasize health promotion for all participants in entitlement programs.
TARGET: CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

D. Encourage health promotion in all public services such as utilities, libraries, parks, etc.
TARGET: LOCAL MUNICIPAL GOVERNMENTS
LOCAL HEALTH DEPARTMENTS

E. Encourage health promotion in all federal, state, or locally funded programs and worksites.
TARGET: ALL FEDERAL, STATE, MUNICIPAL GOVERNMENT OFFICES, INCLUDING HEALTH & HUMAN SERVICES

F. Encourage health promotion at restaurants, grocery stores, and fast food establishments.
TARGET: MUNICIPAL GOVERNMENTS
BUSINESS ASSOCIATIONS
LOCAL HEALTH AGENCIES & ORGANIZATIONS

G. Encourage health promotion in recreation and leisure services (both public and privately owned/operated).
TARGET: PARK & RECREATION DEPARTMENTS
HEALTH-RELATED BUSINESSES

Resource Development Priorities

A. Increase the number of African American health care professionals and lay community residents who can provide education, research and service in medically underserved communities.

B. Develop appropriate culturally sensitive and relevant curricular materials in health promotion, health protection and disease prevention in all levels of education:
   - elementary and secondary
   - college and university
   - adult education
   - continuing professional education

C. Develop surveillance systems to monitor the existence, quality and quantity of community health promotion programs.

D. Develop a statewide and regional resource center and data base on the capability and performance of education and community-based programs.

E. Fund special initiatives to conduct research and develop demonstration programs in health promotion for all age groups and specified segments of the African American population.

F. Enlist community colleges to offer credit to college students doing community work.

G. Recommend the California Black Health Network act as a clearinghouse, and develop conferences using the issues and recommendations of the Task Force.

Cancer

Priority VI. Cancer

Introduction

African Americans have experienced dramatic increases in age-adjusted cancer incidence and mortality since the mid-1950s. African Americans develop and die of certain cancers at greater rates than non-minorities, even when matched for stage of the disease.

Rationale

African American males experience a higher incidence of cancer than whites (523 vs. 427 per 100,000) and a higher mortality rate 305 vs. 207 per 100,000). African American females have a lower overall cancer incidence rate than white females (322 vs. 334 per 100,000) but a higher mortality rate (164 vs. 139 per 100,000).

The trends in cancer mortality rates indicate that for many sites the mortality rate of cancer is decreasing more rapidly among whites than among African Americans. This is especially true for female breast cancer. The mortality rate has decreased among whites while at the same time that it increased among African Americans for pancreas, leukemia, larynx, colorectal, and oral cancers.

In addition, a smaller proportion of African American cancer patients survive for five years after diagnosis than whites. Data from the Surveillance, Epidemiology and End Results (SEER) Program and other cancer registries have documented a worse prognosis for most malignancies in African Americans versus the remainder of the U.S. population.

In addition to extent of disease, delay in seeking treatment for cancer symptoms differs between ethnic groups. This may be due to less knowledge about cancer symptoms, poorer access to care or routine screening or greater pessimism about the successful treatment of cancer.

In Los Angeles, for example, where the various racial/ethnic groups have been divided demographi-cally. Area VI represents a largely African American population of approximately one million. For males, cancer incidence tends to be higher in Area VI, which is consistent with the higher cancer risk status of African Americans, especially for cancer of the lung and prostate. For females, cancer of the cervix is considerably higher in Area VI.

Roughly 1,500 new cancer patients are diagnosed or receive inpatient treatment at Los Angeles County-U.S.C. Medical Center annually. Of these, 25 percent are African American. In 1989, 392 new cancer patients were diagnosed or received inpatient treatment at King-Drew Medical Center. Approximately 60 percent were African American.

A. Health Status Objectives

6.1 Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people.

(Age-adjusted baseline: 133 per 100,000 in 1987.) (Healthy People 2000, Objective 16.1)

6.2 Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people.

