APPENDIX A

1995 Summary List of Objectives

With 1995 Revisions

* Duplicate objectives which appear in two or more priority areas are marked with an asterisk alongside the objective number.

Physical Activity and Fitness

Health Status Objectives

1.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

Special Population Target

	Coronary Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
1.1a	Blacks	168	115

1.2* 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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

	Overweight Prevalence	*1976–80 Baseline*†	*2000 Target*
1.2a	Low-income women aged 20 and older	37%	25%
1.2b	Black women aged 20 and older	44%	30%
1.2c	Hispanic women aged 20 and older		25%
	Mexican-American women	39%‡	
	Cuban women	34%‡	
	Puerto Rican women	37%‡	
1.2d	American Indians/Alaska Natives	29–75%§	30%
1.2e	People with disabilities	36%††	25%
1.2f	Women with high blood pressure	50%	41%
1.2g	Men with high blood pressure	39%	35%
1.2h	Mexican-American men	30%‡	25%

†Baseline for people aged 20–74 ‡1982–84 baseline for Hispanics aged 20–74 § 1984–88 estimates for different tribes ††1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

Risk Reduction Objectives

1.3* 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. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 16 percent were active 7 or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	*1991 Baseline*	*2000 Target*
1.3a	Hispanics aged 18 and older 5 or more times per week	20%	25%

Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.

1.4 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 6–17 who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion. (Baseline: 12 percent for people aged 18 and older in 1985; 66 percent for youth aged 10–17 in 1984)

Special Population Targets

	Vigorous Physical Activity	*1985 Baseline*	*2000 Target*
1.4a	Lower-income people aged 18 and older (annual family income <$20,000)	7%	12%
		1991 Baseline	*2000 Target*
1.4b	Blacks aged 18 and older	11.5%	17%
1.4c	Hispanics aged 18 years	11.9%	17%

Note: Vigorous physical activities are rhythmic, repetitive physical activities that use large muscle groups at 60 percent or more of maximum heart rate for age. An exercise heart rate of 60 percent of maximum heart rate for age is about 50 percent of maximal cardiorespiratory capacity and is sufficient for cardiorespiratory conditioning. Maximum heart rate equals roughly 220 beats per minute minus age.

1.5 Reduce to no more than 15 percent the proportion of people aged 6 and older who engage in no leisure-time physical activity. (Baseline: 24 percent for people aged 18 and older in 1985)

Special Population Targets

	No Leisure-Time Physical Activity	*1985 Baseline*	*2000 Target*
1.5a	People aged 65 and older	43%	22%
1.5b	People with disabilities	35%†	20%
1.5c	Lower-income people (annual family income <20,000)	32%†	17%
		1991 Baseline	*2000 Target*
1.5d	Blacks aged 18 and older	28%	20%
1.5e	Hispanics aged 18 and older	34%	25%
1.5f	American Indians/Alaska Natives	29%	21%

†Baseline for people aged 18 and older

Note: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.

1.6 Increase to at least 40 percent the proportion of people aged 6 and older who regularly perform physical activities that enhance and maintain muscular strength, muscular endurance, and flexibility. (Baseline data unavailable)

1.7* 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)

Special Population Targets

	Adoption of Weight-Loss Practices	*1991 Baseline*	*2000 Target*
1.7a	Overweight Hispanic males aged 18 and older	15%	24%
1.7b	Overweight Hispanic females aged 18 and older	13%	22%

Services and Protection Objectives

1.8 Increase to at least 50 percent the proportion of children and adolescents in 1st–12th grade who participate in daily school physical education. (Baseline: 36 percent in 1984–86)

1.9 Increase to at least 50 percent the proportion of school physical education class time that students spend being physically active, preferably engaged in lifetime physical activities. (Baseline: Students spent an estimated 27 percent of class time being physically active in 1983)

Note: Lifetime activities are activities that may be readily carried into adulthood because they generally need only one or two people. Examples include swimming, bicycling, jogging, and racquet sports. Also counted as lifetime activities are vigorous social activities such as dancing. Competitive group sports and activities typically played only by young children such as group games are excluded.

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

Worksite Size	*1985 Baseline*	*2000 Target*
50–99 employees	14%	20%
100–249 employees	23%	35%
250–749 employees	32%	50%
≥750 employees	54%	80%

1.11 Increase community availability and accessibility of physical activity and fitness facilities as follows:

Facility	*1986 Baseline*	*2000 Target*
Hiking, biking, and 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 and recreation open space	1.8 per 1,000 people (553 people per managed acre)	4 per 1,000 people (250 people per managed acre)

1.12 Increase to at least 50 percent the proportion of primary care providers who routinely assess and counsel their patients regarding the frequency, duration, type, and intensity of each patient's physical activity practices. (Baseline: Physicians provided exercise counseling for about 30 percent of sedentary patients in 1988)

1995 Addition

Health Status Objective

1.13* Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities thereby preserving independence. (Baseline: 111 per 1,000 in 1984–85)

Special Population Targets

	Difficulty Performing Self Care (per 1,000)	*1984–85 Baseline*	*2000 Target*
1.13a	People aged 85 and older	371	325
1.13b	Blacks aged 65 and older	112	98

Note: Personal care activities are bathing, dressing, using the toilet, getting in and out of bed or chair, and eating.

Nutrition

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)

Special Population Target

	Coronary Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
2.1a	Blacks	168	115

2.2* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 134 per 100,000 in 1987)

Note: In its publications, the National Cancer Institute age-adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this health status objective differ from those presented here.

Special Population Target

	Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
2.2a	Blacks	182	175

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

Special Population Targets

	Overweight Prevalence	*1976–80 Baseline*†	*2000 Target*
2.3a	Low-income women aged 20 and older	37%	25%
2.3b	Black women aged 20 and older	44%	30%
2.3c	Hispanic women aged 20 and older		25%
	Mexican-American women	39%‡	
	Cuban women	34%‡	
	Puerto Rican women	37%‡	
2.3d	American Indians/Alaska Natives	29–75%§	30%
2.3e	People with disabilities	36%††	25%
2.3f	Women with high blood pressure	50%	41%
2.3g	Men with high blood pressure	39%	35%
2.3h	Mexican-American men	30%‡	25%

†Baseline for people aged 20–74 ‡1982–84 baseline for Hispanics aged 20–74 §1984–88 estimates for different tribes ††1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and

Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

2.4 Reduce growth retardation among low-income children aged 5 and younger to less than 10 percent. (Baseline: 11 percent among low-income children aged 5 and younger in 1988.)

Special Population Targets

	Prevalence of Short Stature	*1988 Baseline*	*2000 Target*
2.4a	Low-income black children <age 1	15%	10%
2.4b	Low-income Hispanic children <age 1	13%	10%
2.4c	Low-income Hispanic children aged 1	16%	10%
2.4d	Low-income Asian/Pacific Islander children aged 1	14%	10%
2.4e	Low-income Asian/Pacific Islander children aged 2–4	16%	10%

Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population derived from the 1971–74 NHANES.

Risk Reduction Objectives

2.5* 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: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 21 percent met the goal for fat and 21 percent met the goal for saturated fat based on 2-day dietary data from the 1988–91 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

2.6* Increase complex carbohydrate and fiber-containing foods in the diets of people aged 2 and older to an average of 5 or more daily servings for vegetables (including legumes) and fruits, and to an average of 6 or more daily servings for grain products. (Baseline: 4.1 servings of vegetables and fruits and 5.8 servings of grain products for people aged 2 and older based on 3-day dietary data from the 1989–91 CSFII). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of 5 or more

servings of vegetables/fruits, and increase to at least 50 percent the proportion who meet the goal of 6 or more servings of grain products. (Baseline: 29 percent met the goal for fruits and vegetables, and 40 percent met the goal for grain products for people aged 2 and older based on 3-day dietary data in the 1989–91 CSFII)

Note: The definition of vegetables, fruits, and grain products and serving size designations are derived from The Food Guide Pyramid. *Vegetable, fruit, and grain ingredients from mixtures are included in the total, and fractions of servings are counted.*

2.7* 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)

Special Population Targets

	Adoption of Weight-Loss Practices	*1991 Baseline*	*2000 Target*
2.7a	Overweight Hispanic males aged 18 and older	15%	24%
2.7b	Overweight Hispanic females aged 18 and older	13%	22%

2.8 Increase calcium intake so at least 50 percent of people aged 11–24 and 50 percent of pregnant and lactating women consume an average of 3 or more daily servings of foods rich in calcium, and at least 75 percent of children aged 2–10 and 50 percent of people aged 25 and older consume an average of 2 or more servings daily. (Baseline: 20 percent of people 11–24; 22 percent of pregnant and lactating women consumed an average of 3 or more servings; 48 percent of children aged 2–10 and 21 percent of people aged 25 and older who were not pregnant or lactating consumed an average of 2 or more servings based on 3-day dietary data from the 1989–91 CSFII)

Special Population Target

	Percent Meeting Goal	*1989–91 Baseline*	*2000 Target*
2.8a	Females aged 11–24	13%	50%

Note: Calcium-rich foods are defined for this purpose as milk and milk products, and the recommended number of servings and the age groupings are based on The Food Guide Pyramid *and on the National Research Council's Recommended Dietary Allowance (RDA) for calcium, respectively. Milk and milk product ingredients in mixtures are included, and fractions of servings are counted.*

2.9 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: 43 percent of main meal preparers did not use salt in food preparation based on the 1989–90 CSFII, and 60 percent of individuals never or rarely used salt at the table based on the 1989–91 CSFII; 20 percent of all people aged 18 and older regularly purchased foods with reduced salt and sodium content in 1988)

2.10 Reduce iron deficiency to less than 3 percent among children aged 1–4 and among women of childbearing age. (Baseline: 9 percent for children aged 1–2, 4 percent for children aged 3–4, and 5 percent for women aged 20–44 in 1976–80)

Special Population Targets

	Iron Deficiency Prevalence	*1976–80 Baseline*	*2000 Target*
2.10a	Low-income children aged 1–2	21%	10%
2.10b	Low-income children aged 3–4	10%	5%
2.10c	Low-income women of childbearing age	8%†	4%
	Anemia Prevalence	*1983–85 Baseline*	*2000 Target*
2.10d	Alaska Native children aged 1–5	22–28%	10%
2.10e	Black, low-income pregnant women (third trimester)	41%‡	20%

†Baseline for women aged 20–44 ‡1988 baseline for women aged 15–44

Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protoporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hematocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.