(Age-adjusted baseline: 37.9 per 100,000 in 1987.) (Ibid., Objective 16.2)

6.3 Reduce breast cancer deaths to no more than 20.6 per 100,000 women.

(Age-adjusted baseline: 22.9 per 100,000 in 1987.) (Ibid., Objective 16.3)

6.4 Reduce deaths from cancer of the uterine cervix to no more than 1.3 per 100,000 women.

(Age-adjusted baseline: 2.8 per 100,000 in 1987.) (Ibid., Objective 16.4)

6.5 Reduce colorectal cancer deaths to no more than 13,2 per 100,000 people.

(Age-adjusted baseline: 14.4 per 100,000 in 1987.) (Ibid., Objective 16.5)

B. Risk Reduction Objectives

6.6 See Task Force Objective 4.4.

6.7 See Task Force Objective 3.5.

6.8 See Task Force Objective 3.6.

C. Service and Protection Objectives

6.10 Increase to at least 75 percent the proportion of primary care providers who routinely counsel patients about tobacco use cessation, diet modification, and cancer screening recommendations.

(Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986.) (Ibid., Objective 16.10)

6.11 Increase to at least 80 percent the proportion of women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years.

(Baseline: 36 percent of women aged 40 and older "ever" in 1987; 25 percent of women aged 50 and older "within the preceding 2 years in 1987.) (Ibid., Objective 16.11)

Special Population Targets

Clinical Breast Exams & Mammogram Ever Received	**1987 Baseline**	**2000 Target**
6.11b Low-income women aged 40 and older	22%	80%
6.11c Women aged 40 and older with less than high school education	23%	80%
6.11d Women aged 70 and older	25%	80%
6.11e African American women aged 40 and older	28%	80%
Received Within Preceding 2 Years		
6.11b Low-income women aged 50 and older (annual family income <$10,000)	15%	60%
6.11c Women aged 50 and older with less than high school education	16%	60%
6.11d Women aged 70 and older	18%	60%
6.11e African American Women aged 50 and older	19%	60%

6.12 Increase to at least 95 percent the proportion of women aged 18 and older with uterine cervix who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1 to 3 years.

(Baseline: 88 percent "ever" and 75 percent "within the preceding 3 years" in 1987.) (Ibid., Objective 16.12)

Special Population Targets		
Pap Test Every Received	**1987 Baseline**	**2000 Target**
6.12b Women aged 70 and older	76%	95%
6.12c Women aged 18 and older with less than high school education	79%	95%
6.12d Low-income women aged 18 and older (annual family income <$10,000)	80%	95%
Received Within Preceding 3 Years-		
6.12b Women aged 70 and older	44%	70%
6.12c Women aged 18 and older with less than high school education	58%	75%
6.23d Low-income women aged 18 and older (annual family income <$10,000)	64%	80%

6.13 Increase to at least 50 percent the proportion of people aged 50 and older who have received fecal occult blood testing within the preceding 1 to 2 years, and to at least 40 percent those who have ever received proctosigmoidoscopy.

(Baseline: 27 percent received fecal occult blood testing during the preceding 2 years in 1987; 25 percent had ever received proctosigmoidoscopy in 1987.) (Ibid., Objective16.13)

Recommendations:

Recommendations for the risk reduction objectives are addressed in the Tobacco and Nutrition Sections. The following recommendations are for the Health Status and Service and Protection Objectives.

Community Priorities

A. Develop and implement a comprehensive, integrated multi-factor health education program to include television and radio, newspapers, other mass-distributed print media, and direct education efforts through schools, colleges, adult and continuing education.

1. Utilize small businesses for community outreach such as hair salons, barbershops, beauty supply stores, mini-malls, bars, pool halls, movies.

2. Involve the community through coalitions. Focus on the incidence of cancer among males.

3. Develop comprehensive educational programs in schools, such as Project DARE.

4. Develop community coalitions of health providers and educators with community organizations.

5. Focus cancer education and awareness activities on African American males. Conduct prostate screenings in connection with Father's Day.

Policy Priorities

A. Target geographically and culturally delineated areas of high cancer incidence and mortality; target with an intense approach to providing culturally relevant education, control of tobacco use, appropriate screening/access to early diagnosis and treatment, and an improved social support network.
TARGET: CALIFORNIA DEPARTMENT OF HEALTH SERVICES
LOCAL HEALTH DEPARTMENTS
SOCIAL SERVICES DEPARTMENTS & AGENCIES

B. Increase accessibility to screenings through private and public insurance. Change insurance coverage so women can get a mammogram without paying a large deductible; make mammograms part of a routine physical exam.
TARGET: FEDERAL GOVERNMENT
INSURANCE COMPANIES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES
LOCAL HEALTH DEPARTMENTS

C. Emphasize cancer prevention in Department of Health Services and Department of Education programs.
TARGET: CALIFORNIA DEPARTMENT OF HEALTH SERVICES
CALIFORNIA DEPARTMENT OF EDUCATION
LOCAL HEALTH DEPARTMENTS

D. Promote cancer prevention in entitlement programs for adults.
TARGET: U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Resource Development Priorities

A. Direct community resources toward the prevention, detection, diagnosis, and treatment of cancer in economically disadvantaged, high-risk populations.

B. Develop health education programs targeted to working adults and senior citizens.

C. Develop community coalitions of health providers and educators with community organizations.

D. Coordinate programs to maximize existing funding allocations.

Heart Disease and Stroke

Priority VII. Heart Disease and Stroke

Introduction

Despite technological advances and increased knowledge about prevention of cardiovascular diseases, the impact of heart disease and stroke remains unchanged in the African American population. This fact remains despite the emphasis placed on hypertension during the 1970s and '80s. The risk factors associated with the family of diseases represented by heart disease and stroke have been addressed in the topics on Physical Activity and Fitness, Nutrition, and Tobacco. Due to the broad scope and impact on the African American community, this topic area remains relevant to the discussion of the health status African Americans.

Rationale

African Americans can expect to live five years less than their white counterparts;

In 1989, the life expectancy for African Americans decreased while that of other groups increased;

Cardiovascular diseases kill more people than all other diseases combined;

Minorities have excessive death rates for heart disease and diabetes (19 percent and 65 percent greater than for non-minorities, respectively);

Small gains in combatting cardiovascular diseases can mean significant numbers being positively affected;

Two of the most significant risk factors associated with heart disease and stroke, namely hypertension and tobacco use, are disproportionately present in the African American community;

Governmental programs are emphasizing cholesterol awareness education at a time when African American deaths from hypertension and related causes are on the increase, and when among African American patients needing by-pass surgery, more are hypertensive, but only 20 percent had elevated cholesterol levels.

A. Health Status Objectives

7.1 Reduce coronary heart disease deaths to no more than 100 per 100,000 people.

(Age-adjusted baseline: 135 per 100,000 in 1987.) (Healthy People 2000, Objective 15.1)

Special Population Target		
Coronary Deaths (per 100,000)	**1987 Baseline**	**2000 Target**
7.1a Blacks	163	115

7.2 Reduce stroke deaths to no more than 20 per 100,000 people.

(Age-adjusted baseline: 30.3 per 100,000.) (Ibid., Objective 15.2)

Special Population Target		
Stroke Deaths (per 100,000)	**1987 Baseline**	**2000 Target**
7.2a Blacks	51.2	27

7.3 Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) to attain an incidence of no more than 13 per 100,000.

(Baseline: 13.09 per 100,000 in 1987.) (Ibid., Objective 15.3)

Special Population Target		
ESRD Incidence (per 100,000)	**1987 Baseline**	**2000 Target**
7.3a Blacks	32.4	30

B. Risk Reduction Objectives

7.4 Increase to at least 50 percent the people whose blood pressure is under control for those diagnosed with hypertension.