2.11* Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5–6 months old. (Baseline: 54 percent during early postpartum and 21 percent who are still breastfeeding at 5–6 months in 1988)

Special Population Targets

	Mothers Breastfeeding Their Babies During Early Postpartum Period:	*1988 Baseline*	*2000 Target*
2.11a	Low-income mothers	32%	75%
2.11b	Black mothers	25%	75%
2.11c	Hispanic mothers	51%	75%
2.11d	American Indian/ Alaska Native mothers	47%	75%
	At Age 5–6 Months:	*1988 Baseline*	*2000 Target*
2.11a	Low-income mothers	9%	50%
2.11b	Black mothers	8%	50%
2.11c	Hispanic mothers	16%	50%
2.11d	American Indian/ Alaska Native mothers	28%	50%

Note: The definition used for breastfeeding includes exclusive use of human milk or the use of human milk with a supplemental bottle of formula or cow's milk.

2.12* Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline: 55 percent for parents and caregivers of children 6–23 months in 1991)

Special Population Targets

	Appropriate Feeding Practices	*1991 Baseline*	*2000 Target*
2.12a	Parents and caregivers with less than high school education	36%	65%
2.12b	American Indian/Alaska Native parents and caregivers	74%§	65%
2.12c	Blacks	48%	65%
2.12d	Hispanics	39%	65%

§1985–89 data in four IHS Service Areas in a pilot project

* *Note: Percentage of parents and caregivers of children 6–23 months. Appropriate feeding practices are that the child no longer uses a bottle, or if the child still uses a bottle that no bottle was given at bedtime, excluding bottles with plain water, during the past 2 weeks.*

2.13 Increase to at least 85 percent the proportion of people aged 18 and older who use food labels to make nutritious food selections. (Baseline: 74 percent of people aged 18 and older used labels to make food selections in 1988)

Services and Protection Objectives

2.14 Achieve useful and informative nutrition labeling for virtually all processed foods and at least 40 percent of ready-to-eat carry-away foods. Achieve compliance by at least 90 percent of retailers with the voluntary labeling of fresh meats, poultry, seafood, fruits, and vegetables. (Baseline: 60 percent of sales of processed foods regulated by FDA had nutrition labeling in 1988; 77 percent and 75 percent compliance by retailers for fresh produce and fresh seafood respectively based on the 1993 FDA Survey on Labeling of Raw Produce and Raw Fish; baseline data on carry-away foods and fresh meat and poultry are unavailable)

2.15 Increase to at least 5,000 brand items the availability of processed food products that are reduced in fat and saturated fat. (Baseline: 2,500 items reduced in fat in 1986)

Note: A brand item is defined as a particular flavor and/or size of a specific brand and is typically the consumer unit of purchase.

2.16 Increase to at least 90 percent the proportion of restaurants and institutional food service operations that offer identifiable low-fat, low-calorie food choices, consistent with the *Dietary Guidelines for Americans*. (Baseline: 70 percent of fast food and family restaurant chains with 350 or more units had at least one low-fat, low-calorie item on their menu in 1989)

2.17 Increase to at least 90 percent the proportion of school lunch and breakfast services and child care food services with menus that are consistent with the nutri-

tion principles in the *Dietary Guidelines for Americans*. (Baseline: 1 percent of schools offered lunches that provided an average of 30 percent or less of calories from total fat, and less than 1 percent offered lunches that provided an average of less than 10 percent of calories from saturated fat based on the 1992 School Nutrition Dietary Assessment Study. Of the schools participating in the USDA school breakfast program, 44 percent offered breakfasts that provided an average of 30 percent or less of calories from total fat, and 4 percent offered breakfasts that provided an average of less than 10 percent of calories from saturated fat in 1992)

2.18 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: 7 percent in 1991)

2.19 Increase to at least 75 percent the proportion of the Nation's schools that provide nutrition education from preschool–12th grade, preferably as part of comprehensive school health education. (Baseline: 60 percent in 1991)

2.20 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 1985)

2.21 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)

1995 Additions

Health Status Objectives

2.22* Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.3 per 100,000 in 1987)

		Special Population Target	
	Stroke Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
2.22a	Blacks	52.5	27

2.23* Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline 14.4 per 100,000 in 1987)

2.24* Reduce diabetes to an incidence of no more than 2.5 per 1,000 people and a prevalence of 25 per 1,000 people (Baselines: 2.9 per 1,000 in 1986–88; 28 per 1,000 in 1986–88)

Special Population Targets

	Prevalence of Diabetes (per 1,000)	*1982–84 Baseline*†	*2000 Target*
2.24a	American Indians/Alaska Natives	69‡	62
2.24b	Puerto Ricans	55	49
2.24c	Mexican Americans	54	49
2.24d	Cuban Americans	36	32
2.24e	Blacks	36§	32

†1982–84 baseline for people aged 20–74 ‡1987 baseline for American Indians/Alaska Natives aged 15 and older §1987 baseline for blacks of all ages

Risk Reduction Objectives

2.25* 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 20–74 in 1976–80, 29 percent for women and 25 percent for men)

2.26* Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control. (Baseline: 11 percent controlled among people aged 18–74 in 1976–80; an estimated 24 percent for people aged 18 and older in 1982–84)

Special Population Targets

	High Blood Pressure Control	*1976–80 Baseline*	*2000 Target*
2.26a	Men with high blood pressure	6%	40%
		1988–91 Baseline	*2000 Target*
2.26b	Mexican Americans with high blood pressure	14%	50%
2.26c	Women aged 70 and older	19%	50%

Note: People with high blood pressure have blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or take antihypertensive medication. Blood pressure control is defined as maintaining a blood pressure less than 140 mm Hg systolic and 90 mm Hg diastolic. In the 1976–80 NHANES II, control of hypertension did not include nonpharmacologic treatment. In the 1988–91 NHANES III, those controlling their high blood pressure without medication (e.g. through weight loss, low-sodium diets, or restriction of alcohol) will be included.

2.27* Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL. (Baseline: 213 mg/dL among people aged 20–74 in 1976–80, 211 mg/dL for men and 215 mg/dL for women)

Tobacco

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)

Special Population Target

	Coronary Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
3.1a	Blacks	168	115

3.2* Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people. (Age-adjusted baseline: 38.5 per 100,000 in 1987)

Special Population Targets

	Lung Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
3.2a	Females	25.6	27
3.2b	Black males	86.1	91

Note: In its publications, the National Cancer Institute age-adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for this health status objective differ from those presented here.

3.3 Slow the rise in deaths for the total population from chronic obstructive pulmonary disease to achieve a rate of no more than 25 per 100,000 people. (Age-adjusted baseline: 18.9 per 100,000 in 1987)

Note: Deaths from chronic obstructive pulmonary disease include deaths due to chronic bronchitis, emphysema, asthma, and other chronic obstructive pulmonary diseases and allied conditions.

3.4* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 percent for men and 27 percent for women)

Special Population Targets

	Cigarette Smoking Prevalence	*1987 Baseline*	*2000 Target*
3.4a	People with a high school education or less aged 20 and older	34%	20%
3.4b	Blue-collar workers aged 18 and older	41%	20%
3.4c	Military personnel	42%†	20%
3.4d	Blacks aged 18 and older	33%	18%
3.4e	Hispanics aged 18 and older	24%	15%
3.4f	American Indians/Alaska Natives	42–70%‡	20%
3.4g	Southeast Asian men	55%§	20%
3.4h	Women of reproductive age	29%††	12%
3.4i	Pregnant women	25%‡‡	10%
3.4j	Women who use oral contraceptives	36%§§	10%

†1988 baseline ‡1979–87 estimates for different tribes §1984–88 baseline ††Baseline for women aged 18–44 ‡‡1985 baseline §§1983 baseline

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes. Since 1992, estimates include some-day (intermittent) smokers.

Risk Reduction Objectives

3.5 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 20–24 in 1987)

Special Population Target

	Initiation of Smoking	*1987 Baseline*	*2000 Target*
3.5a	Lower socioeconomic status youth[†]	40%	18%

[†]As measured by people aged 20–24 with a high school education or less

3.6 Increase to at least 50 percent the proportion of cigarette smokers aged 18 and older who stopped smoking cigarettes for at least 1 day during the preceding year. (Baseline: In 1986, 34 percent of people who smoked in the preceding year stopped for at least 1 day during that year)

3.7 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 20–44 quit at any time during pregnancy in 1985)

Special Population Target

	Cessation and Abstinence During Pregnancy	*1985 Baseline*	*2000 Target*
3.7a	Women with less than a high school education	28%[†]	45%

[†]Baseline for white women aged 20–44

3.8[*] Reduce to no more than 20 percent the proportion of children aged 6 and younger who are regularly exposed to tobacco smoke at home. (Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 6 or younger had a cigarette smoker in the household)

Note: Regular exposure to tobacco smoke at home is defined as the occurrence of tobacco smoking anywhere in the home on more than 3 days each week.

3.9 Reduce smokeless tobacco use by males aged 12–24 to a prevalence of no more than 4 percent. (Baseline: 6.6 percent among males aged 12–17 in 1988; 8.9 percent among males aged 18–24 in 1987)

Special Population Target

	Smokeless Tobacco Use	*1986–87 Baseline*	*2000 Target*
3.9a	American Indian/Alaska Natives aged 18–24	18–64%	10%

Note: For males aged 12–17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18–24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.

Services and Protection Objectives

3.10 Establish tobacco-free environments and include tobacco use prevention in the curricula of all elementary, middle, and secondary schools, preferably as part of comprehensive 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)

3.11 Increase to 100 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)

3.12* Enact in 50 States and the District of Columbia comprehensive laws on clean indoor air that prohibit smoking or limit it to separately ventilated areas in the workplace and enclosed public places. (Baseline: 4 States regulated private workplaces; 8 States regulated public workplaces, including those that banned smoking through Executive Orders; 2 States regulated restaurants; 14 States and the District of Columbia regulated public transportation; 9 States regulated hospitals; 21 States regulated day care centers; and 6 States regulated grocery stores with comprehensive laws as of January 1995)

3.13 Enact in 50 States and the District of Columbia laws prohibiting the sale and distribution of tobacco products to youth younger than age 18. Enforce these laws so that the buy rate in compliance checks conducted in all 50 States and the District of Columbia is no higher than 20 percent. (Baseline: 44 States and the District of Columbia 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. Baseline and followup data on enforcement will be provided in State reports to the Substance Abuse and Mental Health Services Administration as a part of compliance with the Synar amendment.)

Note: In July 1992, the President signed Public Law 102-321, the reorganization of the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act, which included the "Synar Amendment." The new law requires all 50 States and the District of Columbia to ban the sale and distribution of tobacco products to everyone under the age of 18. It also required States to enforce their law "in a manner that can be reasonably be expected to reduce the extent to which tobacco products are available to underage youths" or risk the loss of a percentage of Federal Substance Abuse Prevention and Treatment Block Grants.

Although all States have enacted youth access laws, enforcement is variable. Therefore, this objective will separately report on the enactment and enforcement of youth access laws. Enforcement will be measured based on HHS regulations implementing the amendment.

Model legislation proposed by HHS recommends licensure of tobacco vendors, civil money penalties and license suspension or revocation for violations, and a ban on cigarette vending machines.

3.14 Establish in 50 States and the District of Columbia plans to reduce tobacco use, especially among youth. (Baseline: 12 States in 1989)

3.15 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)

3.16 Increase to at least 75 percent the proportion of primary care and oral health care providers who routinely advise cessation and provide assistance and followup for all of their tobacco-using patients. (Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986; about 35 percent of dentists reported counseling at least 75 percent of their smoking patients about smoking in 1986)

1995 Additions

Health Status Objectives

3.17* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

3.18* Reduce stroke deaths to no more than 20 per 100,000 people (Age-adjusted baseline: 30.4 per 100,000 in 1987)

		Special Population Target	
	Stroke Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
3.18a	Blacks	52.5	27.0

Risk Reduction Objectives

3.19* Increase by at least 1 year the average age of first use of cigarettes, alcohol, and marijuana by adolescents aged 12–17. (Baseline: Age 11.6 for cigarettes, age 13.1 for alcohol, and age 13.4 for marijuana in 1988)

3.20* Reduce the proportion of young people who have used alcohol, marijuana, cocaine, or cigarettes in the past month as follows:

Substance/Age	*1988 Baseline*	*2000 Target*
Alcohol/aged 12–17	25.2%	12.6%
Alcohol/aged 18–20	57.9%	29.0%
Marijuana/aged 12–17	6.4%	3.2%
Marijuana/aged 18–25	15.5%	7.8%
Cocaine/aged 12–17	1.1%	0.6%
Cocaine/aged 18–25	4.5%	2.3%

Use in past month	*1991 Baseline*	*2000 Target*
Alcohol		
Hispanic 12–17 years	22.5%	12.0%
Cocaine		
Hispanic 12–17 years	1.3%	0.6%
Hispanic 18–25 years	2.7%	1.0%
Cigarettes		
12–17 years	10.8%	6.0%

Note: The targets of this objective are consistent with the goals established by the Office of National Drug Control Policy, Executive Office of the President.

3.21* Increase the proportion of high school seniors who perceive social disapproval of heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of cigarettes, as follows:

Behavior	*1989 Baseline*	*2000 Target*
Heavy use of alcohol	56.4%	70%
Occasional use of marijuana	71.1%	85%
Trying cocaine once or twice	88.9%	95%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more pack of cigarettes per day	74.2%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

3.22* Increase the proportion of high school seniors who associate physical or psychological harm with heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of tobacco, as follows:

Behavior	*1989 Baseline*	*2000 Target*
Heavy use of alcohol	44.0%	70%
Regular use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more packs of cigarettes per day	68.6%	95%
Using smokeless tobacco regularly	37.4%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

Services and Protection Objectives

3.23 Increase the average (State and Federal combined) tobacco excise tax to at least 50 percent of the average retail price of all cigarettes and smokeless tobacco.

Tax as a Percent of Retail Price (State and Federal)	*1993 Baseline*	*2000 Target*
Cigarettes	31.4%	50%
Smokeless Tobacco	11.8%	50%

Source: "The Tax Burden on Tobacco," *The Tobacco Institute, 1994 and CDC, Office on Smoking and Health.*

Commentary:

Cigarettes

Enacting increases in taxes on tobacco products is good health policy. Changes in price can have a dramatic impact on the levels of tobacco consumption and tobacco use prevalence among youth and adults. Price increases will encourage smoking cessation among current smokers and discourage smoking initiation among youth, preventing millions of premature deaths and saving millions in health care costs. A panel convened by the National Cancer Institute (NCI) in 1991 reviewed the role of excise taxes as a deterrent to smoking. In the summary report, the expert panel concluded that excise taxes may be the single most effective approach to reducing tobacco use by youth. The panel stated that youth consumption would decrease in response to increased prices at a rate of at least 3–5 percent for every 10 percent increase in the price, a rate equal to the decline in tobacco use among adults. In addition, the panel concluded that youth price sensitivity may be as high as 3 times the adult rates, although the data on this were inconclusive.[1]

Tax incidence reflects the average State and Federal tax on a pack of cigarettes as a proportion of the average retail price of a pack of cigarettes. From the mid-1950s through the early 1970s the State and Federal cigarette tax incidence was over 46 percent, with a high of 51.4 percent in 1965. By 1987, the tax incidence had dropped to 28.8 percent. Furthermore, the U.S. cigarette tax incidence is considerably lower than that for many industrialized nations. The average tax incidence across 23 developed nations is 68.5 percent. By the year 2000, the United States should be taxing tobacco products consistent with historic levels in the United States.

The Federal excise tax on cigarettes is currently 24 cents per pack, having been raised from 20 to 24 cents in 1993 as part of the Budget Reconciliation Act of 1990. In addition to the Federal tax, all States, the District of Columbia, 369 towns, and 20 counties currently impose excise taxes on cigarettes. As of September 30, 1994, State excise taxes ranged from 2.5 cents per pack in Virginia to 75 cents per pack in Michigan and averaged 30.5 cents per pack.[2]

In real terms, the Federal excise tax on cigarettes decreased by 68 percent from 1964 to 1982, and the average State tax on cigarettes declined by more than 40 percent

from 1975 to 1990. To serve as an effective deterrent over time, excise taxes on tobacco products should be restructured from unit taxes on cigarettes and other tobacco products to equivalent-yield *ad valorem* taxes, which would allow revenues to keep pace with inflation-induced increases in product prices.[3]

Excise tax increases offer the added benefit of generating public revenue with relatively low administrative costs. A portion of the funds could be earmarked for tobacco use prevention programs to further deter tobacco use by youth. In 1988 California voters passed Proposition 99, which increased the State excise tax on tobacco by 25 cents per pack. Some of the revenue derived from this increase was earmarked for tobacco use prevention and reduction programs. The combination of a tax increase and a comprehensive tobacco control program reduced per capita consumption by 17 percent from January 1989 through January 1991.[4] Additional economic research has demonstrated that the tax increase had an impact on the decline in consumption independent of the impact of the comprehensive tobacco control program.[5]

Most public opinion polls and surveys indicate that at least 75 percent of the American public supports an increase in the current excise tax on tobacco. A 1993 Gallup poll, which surveyed smoker and nonsmoker support, found that 40 percent of smokers and 85 percent of nonsmokers favored a tobacco excise tax increase to finance national health reform.[6] A 1993 poll conducted by the American Cancer Society (ACS) found strong support (66 percent) for a significant tobacco tax increase (2 dollars) to support a national health plan. This support was broad-based demographically, with 64 percent of African Americans supporting a 2 dollar increase and 71 percent of Hispanic Americans supporting the increase.[7]

Smokeless Tobacco Products

Smokeless tobacco products are highly addictive and are not safe alternatives to smoking. Moist snuff (dip) and chewing tobacco (chew) are the dominant forms of smokeless tobacco. The standard unit for retail purchase for snuff is a 1.2 ounce tin; and for chew, a 3-ounce pouch. A typical dose of snuff contains two to three times the amount of nicotine in a single cigarette.

The Federal excise tax on smokeless tobacco products is 36 cents per pound for snuff and 12 cents per pound for chewing tobacco; this translates into 2.7 cents per can for snuff and 2.3 cents per package of chewing tobacco. These taxes are considerably less than the 24 cents per pack of cigarettes. State taxes on smokeless tobacco products vary greatly. As of September 30, 1994, 9 States and the District of Columbia had no tax on smokeless tobacco products.

Smokeless tobacco is taxed at about one-tenth the rate of cigarettes. The tax discrepancy between cigarettes and smokeless tobacco may encourage children to start using smokeless tobacco as an alternative to smoking or may encourage the substitution of smokeless tobacco for cigarettes among young people who already smoke.[8]

Among high school seniors who have ever used smokeless tobacco, 73 percent did so by the ninth grade.[9]

The American Public Health Association, the American Dental Association, and the Association of State and Territorial Dental Directors have recommended that taxes on smokeless tobacco products be at least equal to those on cigarettes. In addition, the Association of Public Health Dentistry has supported significant increases in excise taxes on tobacco products. Failure to equalize the tax may result in many smokers switching from cigarettes to smokeless tobacco and many youngsters who would not smoke taking up smokeless tobacco instead.

3.24 Increase to 100 percent the proportion of health plans that offer treatment of nicotine addiction (e.g., tobacco use cessation counseling by health care providers, tobacco use cessation classes, prescriptions for nicotine replacement therapies, and/or other cessation services). (Baseline: 11 percent of health plans cover treatment for nicotine addiction in 1985)

Source: Gelb, B.D. Preventive Medicine and Employee Productivity. Harvard Business Review *64(2):12. 1985.*[10]

Commentary:

Extensive evidence suggests that treatment of nicotine addiction substantially reduces morbidity and mortality due to tobacco-related diseases. In the 1988 report, *The Health Consequences of Smoking: Nicotine Addiction*, the Surgeon General asserted that treatment of nicotine addiction should be more widely available and that it should be considered at least as favorably by third-party payers as treatment of alcoholism and illicit drug addiction.[11] Furthermore, the U.S. Preventive Services Task Force has recommended that smoking cessation counseling be reimbursed by third-party payers.[12]

This new objective seeks to ensure that no tobacco user has financial barriers to seeking effective treatment for their nicotine addiction.

More than 70 percent of U.S. smokers see their physician each year, giving physicians considerable access to smokers.[13] In addition, dentists see over 60 percent of the U.S. population aged 5 and older within 1 year.[14] Clinical trials have demonstrated that physicians and dentists can help their patients stop smoking.[15] If only half of all U.S. physicians and dentists gave brief advice to their patients and were successful with only 10 percent of them, there would still be more than 2 million new nonsmokers in the United States each year.[13] The National Cancer Institute has developed manuals for physicians and dentists to assist patients to quit smoking.[13,16] The National Heart, Lung, and Blood Institute has produced a similar manual for nurses.[17]

It has been estimated that cessation counseling is more cost effective than beta-adrenergic antagonist therapy after a myocardial infarction.[18] Other studies have

shown that physician counseling against smoking is at least as cost effective as several other preventive medical practices, including treatment of mild or moderate hypertension or high cholesterol.[19]

Cessation rates improve as the intensity of the intervention increases. Greater cessation rates have been achieved with counseling by health care providers compared to providing advice alone. Even higher rates have been achieved with counseling combined with nicotine replacement therapy. Support for the maintenance of cessation is critical to long-term success.