(Baseline: 11 percent controlled among people aged 18 through 74 in 1976-80; an estimated 24 percent for people aged 18 and older in 1982-84.) (Ibid., Objective 15.4)

Special Population Target			
High Blood Pressure	**1976-80 Baseline**	**1982-84 Baseline**	**2000 Control Target**
7.4a Men with high blood pressure	6%	16%	40%

7.5 Increase to at least 90 percent the proportion of people with high blood pressure who are taking action to help control their blood pressure.

(Baseline: 79 percent of aware hypertensives aged 18 and older were taking action to control their blood pressure in 1985.) (Ibid., Objective 15.5)

Special Population Target

Taking Action to Control Blood Pressure	**1985 Baseline**	**2000 Target**
7.5b Black hypertensive men aged 18-34	63%	80%

7.6 Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL.

(Baseline: 213 mg/dL among people aged 20 through 74, in 1976-80, 211 mg/dL for men and 215 mg/dL for women.) (Ibid., Objective 15.6)

7.7 Reduce the prevalence of blood cholesterol levels of 240 mg/dL or greater to no more than 20 percent among adults.

(Baseline: 27 percent for people aged 20 through 74, in 1976-80, 29 percent for women and 25 percent for men.) (Ibid., Objective 15.7)

7.8 Increase to at least 60 percent the proportion of adults with high blood cholesterol who are aware of their condition and are taking action to reduce their blood cholesterol to recommended levels.

(Baseline: 11 percent of all people aged 18 and older, and thus an estimated 30 percent of people with high blood cholesterol, were aware that their blood cholesterol level was high in 1988.) (Ibid., Objective 15.8)

7.9 See Task Force Objective 3.5.

7.10 See Task Force Objective 3.3.

7.11 See Task Force Objective 2.3.

7.12 See Task Force Objective 4.4.

C. Service and Protection Objectives

7.13 Increase to at least 90 percent the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high.

(Baseline: 61 percent of people aged 18 and older had their blood pressure measured within the preceding 2 years and were given the systolic and diastolic values in 1985.)(Ibid., Objective 15.13)

7.14 Increase to at least 75 percent the proportion of adults who have had their blood cholesterol checked within the preceding 5 years.

(Baseline: 59 percent of people aged 18 and older had "ever" had their cholesterol checked in 1988; 52 percent were checked "within the preceding 2 years" in 1988.) (Ibid., Objective 15.14)

7.15 Increase to at least 75 percent the proportion of primary care providers who initiate diet and, if necessary, drug therapy at levels of blood cholesterol consistent with current management guidelines for patients with high blood cholesterol.

(Baseline data available in 1991.) (Ibid., Objective 15.15)

7.16 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer high blood pressure and/or cholesterol education and control activities to their employees.

(Baseline: 16.5 percent offered high blood pressure activities and 16.8 percent offered nutrition education activities in 1985.) (Ibid., Objective 15.16)

7.17 Increase to at least 90 percent the proportion of clinical laboratories that meet the recommended accuracy standard for cholesterol measurement.

(Baseline: 53 percent in 1985.) (Ibid., Objective 15.17)

Recommendations:

Community Priorities

A. Primary prevention is preferred.

1. Initiate an Afro-centric media campaign; focus on outreach activities and blood pressure screenings.

2. Implement and expand the number of stress reduction programs.

3. Involve existing organizations in the African American community: fraternities and sororities, churches, community advisory committees, and service organizations.

4. Increase awareness of health practitioners in the African American community on the impact of multiple risk factors, such as smoking, drinking and diet, on hypertension and heart conditions.

5. Increase the proportion of time physicians, health educators and other health practitioners spend on hypertensive awareness education/treatment and smoking cessation.