3.25* Reduce to zero the number of States that have clean indoor air laws preempting stronger clean indoor air laws on the local level. (Baseline: 17 States had preemptive clean indoor air laws as of January 1995)

Source: Legislative Tracking System, CDC, and State Cancer Legislative Database, NCI

Commentary:

Preemptive State tobacco control laws prevent local jurisdictions from enacting more stringent restrictions than the State law, enacting restrictions varying from the State law, or enacting related restrictions. Although the tobacco industry attempts to promote such laws as health promotion efforts to ensure a minimum uniform set of restriction for all communities, such laws usually afford less protection and prevent local governments from adopting more restrictive provisions in the future.[20]

Consequences of preemptive laws have included weaker public health standards, loss of community education involved in the passage of local ordinances; more difficulty with enforcement at the local level; and lower compliance with the laws.[21]

Several national organizations have expressed opposition to the enactment of preemptive laws including the American Public Health Association, the Institute of Medicine, and a working group of State Attorneys General.

3.26 Enact in 50 States and the District of Columbia laws banning cigarette vending machines except in places inaccessible to minors. (Baseline: 12 States and the District of Columbia as of January 1995)

Source: Legislative Tracking System, CDC

Commentary:

There are an estimated 3 million underage smokers in the United States. They purchase 947 million packs of cigarettes and 26 million cans of smokeless tobacco each year, resulting in $1.26 billion in tobacco sales.[22] A 1992 study by the CDC concluded that more than half of underage smokers buy their own cigarettes.[23] Although studies also show that only 23 percent of smoking youth now use vending machines often or occasionally, anticipated changes in State enforcement of minors' access laws may increase the number of underage smokers who use tobacco vending machines.

Vending machines suggest a universal availability of cigarettes in our society. They provide an easy source of tobacco for the youngest underage smokers. A study concluded that most teens (56 percent) say they use vending machines "because no one will stop me from buying cigarettes this way."[24] This same study found that 60 percent of teenage smokers who buy their own cigarettes have ever been refused when they were trying to buy them. Of these, virtually all (98 percent) had been stopped from buying cigarettes over the counter, but only about 1 in 10 had ever been stopped from buying cigarettes from a vending machine.[24] Furthermore, because vending machines are self-service, it is difficult to attach responsibility and liability to a particular individual for illegal sales to minors from vending machines, and sales personnel at a register cannot effectively supervise even nearby machines while serving other customers.

Selling candy and cigarettes from the same vending machine, and unrestricted accessibility to tobacco vending machines encourages and facilitates cigarette sales to minors. Although all States have enacted laws prohibiting the purchase of tobacco products under the age of 18, few States have strong vending machine restrictions.

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Substance Abuse: Alcohol and Other Drugs

Health Status Objectives

4.1* Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people. (Age-adjusted baseline: 9.8 per 100,000 in 1987)

Special Population Targets

	Alcohol-Related Motor Vehicle Crash Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
4.1a	American Indian/Alaska Native men	40.4	35.0
4.1b	People aged 15–24	21.5	12.5

4.2 Reduce cirrhosis deaths to no more than 6 per 100,000 people. (Age-adjusted baseline: 9.2 per 100,000 in 1987)

Special Population Targets

	Cirrhosis Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
4.2a	Black men	22.6	12
4.2b	American Indians/Alaska Natives	20.5	10
		1990 Baseline	*2000 Target*
4.2c	Hispanics	14.0	10

4.3 Reduce drug-related deaths to no more than 3 per 100,000 people. (Age-adjusted baseline: 3.8 per 100,000 in 1987)

Special Population Targets

	Drug-Related Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
4.3a	Blacks	5.7	3
4.3b	Hispanics	4.3	3

4.4 Reduce drug abuse-related hospital emergency department visits by at least 20 percent. (Baseline: 175.8 per 100,000 people in 1991)

Risk Reduction Objectives

4.5* Increase by at least 1 year the average age of first use of cigarettes, alcohol, and marijuana by adolescents aged 12–17. (Baseline: Age 11.6 for cigarettes, age 13.1 for alcohol, and age 13.4 for marijuana in 1988)

4.6* Reduce the proportion of young people who have used alcohol, marijuana, cocaine, or cigarettes in the past month as follows:

Substance/Age	*1988 Baseline*	*2000 Target*
Alcohol/aged 12–17	25.2%	12.6%
Alcohol/aged 18–20	57.9%	29.0%
Marijuana/aged 12–17	6.4%	3.2%
Marijuana/aged 18–25	15.5%	7.8%
Cocaine/aged 12–17	1.1%	0.6%
Cocaine/aged 18–25	4.5%	2.3%

Use in Past Month	*1991 Baseline*	*2000 Target*
Alcohol		
Hispanic 12–17 years	22.5%	12.0%
Cocaine		
Hispanic 12–17 years	1.3%	0.6%
Hispanic 18–25 years	2.7%	1.0%
Cigarettes		
12–17 years	10.8%	6.0%

Note: The targets of this objective are consistent with the goals established by the Office of National Drug Control Policy, Executive Office of the President.

4.7 Reduce the proportion of high school seniors and college students engaging in recent occasions of heavy drinking of alcoholic beverages to no more than 28 percent of high school seniors and 32 percent of college students. (Baseline: 33 percent of high school seniors and 41.7 percent of college students in 1989)

Note: Recent heavy drinking is defined as having five or more drinks on one occasion in the previous 2-week period as monitored by self-reports.

4.8 Reduce alcohol consumption by people aged 14 and older to an annual average of no more than 2 gallons of ethanol per person. (Baseline: 2.54 gallons of ethanol in 1987)

4.9* Increase the proportion of high school seniors who perceive social disapproval of heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of tobacco, as follows:

Behavior	*1989 Baseline*	*2000 Target*
Heavy use of alcohol	56.4%	70%
Occasional use of marijuana	71.1%	85%
Trying cocaine once or twice	88.9%	95%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more pack of cigarettes per day	74.2%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

4.10* Increase the proportion of high school seniors who associate physical or psychological harm with heavy use of alcohol, occasional use of marijuana, and experimentation with cocaine, or regular use of cigarettes, as follows:

Behavior	*1989 Baseline*	*2000 Target*
Heavy use of alcohol	44.0%	70%
Regular use of marijuana	77.5%	90%
Trying cocaine once or twice	54.9%	80%

Note: Heavy drinking is defined as having five or more drinks once or twice each weekend.

Behavior	*1987 Baseline*	*2000 Target*
Smoking one or more packs of cigarettes per day	68.6%	95%
Using smokeless tobacco regularly	37.4%	95%

Note: The Monitoring the Future Survey defines regular use of cigarettes as smoking one or more packs daily.

4.11 Reduce to no more than 3 percent the proportion of male high school seniors who use anabolic steroids. (Baseline: 4.7 percent in 1989)

Services and Protection Objectives

4.12 Establish and monitor in 50 States comprehensive plans to ensure access to alcohol and drug treatment programs for traditionally underserved people. (Baseline data unavailable)

4.13 Provide to children in all school districts and private schools primary and secondary school educational programs on alcohol and other drugs, preferably as part of comprehensive school health education. (Baseline: 63 percent provided some instruction, 39 percent provided counseling, and 23 percent referred students for clinical assessments in 1987)

4.14 Extend adoption of alcohol and drug policies for the work environment to at least 60 percent of worksites with 50 or more employees. (Baseline: 88 percent of worksites had adopted alcohol policies; 89 percent of worksites had adopted drug policies in 1992)

4.15 Extend to 50 States administrative driver's license suspension/revocation laws or programs of equal effectiveness for people determined to have been driving under the influence of intoxicants. (Baseline: 28 States and the District of Columbia in 1990)

4.16 Increase to 50 the number of States that have enacted and enforce policies, beyond those in existence in 1989, to reduce access to alcoholic beverages by minors. (Baseline data unavailable)

Note: Policies to reduce access to alcoholic beverages by minors may include those that address restriction of the sale of alcoholic beverages at recreational and entertainment events at which youth make up a majority of participants/consumers, product pricing, penalties and license revocation for sale of alcoholic beverages to minors, and other approaches designed to discourage and restrict purchase of alcoholic beverages by minors.

4.17 Increase to at least 20 the number of States that have enacted statutes to restrict promotion of alcoholic beverages that is focused principally on young audiences. (Baseline data unavailable)

4.18 Extend to 50 States legal blood alcohol concentration tolerance levels of .08 percent for motor vehicle drivers aged 21 and older and zero tolerance (.02 percent and lower) for those younger than age 21. (Baseline: 7 States with .08 BAC laws and 9 States with zero tolerance laws in 1993)

Note: The legal blood alcohol concentration tolerance level for adults was revised to be consistent with the goals established by the National Highway Traffic Safety Administration.

4.19 Increase to at least 75 percent the proportion of primary care providers who screen for alcohol and other drug use problems and provide counseling and referral as needed. (Baseline: 19–63 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

1995 Addition

Services and Protection Objective

4.20 Increase to 30 the number of States with Hospitality Resource Panels (including representatives from State regulatory, public health, and highway safety agencies, law enforcement, insurance associations, alcohol retail and licensed beverage associations) to ensure a process of management and server training and define standards of responsible hospitality. (Baseline: 8 States in 1994)

Source: California Coordinating Council on Responsible Beverage Service, National Survey Report

Commentary:

The primary purpose of this objective is to build upon voluntary models of management and server training. By establishing Hospitality Resource Panels that are broadly representative of the community—alcohol industry, insurance associations, State regulatory, public health, highway safety, and law enforcement agencies—a partnership can be formed to promote responsible drinking. Prevention goals that focus on voluntary standards for management and server training can be an effective prevention strategy with the potential to reduce alcohol-related injuries. While some States do mandate training in the hospitality industry, other States have increased incentives through public recognition and reduced liability to achieve its public health objectives.

A recent study of the research on responsible beverage service by A. James McKnight[1] concludes that server training can change attitudes and knowledge but does not change behavior as much as enforcement of alcohol regulation and strong policies and commitments to responsible service from the managers of public drinking establishments. This research underscores the importance of having members of the hospitality industry working with public health and highway safety agencies on Hospitality Resource Panels.

Training managers and servers in the hospitality industry to address issues such as service to minors and intoxicated persons can, from a public health standpoint, reduce harm to society. It encourages server intervention which can be a forceful deterrent to irresponsible drinking practices and contributes to the prevention of alcohol-related injuries.

A recent analysis of the role of management and server training is described in the following:

Only when a community recognizes the problems resulting from irresponsible alcohol service and is prepared to take action at the community-wide level can an effective program be launched. Such a program would include strong enforcement of alcohol control laws, strong policies on and commitments to responsible service from the managers of public drinking establishments, and server training.[2]

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Family Planning

Health Status Objectives

5.1 Reduce pregnancies among females aged 15–17 to no more than 50 per 1,000 adolescents. (Baseline: 71.1 pregnancies per 1,000 females aged 15–17 in 1985)

Special Population Targets

	Pregnancies (per 1,000)	*1985 Baseline*	*2000 Target*
5.1a	Black adolescent females aged 15–19	169	120
5.1b	Hispanic adolescent females aged 15–19	143	105

Note: For black and Hispanic adolescent females, baseline data are unavailable for those aged 15–17. The targets for these two populations are based on data for females aged 15–19. If more complete data become available, a 35-percent reduction from baseline figures should be used as the target.

5.2 Reduce to no more than 30 percent the proportion of all pregnancies that are unintended. (Baseline: 56 percent of pregnancies in the previous 5 years were unintended, either unwanted or earlier than desired, in 1988)

Special Population Targets

	Unintended Pregnancies	*1988 Baseline*	*2000 Target*
5.2a	Black females	78.0%	40%
5.2b	Hispanic females	54.9%	30%

5.3 Reduce the prevalence of infertility to no more than 6.5 percent. (Baseline: 7.9 percent of married couples with wives aged 15–44 in 1988)

Special Population Targets

	Prevalence of Infertility	*1988 Baseline*	*2000 Target*
5.3a	Black couples	12.1%	9%
5.3b	Hispanic couples	12.4%	9%

Note: Infertility is the failure of couples to conceive after 12 months of intercourse without contraception.

Risk Reduction Objectives

5.4* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17; reported in 1988)

Special Population Targets

	Adolescents Engaged in Sexual Intercourse	*1988 Baseline*	*2000 Target*
5.4a	Black males aged 15	69%	15%
5.4b	Black males aged 17	90%	40%
5.4c	Black females aged 17	66%	40%

5.5* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse during the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 in 1988 and 33 percent of sexually active males aged 15–17 in 1988)

5.6 Increase to at least 90 percent the proportion of sexually active, unmarried people aged 15–24 who use contraception, especially combined method contraception that both effectively prevents pregnancy and provides barrier protection against disease. (Baseline: 78 percent at most recent intercourse and 63 percent at first intercourse; 2 percent used oral contraceptives and the condom at most recent intercourse; among young women aged 15–19 in 1988)

5.7 Increase the effectiveness with which family planning methods are used, as measured by a decrease to no more than 7 percent in the proportion of women experiencing pregnancy despite use of a contraceptive method. (Baseline: Approximately 14 percent of women using reversible contraceptive methods experienced an unintended pregnancy in 1988)

Special Population Targets

	Percent of Users Who Became Pregnant In the Last Year	*1988 Baseline*	*2000 Target*
5.7a	Black females	17.6%	8%
5.7b	Hispanic females	16.4%	8%

Services and Protection Objectives

5.8 Increase to at least 85 percent the proportion of people aged 10–18 who have discussed human sexuality, including correct anatomical names, sexual abuse, and values surrounding sexuality, with their parents and/or have received information through another parentally endorsed source, such as youth, school, or religious programs. (Baseline: 66 percent of people aged 13–18 have discussed sexuality with their parents; reported in 1986)

5.9 Increase to at least 90 percent the proportion of family planning counselors who offer accurate information about all options, including prenatal care and delivery, infant care, foster care, or adoption and pregnancy termination to their patients with unintended pregnancies. (Baseline: 60 percent in 1984)

5.10* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: 18–65 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

5.11* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide on site primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

1995 Addition

Risk Reduction Objective

5.12 Increase to at least 95 percent the proportion of all females aged 15–44 at risk of unintended pregnancy who use contraception. (Baseline: 88.2 percent of all females aged 15–44 in 1982)

		Special Population Targets		
	Percent Using Contraception Among Females Aged 15–44 at Risk of Unintended Pregnancy	*1982 Baseline*	*1988*	*2000 Target*
5.12a	Black females	78.9%	84.7%	95%
5.12b	Females with income less than 100 percent of poverty	79.6%	80.2%	95%
5.12c	Females aged 15–19 under 200 percent poverty	67.4%	74.9%	95%

Source: Forrest, J.D. and Singh, S. The sexual and reproductive behavior of American women, 1982–1988. Family Planning Perspectives *22(5):206–14. 1990; also unpublished tabulations of the 1982 and 1988 National Survey of Family Growth, CDC.*

Commentary:

Females at risk of unintended pregnancy are those who are fecund and who are sexually active but do not wish to have a child in the near future. This group includes females who are protected by contraception and those who are not using any method at all. In 1982, 63 percent of all females aged 15–44 were considered to be at risk of unintended pregnancy, compared to 67 percent in 1988. The proportion not using any method was approximately 10 percent in 1988, compared to 12 percent in 1982. However, even this apparently small proportion is an important group, since in absolute numbers this was about 4 million females in 1988. This group of women accounts for a large part of the need for women to resort to abortion. The proportion

not using a method of contraception is even higher among some subgroups; poor females are much more likely to be using no method of contraception, and among poor teenagers this proportion reaches 25 percent.

In 1988, 90.1 percent of all females who were at risk of unintended pregnancy used contraception. However, only 85.3 percent of females whose income fell below 200 percent of the poverty line and only 80.2 percent of the poorest females—below 100 percent of the poverty line—used contraception in 1988. Thus nearly 20 percent of the Nation's lowest income females at risk of unintended pregnancy used no form of contraception to protect themselves against unintended pregnancy.

This objective is aimed at increasing the proportion of all females who are at risk of unintended pregnancy who are protected by contraception to 95 percent, and to reduce differences between income groups. Among low-income females at risk of unintended pregnancy in 1988:

- 23 percent (nearly one out of four) of low-income females at risk of unintended pregnancy who used contraception depended on publicly funded family planning providers for their contraception;
- only 16.5 percent went to a private provider;
- 31.5 percent relied on sterilization;
- 14.5 percent relied on methods that do not require medical intervention; and
- 15 percent were in need of family planning services and not getting them.

With regard to international comparisons of contraceptive use, nationally representative survey data on contraceptive use is not collected as regularly in other developed countries as it is in the United States. More importantly, the data that are available do not use the concept of women at risk as it is defined in the United States. As a result, exactly comparable data are not available. However, comparable data for the early 1980s for several developed countries does show that among married or cohabiting women aged 20–29 and 35–44, use of any method was somewhat lower in the United States than in some developed countries. In the United States, 68 percent of married or cohabiting women aged 20–29 used a method, compared to 76 percent in Greece and the Netherlands, 73–74 percent in Finland, France, Norway, and Portugal, and 72 percent in Italy and the United Kingdom. Even larger differences exist among women aged 35–44, with about 63 percent of this group using a method in the United States, compared to 75–83 percent in a number of European countries, including all of those listed above, as well as some others.[1]

Reference

1. Jones, E., et al. *Pregnancy, Contraception and Family Planning Services in Industrialized Countries*, Yale University Press, 1988.

Mental Health and Mental Disorders

Health Status Objectives

6.1* Reduce suicides to no more than 10.5 per 100,000 people. (Age-adjusted baseline: 11.7 per 100,000 in 1987)

Special Population Targets

	Suicides (per 100,000)	*1987 Baseline*	*2000 Target*
6.1a	Youth aged 15–19	10.2	8.2
6.1b	Men aged 20–34	25.2	21.4
6.1c	White men aged 65 and older	46.7	39.2
6.1d	American Indian/ Alaska Native men	20.1	17.0

6.2* Reduce to 1.8 percent the incidence of injurious suicide attempts among adolescents aged 14–17. (Baseline: 2.1 percent in 1990)

Special Population Target

	Injurious Suicide Attempts	*1991 Baseline*	*2000 Target*
6.2a	Female adolescents aged 14–17	2.5	2.0

Note: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

6.3 Reduce to less than 17 percent the prevalence of mental disorders among children and adolescents. (Baseline: An estimated 20 percent among youth younger than age 18 in 1992)

Note: The baseline has been revised based on Bird, H.R., et al., Estimates of the Prevalence of Childhood Maladjustment in a Community Survey in Puerto Rico, 1988, and Costello, E.J., et al., "Psychiatric Disorders in Pediatric Primary Care: Prevalence Risk Factors," 1988; in Archives of General Psychiatry, *Vol. 45. The ongoing data source will be the Multi-site Study of Service, Use, Need, Outcomes and Costs for Child and Adolescent Populations (UNO-CAP), NIH. The baseline revision has resulted in a year 2000 target revision.*

6.4 Reduce the prevalence of mental disorders (exclusive of substance abuse) among adults living in the community to less than 10.7 percent. (Baseline: 1-month point prevalence of 12.6 percent in 1984)

6.5 Reduce to less than 35 percent the proportion of people aged 18 and older who report adverse health effects from stress within the past year. (Baseline: 44.2 percent in 1985)

Special Population Target

		1985 Baseline	*2000 Target*
6.5a	People with disabilities	53.5%	40%

Note: For this objective, people with disabilities are people who report any limitation in activity due to chronic conditions.

Risk Reduction Objectives

6.6 Increase to at least 30 percent the proportion of people aged 18 and older with severe, persistent mental disorders who use community support programs. (Baseline: 15 percent in 1986)

6.7 Increase to at least 54 percent the proportion of people with major depressive disorders who obtain treatment. (Baseline: 31 percent in 1982)

6.8 Increase to at least 20 percent the proportion of people aged 18 and older who seek help in coping with personal and emotional problems. (Baseline: 11.1 percent in 1985)

Special Population Target

		1985 Baseline	*2000 Target*
6.8a	People with disabilities	14.7%	30%

6.9 Decrease to no more than 5 percent the proportion of people aged 18 and older who report experiencing significant levels of stress who do not take steps to reduce or control their stress. (Baseline: 24 percent in 1985)

Services and Protection Objectives

6.10* 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 by jail inmates. (Baseline: 3 States in 1992)

6.11 Increase to at least 40 percent the proportion of worksites employing 50 or more people that provide programs to reduce employee stress. (Baseline: 26.6 percent in 1985)

6.12 Establish a network to facilitate access to mutual self-help activities, resources, and information by people and their family members who are experiencing emotional distress resulting from mental or physical illness. (Baseline: 2 Federal and 8 State clearinghouses in 1995)

6.13 Increase to at least 60 percent the proportion of primary care providers who routinely review with patients their patients' cognitive, emotional, and behavioral functioning and the resources available to deal with any problems that are identified. (Baseline: 7–40 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

6.14 Increase to at least 75 percent the proportion of providers of primary care for children who include assessment of cognitive, emotional, and parent-child functioning, with appropriate counseling, referral, and followup, in their clinical practices. (Baseline: 24–62 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, and family physicians reported rountinely providing services to patients in 1992)

1995 Addition

Health Status Objective

6.15 Reduce the prevalence of depressive (affective) disorders among adults living in the community to less than 4.3 percent. (Baseline: 1 month prevalence of 5.1 percent in 1984)

		Special Population Target	
	Depressive Disorders	*1991 Baseline*	*2000 Target*
6.15a	Women	6.6%	5.5%

Source: Baseline: Epidemiologic Catchment Area Study, NIH, 1981–1985. Ongoing Source: National Comorbidity Survey, NIH.