6. Make greater use of left ventricular hypertrophy (LVH) as an indicator of heart disease and an indication of the need for a more rigorous treatment regimen by physicians. The presence of LVH increases death rate potential by a factor of eight.

Policy Priorities

A. Support other health education programs in the African American community that address lifestyle changes such as alcohol consumption, nutrition, and exercise. Identify effective health education programs and methods and match with community needs.
TARGET: FEDERAL LEGISLATURE
STATE LEGISLATURE

B. Increase accessibility to screenings through private and public insurance.
TARGET: FEDERAL GOVERNMENT
INSURANCE COMPANIES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES
LOCAL HEALTH DEPARTMENTS

C. Implement all of the recommendations made in the Tobacco Section of this document.

D. Reassess existing policies that seem to stress significance of cholesterol awareness at the expense of hypertension awareness programs, and the resultant detrimental impact on the African American community.
TARGET: FEDERAL LEGISLATURE
STATE LEGISLATURE
AMERICAN HEART ASSOCIATION

E. Increase research on the side effects and efficacy of hypertensive medication.
TARGET: FEDERAL GOVERNMENT
COLLEGES & UNIVERSITIES
MEDICAL ASSOCIATIONS

F. Mandate annual check-ups, particularly blood pressure, cholesterol/triglycerides, EKG, as a mandatory component of health insurance coverage, including Medi-Cal and private health plans.
TARGET: INSURANCE COMPANIES
FEDERAL LEGISLATURE
STATE LEGISLATURE

G. Streamline red tape to allow for mandated health education in current subsidy programs such as WIC.
TARGET: CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
CALIFORNIA DEPARTMENT OF HEALTH SERVICES
CALIFORNIA DEPARTMENT OF EDUCATION

H. Increase the tobacco tax by $0.25; use the monies to fund multicultural health promotion programs.
TARGET: STATE LEGISLATURE
FEDERAL LEGISLATURE

I. Prohibit, at the State level, tobacco companies from sponsoring sporting or entertainment festivals. Encourage the apricot and raisin boards or similar organizations to assume that role.
TARGET: STATE LEGISLATURE
MUNICIPAL GOVERNMENTS
FOOD INDUSTRY

J. Address zoning laws that allow alcohol and tobacco sales and advertising in African American communities.
TARGET: MUNICIPAL GOVERNMENTS

K. Recommend that African Americans be included in research programs as principal investigators and that research on alternative methods of hypertension control be funded.
TARGET: NATIONAL INSTITUTE OF HEALTH (NIH)

L. Implement preventive health screenings nationwide. Advocate inclusion of screenings as part of union bargaining contracts.
TARGET: FEDERAL LEGISLATURE
STATE LEGISLATURE
LABOR UNIONS
INSURANCE COMPANIES

Resource Development Priorities

A. Provide technical assistance to community-based organizations to allow them to compete for contracts to provide services in their home communities.
TARGET: FEDERAL LEGISLATURE
STATE LEGISLATURE
FOUNDATIONS

B. Continue health education model developed for the tobacco control program, and extend it to alcohol and other health promotion programs.
TARGET: STATE GOVERNMENT

C. Fund more research activities directed towards improving African American health status.
TARGET: FEDERAL GOVERNMENT
STATE GOVERNMENT

D. Develop a "Framingham" model for long-term study of African American health status and the impact of interventions over extended period of time.
TARGET: FEDERAL GOVERNMENT
UNIVERSITIES
FOUNDATIONS

E. Utilize comprehensive school-based programs emphasizing health education and self-esteem.
TARGET: CALIFORNIA DEPARTMENT OF EDUCATION
CALIFORNIA DEPARTMENT OF HEALTH SERVICES

The front cover graphic was designed by Joan Tarika Lewis of Oakland, CA. Ms. Lewis strived to illustrate unity with her circular design of symbols from different cultures. She was impressed by the similarity between the symbols and how well they blend into one another. She commented,

"We are all closer to one another than we think."