Commentary:

Depression is a highly prevalent disorder, particularly among women. Research shows that depression is often comorbid with other psychiatric and physical illnesses. There is a high correlation between depression and attempted and completed suicides. Primary care physicians often fail to recognize the symptoms of depression in their patients, and the symptoms of depression often mimic those of physical illnesses. Depression is a significant public health problem that can be effectively treated. Approximately 80 percent of patients can be successfully treated, yet less than 40 percent of individuals with depression are treated by a health care provider. Particularly disturbing is the high rate of affective disorders among females. The rate for females is 6.6 percent which is nearly twice that of males—3.5 percent. The overall rate is 5.1 percent.

There were two large population surveys in which trained interviewers collected information on clinical diagnosis: The Epidemiologic Catchment Area Study (conducted in the early 1980s) and the National Comorbidity Survey (conducted in the early 1990s).

Violent and Abusive Behavior

Health Status Objectives

7.1 Reduce homicides to no more than 7.2 per 100,000 people. (Age-adjusted baseline: 8.5 per 100,000 in 1987)

Special Population Targets

	Homicide Rate (per 100,000)	*1987 Baseline*	*2000 Target*
7.1a	Children aged 3 and younger	3.9	3.1
7.1b	Spouses aged 15–34	1.7	1.4
7.1c	Black men aged 15–34	91.1	72.4
7.1d	Hispanic men aged 15–34	41.3	33.0
7.1e	Black women aged 15–34	20.2	16.0
7.1f	American Indians/Alaska Natives	11.2	9.0

7.2* Reduce suicides to no more than 10.5 per 100,000 people. (Age-adjusted baseline: 11.7 per 100,000 in 1987)

Special Population Targets

	Suicides (per 100,000)	*1987 Baseline*	*2000 Target*
7.2a	Youth aged 15–19	10.2	8.2
7.2b	Men aged 20–34	25.2	21.4
7.2c	White men aged 65 and older	46.7	39.2
7.2d	American Indian/Alaska Native men	20.1	17.0

7.3 Reduce firearm-related deaths to no more than 11.6 per 100,000 people from major causes. (Baseline: 14.6 firearm-related deaths in 1990)

Special Population Target

	Firearm-Related Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
7.3a	Blacks	33.4	30.0

7.4 Reverse to less than 22.6 per 1,000 children the rising incidence of maltreatment of children younger than age 18. (Baseline: 22.6 per 1,000 in 1986)

Type-Specific Targets

	Incidence of Types of Maltreatment (per 1,000)	*1986 Baseline*	*2000 Target*
7.4a	Physical abuse	4.9	<4.9
7.4b	Sexual abuse	2.1	<2.1
7.4c	Emotional abuse	3.0	<3.0
7.4d	Neglect	14.6	<14.6

7.5 Reduce physical abuse directed at women by male partners to no more than 27 per 1,000 couples. (Baseline: 30 per 1,000 in 1985)

7.6 Reduce assault injuries among people aged 12 and older to no more than 8.7 per 1,000 people. (Baseline: 9.7 per 1,000 in 1986)

7.7 Reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women. (Baseline: 120 per 100,000 in 1986)

		Special Population Target	
	Incidence of Rape and Attempted Rape (per 100,000)	*1986 Baseline*	*2000 Target*
7.7a	Women aged 12–34	250	225

7.8* Reduce by 15 percent the incidence of injurious suicide attempts among adolescents aged 14–17. (Baseline: 2.1 percent in 1991)

		Special Population Target	
	Injurious Suicide Attempts	*1986 Baseline*	*2000 Target*
7.8a	Female Adolescents aged 14–17	2.5%	2.0%

Note: Data are limited to those suicide attempts that result in hospitalization and are based on self-reports.

Risk Reduction Objectives

7.9 Reduce to 110 per 1,000 the incidence of physical fighting among adolescents aged 14–17. (Baseline: 137 incidents per 1,000 high school students per month in 1991)

		Special Population Target	
	Adolescent Physical Fighting (per 1,000)	*1991 Baseline*	*2000 Target*
7.9a	Black males	207	160

7.10 Reduce to 86 per 1,000 the incidence of weapon-carrying by adolescents aged 14–17. (Baseline: 107 incidents per 1,000 high school students per month in 1991)

		Special Population Target	
	Adolescent Weapon-Carrying (per 1,000)	*1991 Baseline*	*2000 Target*
7.10a	Blacks	134	105

7.11 Reduce by 20 percent the proportion of people who possess weapons that are inappropriately stored and therefore dangerously available. (Baseline data unavailable)

Services and Protection Objectives

7.12 Extend protocols for routinely identifying, treating, and properly referring suicide attempters, victims of sexual assault, and victims of spouse, elder, and child abuse to at least 90 percent of hospital emergency departments. (Baseline data unavailable)

7.13 Extend to at least 45 States implementation of unexplained child death review systems. (Baseline: 33 States in 1991)

7.14 Increase to at least 30 the number of States in which at least 50 percent of children identified as neglected or physically or sexually abused receive physical and mental evaluation with appropriate followup as a means of breaking the intergenerational cycle of abuse. (Baseline data unavailable)

7.15 Reduce to less than 10 percent the proportion of battered women and their children turned away from emergency housing due to lack of space. (Baseline: 40 percent in 1987)

7.16 Increase to at least 50 percent the proportion of elementary and secondary schools that teach nonviolent conflict resolution skills, preferably as a part of comprehensive school health education. (Baseline data unavailable)

7.17 Extend coordinated, comprehensive violence prevention programs to at least 80 percent of local jurisdictions with populations over 100,000. (Baseline data unavailable)

7.18* 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 by jail inmates. (Baseline: 3 States in 1992)

1995 Addition

Services and Protection Objective

7.19* Enact in 50 States and the District of Columbia laws requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. (Baseline: zero States in 1993)

Source: Center to Prevent Handgun Violence

Commentary:

In 1988, approximately 1,500 people were killed in the United States by the accidental discharge of firearms, and many more sustained injuries. Firearms were the fourth leading cause of unintentional injury deaths among children aged 5–14 and the third leading cause of unintentional injury deaths among 15- to 24-year olds. Guns that are accessible to children in unsupervised settings may produce fatal or serious injury. Adult caretakers must be educated about the need to protect minors from firearms, while laws must be enacted to highlight this need and provide enforcement measures. Although storing unloaded guns in locked boxes will minimize access by children, approaches such as trigger locks, childproof safety catches, and loading indicators should be explored as viable ways to reduce unintentional firearm-related deaths.

Firearm-related deaths account for the majority of recent increases in youth suicide and homicide. A distinction is made between supervised sport shooting settings and unsupervised youth with access to guns in high-risk settings, such as home, school, and streets.

This new objective also appears in Unintentional Injuries.

Educational and Community-Based Programs

Health Status Objectives

8.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	*1990 Baseline*	*2000 Target*
8.1a	Blacks	56.0	60
8.1b	Hispanics	64.8	65
8.1c	People aged 65 and older	11.9†	14†

†Years of healthy life remaining at age 65

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure.

Risk Reduction Objectives

8.2 Increase the high school completion rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health. (Baseline: 87 percent of adults aged 19–20 in 1992)

Note: This objective and its target are consistent with the National Education Goal to increase high school graduation rates. The National Education Goal, the same measure and data source, is used to track this objective.

Special Population Targets

	Completion of High School	*1992 Baseline*	*2000 Target*
8.2a	Hispanics	65%	90%
8.2b	Blacks	81%	90%

Services and Protection Objectives

8.3 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)

Note: This objective and its target are consistent with the National Education Goal to increase school readiness and its objective to increase access to preschool programs for disadvantaged and disabled children.

8.4 Increase to at least 75 percent the proportion of the Nation's elementary and secondary schools that provide planned and sequential kindergarten–12th grade comprehensive school health education. (Baseline data unavailable)

8.5 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)

8.6 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; 63 percent of medium and large companies had a wellness program in 1987)

8.7 Increase to at least 20 percent the proportion of hourly workers who participate regularly in employer-sponsored health promotion activities. (Baseline data unavailable)

8.8 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 serves older adults. (Baseline data unavailable)

8.9 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: 54 percent of 9th–12th graders engaging in family discussion of HIV/AIDS)

8.10 Establish community health promotion programs that separately or together address at least three of the HEALTHY PEOPLE 2000 priorities and reach at least 40 percent of each State's population. (Baseline data unavailable)

8.11 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 unavailable)

Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.

8.12 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: 68 percent of registered hospitals provided patient education services in 1987; 60 percent of community hospitals offered community health promotion programs in 1989)

8.13 Increase to at least 75 percent the proportion of local television network affiliates in the top 20 television markets that have become partners with one or more community organizations around one of the health problems addressed by the HEALTHY PEOPLE 2000 objectives. (Baseline data unavailable)

8.14 Increase to at least 90 percent the proportion of people who are served by a local health department that is effectively carrying out the core functions of public health. (Baseline: percent of local health departments reporting health assessment, policy development, and health assurance activities in 1990)

Note: The core functions of public health have been defined as assessment, policy development, and assurance. Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.

Unintentional Injuries

Health Status Objectives

9.1 Reduce deaths caused by unintentional injuries to no more than 29.3 per 100,000 people. (Age-adjusted baseline: 34.7 per 100,000 in 1987)

Special Population Targets

	Deaths Caused By Unintentional Injuries (per 100,000)	*1987 Baseline*	*2000 Target*
9.1a	American Indians/Alaska Natives	66.0	53.0
9.1b	Black males	64.9	51.9
9.1c	White males	53.6	42.9
		1990 Baseline	*2000 Target*
9.1d	Mexican-American males	53.3	43.0

9.2 Reduce nonfatal unintentional injuries so that hospitalizations for this condition are no more than 754 per 100,000 people. (Baseline: 887 per 100,000 in 1988)

Special Population Target

	Nonfatal Injuries (per 100,000)	*1991 Baseline*	*2000 Target*
9.2a	Black males	1,007	856

9.3 Reduce deaths caused by motor vehicle crashes to no more than 1.5 per 100 million vehicle miles traveled (VMT) and 14.2 per 100,000 people. (Baseline: 2.4 per 100 million vehicle miles traveled and 19.2 per 100,000 people in 1987)

Special Population Targets

	Deaths Caused By Motor Vehicle Crashes (per 100,000)	*1987 Baseline*	*2000 Target*
9.3a	Children aged 14 and younger	6.2	4.4
9.3b	Youth aged 15–24	36.9	26.8
9.3c	People aged 70 and older	22.6	20.0
9.3d	American Indians/Alaska Natives	37.7	32.0
		1990 Baseline	*2000 Target*
9.3g	Mexican Americans	20.9	18.0

Type-Specific Targets

	Deaths Caused By Motor Vehicle Crashes	*1987 Baseline*	*2000 Target*
9.3e	Motorcyclists	40.9/100 million VMT 1.7/100,000	25.6/100 million VMT 0.9/100,000
9.3f	Pedestrians	2.8/100,000	2.0/100,000

9.4 Reduce deaths from falls and fall-related injuries to no more than 2.3 per 100,000 people. (Age-adjusted baseline: 2.7 per 100,000 in 1987)

Special Population Targets

	Deaths From Falls and Fall-Related Injuries (per 100,000)	*1987 Baseline*	*2000 Target*
9.4a	People aged 65–84	18.1	14.4
9.4b	People aged 85 and older	133.0	105.0
9.4c	Black men aged 30–69	8.1	5.6
		1990 Baseline	*2000 Target*
9.4d	American Indians/Alaska Natives	3.2	2.8

9.5 Reduce drowning deaths to no more than 1.3 per 100,000 people. (Age-adjusted baseline: 2.1 per 100,000 in 1987)

Special Population Targets

	Drowning Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
9.5a	Children aged 4 and younger	4.2	2.3
9.5b	Men aged 15–34	4.5	2.5
9.5c	Black males	6.6	3.6
		1990 Baseline	*2000 Target*
9.5d	American Indians/Alaska Natives	4.3	2.0

9.6 Reduce residential fire deaths to no more than 1.2 per 100,000 people. (Age-adjusted baseline: 1.5 per 100,000 in 1987)

Special Population Targets

	Residential Fire Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
9.6a	Children aged 4 and younger	4.4	3.3
9.6b	People aged 65 and older	4.4	3.3
9.6c	Black males	5.7	4.3
9.6d	Black females	3.4	2.6
		1990 Baseline	*2000 Target*
9.6f	American Indians/Alaska Natives	2.1	1.4
9.6g	Puerto Ricans	2.4	2.0

Type-Specific Target

		1983 Baseline	*2000 Target*
9.6e	Residential fire deaths caused by smoking	26%	8%

9.7 Reduce hip fractures among people aged 65 and older so that hospitalizations for this condition are no more than 607 per 100,000. (Baseline: 714 per 100,000 in 1988)

Special Population Target

	Hip Fractures (per 100,000)	*1988 Baseline*	*2000 Target*
9.7a	White women aged 85 and older	2,721	2,177

9.8 Reduce nonfatal poisoning to no more than 88 emergency department treatments per 100,000 people. (Baseline: 108 per 100,000 in 1986)

Special Population Target

	Nonfatal Poisoning (per 100,000)	*1986 Baseline*	*2000 Target*
9.8a	Among children aged 4 and younger	648	520

9.9 Reduce nonfatal head injuries so that hospitalizations for this condition are no more than 106 per 100,000 people. (Baseline: 118 per 100,000 in 1988)

9.10 Reduce nonfatal spinal cord injuries so that hospitalizations for this condition are no more than 5 per 100,000 people. (Baseline: 5.3 per 100,000 in 1988)

Special Population Target

	Nonfatal Spinal Cord Injuries (per 100,000)	*1988 Baseline*	*2000 Target*
9.10a	Males	9.6	7.1

Risk Reduction Objectives

9.11 Reduce by 20 percent the incidence of secondary conditions (i.e., pressure sores) associated with traumatic spinal cord injuries. (Baseline data unavailable)

Note: Secondary conditions are defined as conditions causally related to a disabling condition (i.e., occurring as a result of the primary disabling condition) and can be either a pathology, an impairment, a functional limitation, or a disability).

9.12 Increase use of safety belts and child safety seats to at least 85 percent of motor vehicle occupants. (Baseline: 42 percent in 1988)

Special Population Target

	Use of Child Restraint Systems Among Children Aged 4 and Younger Involved in Potentially Fatal Crashes	*1988 Baseline*	*2000 Target*
9.12a		48%	70%

9.13 Increase use of helmets to at least 80 percent of motorcyclists and at least 50 percent of bicyclists. (Baseline: 60 percent of motorcyclists in 1988 and an estimated 8 percent of bicyclists in 1984)

Services and Protection Objectives

9.14 Extend to 50 States laws requiring safety belt and motorcycle helmet use for all ages. (Baseline: 33 States and the District of Columbia in 1989 for automobiles; 22 States, the District of Columbia, and Puerto Rico for motorcycles)

9.15 Enact in 50 States laws requiring that new handguns be designed to minimize the likelihood of discharge by children. (Baseline: 0 States in 1989)

9.16 Extend to 2,000 local jurisdictions the number whose codes address the installation of fire suppression sprinkler systems in those residences at highest risk for fires. (Baseline: 700 jurisdictions in 1989)

9.17 Increase the presence of functional smoke detectors to at least one on each habitable floor of all inhabited residential dwellings. (Baseline: 81 percent of residential dwellings in 1989)

9.18 Provide academic instruction on injury prevention and control, preferably as part of comprehensive school health education, in at least 50 percent of public school systems (grades K–12). (Baseline data unavailable)

9.19* Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

9.20 Increase to at least 50 the number of States that have design standards for markings, signing, and other characteristics of the roadway environment to improve the visual stimuli and protect the safety of older drivers and pedestrians. (Baseline data unavailable)

9.21 Increase to at least 50 percent the proportion of primary care providers who routinely provide age-appropriate counseling on safety precautions to prevent unintentional injury. (Baseline: percentage of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians providing this service to 81–100 percent of patients in 1992)

9.22 Extend to 20 States the capability to link emergency medical services, trauma systems, and hospital data. (Baseline: 7 States in 1993)

1995 Additions

Health Status Objective

9.23* Reduce deaths caused by alcohol-related motor vehicle crashes to no more than 5.5 per 100,000 people. (Baseline: 9.8 per 100,000 in 1987)

Services and Protection Objectives

9.24 Extend to 50 States laws requiring helmets for bicycle riders (Baseline: 9 States in 1994)

Source: National SAFE KIDS Campaign

Commentary:

Bicycle crashes result in 900 fatalities, 20,000 hospital admissions, and 580,000 emergency department visits each year. Children under age 16 represent about 42 percent of fatalities and 70 percent of nonfatal injuries. The societal costs of bicycle-related injuries and deaths is estimated to be about $8 billion per year.

Head injury is involved in about 62 percent of bicycle-related deaths. Approximately one-third of all bicycle-related emergency department visits involve head injuries, as do two-thirds of all bicycle-related hospital admissions. Head injury is responsible for about 44 percent of all injury deaths in the United States, and approximately 7 percent of brain injuries are bicycle-related. Among survivors of nonfatal head injuries, the effects of brain injury can be profound, disabling, and long lasting.

Bicycle helmets are 85–88 percent effective in mitigating head and brain injury, making the use of helmets the single most effective countermeasure available to reduce head injuries and fatalities resulting from bicycle crashes. If a presumed helmet use rate of 10 percent in 1984–1988 had in fact been increased to 100 percent (i.e., universal helmet use) an average of 500 fatal and 151,400 nonfatal bicycle-related head injuries could have been prevented each year.

Helmet usage is currently about 15 percent for children under age 15 as reported in a 1991 study completed by the Consumer Product Safety Commission. Nine States have enacted statewide bicycle helmet laws, most of which cover only young riders. Although there have been few evaluations of these laws, those which have been conducted have shown significant improvements in helmet usage after enactment of the laws. Particularly when combined with a promotion campaign, legislation appears to be an effective approach to increase helmet use. While education is a necessary part of behavior change, it is rarely enough to convince the majority of people to change. Laws mandating helmet use supplement and reinforce the message of a promotional campaign and have the additional benefit of obviating a barrier to use by children—fear of peer derision.

9.25* Enact in 50 States laws requiring that firearms be properly stored to minimize access and the likelihood of discharge by minors. (Baseline: 0 States in 1993)

Source: Center to Prevent Handgun Violence

Commentary:

See commentary for objective 7.19 in *Violent and Abusive Behavior.*

9.26 Increase to 35 the number of States having a graduated driver licensing system for novice drivers and riders under the age of 18. (Baseline: 16 States in 1993)

Source: National Highway Traffic Safety Administration

A graduated driver licensing system is designed to ease young novice drivers into the driving environment through controlled exposure to progressively more difficult driving experience, or driver licensing stages, before full licensure. This system consists of three stages, learner's permit, intermediate license, and full license.

Teenage drivers are overrepresented in traffic crashes and twice as likely to be in a fatal crash as adult drivers. The problems contributing to their high crash rates include driving inexperience and lack of adequate driving skills, excessive driving during nighttime high-risk hours, excessive risk-taking, and poor driving judgment. Driving experience is required before young drivers achieve dependable skills, judgment, and performance. A graduated driver licensing system addresses the driving problems attributed to this group by increasing the amount of their supervised behind-the-wheel driving practice, increasing their exposure to progressively more difficult driving experiences under controlled conditions, and requiring them to earn full driving privileges by demonstrating crash- and conviction-free driving performance for a minimum period of time before advancing to the next stage of licensing.

The early stages of a graduated driver licensing system include provisions such as adult supervised driving, no alcohol use, nighttime driving restrictions, mandatory safety belt usage, license suspension for major violations, distinctive license from the regular driver's license, and mandatory helmet and eye protection usage by motorcycle riders. Evaluations done in three States with graduated licensing system components showed a 5–16 percent reduction in crashes involving 15- to 17-year-olds.

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Occupational Safety and Health

Health Status Objectives

10.1 Reduce deaths from work-related injuries to no more than 4 per 100,000 full-time workers. (Baseline: Average of 6 per 100,000 during 1983–87)

Special Population Targets

	Work-Related Deaths (per 100,000)	*1983–87 Average*	*2000 Target*
10.1a	Mine workers	30.3	21.0
10.1b	Construction workers	25.0	17.0
10.1c	Transportation workers	15.2	10.0
10.1d	Farm workers	14.0	9.5

10.2 Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity to no more than 6 cases per 100 full-time workers. (Baseline: 7.7 per 100 in 1983–87)

Special Population Targets

	Work-Related Injuries (per 100)	*1983–87 Average*	*2000 Target*
10.2a	Construction workers	14.9	10.0
10.2b	Nursing and personal care workers	12.7	9.0
10.2c	Farm workers	12.4	8.0
10.2d	Transportation workers	8.3	6.0
10.2e	Mine workers	8.3	6.0
		1992 Baseline	*2000 Target*
10.2f	Adolescent workers	5.8	3.8

10.3 Reduce cumulative trauma disorders to an incidence of no more than 60 cases per 100,000 full-time workers. (Baseline: 100 per 100,000 in 1987)

Special Population Targets

	Cumulative Trauma Disorders (per 100,000)	*1987 Baseline*	*2000 Target*
10.3a	Manufacturing industry workers	355	150
10.3b	Meat product workers	3,920	2,000

10.4 Reduce occupational skin disorders or diseases to an incidence of no more than 55 per 100,000 full-time workers. (Baseline: Average of 64 per 100,000 during 1983–87)

Risk Reduction Objectives

10.5* Reduce hepatitis B among occupationally exposed workers to an incidence of no more than 623 clinical cases. (Baseline: An estimated 3,090 clinical cases in 1987)

10.6 Increase to at least 95 percent the proportion of worksites with 50 or more employees that mandate employee use of occupant protection systems, such as seatbelts, during all work-related motor vehicle travel. (Baseline: 82.4 percent of worksites in 1992)

10.7 Reduce to no more than 15 percent the proportion of workers exposed to average daily noise levels that exceed 85 dBA. (Baseline: 16 percent in 1989)

10.8 Eliminate exposures which result in workers having blood lead concentrations greater than 25 μ/dL of whole blood. (Baseline: 4,804 workers with blood lead levels above 25 μg/dL in 7 States in 1988)

10.9* Increase hepatitis B immunization levels to 90 percent among occupationally exposed workers. (Baseline: 37 percent in 1991)

Services and Protection Objectives

10.10 Implement occupational safety and health plans in 50 States for the identification, management, and prevention of leading work-related diseases and injuries within the State. (Baseline: 10 States in 1989)

10.11 Establish in 50 States exposure standards adequate to prevent the major occupational lung diseases to which their worker populations are exposed (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis). (Baseline: Federal standards have been established for occupational exposure to airborne asbestos fibers, cotton dust, coal mine dust, and silica dust which apply to all 50 States.)

10.12 Increase to at least 70 percent the proportion of worksites with 50 or more employees that have implemented programs on worker health and safety. (Baseline: 63.8 percent in 1992)

10.13 Increase to at least 50 percent the proportion of worksites with 50 or more employees that offer back injury prevention and rehabilitation programs. (Baseline: 28.6 percent offered back care activities in 1985)

10.14 Establish in 50 States either public health or labor department programs that provide consultation and assistance to small businesses to implement safety and health programs for their employees. (Baseline: 26 States in 1991)

10.15 Increase to at least 75 percent the proportion of primary care providers who routinely elicit occupational health exposures as a part of patient history and provide relevant counseling. (Baseline: 6–14 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing this service to patients in 1992)

1995 Additions

Health Status Objectives

10.16 Reduce deaths from work-related homicides to no more than 0.5 per 100,000 full-time workers (Baseline: Average of 0.7 per 100,000 during 1980–1989)

Sources: National Traumatic Occupational Fatality (NTOF) Surveillance System, CDC in the numerator; U.S. Bureau of Census, Current Population Survey in the denominator. The U.S. Department of Labor, Bureau of Labor Statistics, Census of Fatal Occupational Injuries will also be used for tracking this objective.

Commentary:

Homicide is the third leading cause of fatal injury for all workers and the leading cause of fatal injury for women. Ongoing surveillance of occupational injury deaths in the United States, using the NTOF System, found that more than 7,600 workers lost their lives at work during the 1980s as a result of homicide. This translates into an average of 15 workers murdered at work each week during this decade. For the period 1980–1989, 12 percent of all injury deaths on the job were homicides. Among women, 41 percent of occupational injury deaths resulted from assaults. No current OSHA regulations apply specifically to occupational homicide.

Over 50 percent of work-related homicides occurred in two industry sectors, retail trades and services. NTOF data indicated that workers at greatest risk of work-related homicide were employees in the taxi industry (27 homicides per 100,000 workers), law enforcement officers (9 per 100,000), security guards (4 per 100,000) and employees of retail trades such as liquor stores (8 per 100,000), gasoline stations (6 per 100,000), grocery stores (3 per 100,000), and restaurants and bars (2 per 100,000). Employers in these high-risk establishments and occupations need to be aware of the risk for homicide and take steps to ensure a safe workplace. Although it was not possible to enumerate the number of work-related homicides in NTOF which occurred in convenience stores, an industry-funded study indicated a homicide rate of 20 per 100,000 for convenience store employees.

Seventy-five percent of work-related homicides were committed with firearms. Data from the Bureau of Labor Statistics' Census of Fatal Occupational Injuries in 1992 confirmed that the overwhelming majority of work-related homicides, 82 percent, were associated with robbery or miscellaneous crimes.

10.17 Reduce the overall age-adjusted mortality rate for four major preventable occupational lung diseases (byssinosis, asbestosis, coal workers' pneumoconiosis, and silicosis) to 7.7 per 100,000. (Baseline: 9.6 per 100,000 in 1990)

Source: CDC/NCHS, National Vital Statistics Systems

Note: Secondary conditions are defined as conditions causally related to a disabling condition (i.e., occurs as a result of the primary disabling condition) and that can be either a pathology, an impairment, a functional limitation or a disability).

Commentary:

This new objective complements the services and protection objective 10.11. NIOSH has tracked these rates since 1970 and published the Work-Related Lung Disease Surveillance Report in 1991 and its supplement in 1992. Using 1990 as a base year (with an overall age-adjusted mortality rate with asbestosis, byssinosis, coal workers' pneumoconiosis, or silicosis of 9.6), a 20 percent reduction per decade would suggest an overall age-adjusted mortality rate of no more than 7.7 per 100,000 by the year 2000. This reduction per decade targeting will enable continuation of setting lower targets at the beginning of each subsequent decade. The mortality rate will be targeted to decline until these diseases are at extremely low levels, while reflecting the realistic expectation of not achieving a total elimination of diseases with such long latency in the near term.

Exposure standards alone do not guarantee success in preventing disease. NIOSH hazard surveillance activities demonstrate that standards are frequently violated with worker exposures far exceeding those considered permissible by regulatory agencies. In addition, many standards are outdated and may not be adequate to prevent disease.

In 1992 NIOSH published two Alerts requesting assistance in preventing morbidity and mortality with silicosis in sandblasting and rock drilling operations. The publications describe results from health hazard evaluations at worksites where current OSHA permissible exposure limit (PEL) for respirable crystalline silica were grossly violated, resulting in death of workers as young as 34. At one worksite, a sandblaster developed acute silicosis at the age of 23. The current PEL is 100 micrograms per cubic meter (100 ìg/m3) as an 8-hour time-weighted average (TWA), with a NIOSH recommended exposure level (REL) of 50 ìg/m3. At one location, NIOSH recorded exposures to respirable crystalline silica as high as 3,400 ìg/m3 as a TWA. Therefore, establishment of standards has not resulted in the elimination of conditions leading to disease. Rather, it is the application of adequate control measures in workplaces that protects workers.

Services and Protection Objectives

10.18* Increase to 100 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)

10.19* Enact in 50 States and the District of Columbia comprehensive laws on clean indoor air that prohibit smoking or limit it to separately ventilated areas in the workplace and enclosed public places (Baseline: 4 States regulated private workplaces; 8 States regulated public workplaces including those that banned smoking through Executive Orders; 2 States regulated restaurants; 14 States and the District of Columbia regulated public transportation; 9 States regulated hospitals; 21 States regulated day care centers, and 6 States regulated grocery stores with comprehensive laws as of January 1995)

10.20* Reduce to 0 the number of States that have clean indoor air laws preempting stronger clean indoor air laws on the local level. (Baseline: 17 States had preemptive clean indoor air laws as of January 1995)

Environmental Health

Health Status Objectives

11.1 Reduce asthma morbidity, as measured by a reduction in asthma hospitalizations to no more than 160 per 100,000 people. (Baseline: 188 per 100,000 in 1987)

		Special Population Targets	
	Asthma Hospitalizations (per 100,000)	*1987 Baseline*	*2000 Target*
11.1a	Blacks and other nonwhites	334	265
11.1b	Children	284†	225
		1988 Baseline	*2000 Target*
11.1c	Women	229	183

†Children aged 14 and younger

11.2* Reduce the prevalence of serious mental retardation among school-aged children to no more than 2 per 1,000 children. (Baseline: 2.7 per 1,000 children aged 10 in 1985–88)

Note: Serious mental retardation is defined as an Intelligence Quotient (I.Q.) less than 50. This includes individuals defined by the American Association of Mental Retardation as profoundly retarded (I.Q. of 20 or less), severely retarded (I.Q. of 21–35), and moderately retarded (I.Q. of 36–50).

11.3 Reduce outbreaks of waterborne disease from infectious agents and chemical poisoning to no more than 11 per year. (Baseline: 16 outbreaks in 1988)

		Type-Specific Target	
	Average Annual Number of Waterborne Disease Outbreaks	*1988 Baseline*	*2000 Target*
11.3a	People served by community water systems	4	2

Note: Includes only outbreaks from water intended for drinking. Community water systems are public or investor-owned water systems that serve large or small communities, subdivisions, or trailer parks with at least 15 service connections or 25 year-round residents.

11.4 Reduce the prevalence of blood lead levels exceeding 15 µg/dL and 25 µg/dL among children aged 6 months – 5 years to no more than 300,000 and zero, respectively. (Baseline: An estimated 3 million children had levels exceeding 15 µg/dL, and 234,000 had levels exceeding 25 µg/dL, in 1984)

		Special Population Targets	
	Prevalence of Blood Lead Levels	*1984 Baseline*	*2000 Target*
11.4a	Inner-city low-income black children (annual family income <$6,000 in 1984 dollars)		
	exceeding 15 mg/dL	234,900	75,000
	exceeding 25 µg/dL	36,700	0

Risk Reduction Objectives

11.5 Reduce human exposure to criteria air pollutants, as measured by an increase to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months. (Baseline: 49.7 percent in 1988)

Proportion Living in Counties That Have Not Exceeded Criteria Air Pollutant Standards	*1988 Baseline*	*2000 Target*
Ozone	53.6%	—
Carbon monoxide	87.8%	—
Nitrogen dioxide	96.6%	—
Sulfur dioxide	99.3%	—
Particulates	89.4%	—
Lead	99.3%	—
Total (any of above pollutants)	49.7%	85%

Note: An individual living in a county that exceeds an air quality standard may not actually be exposed to unhealthy air. Of all criteria air pollutants, ozone is the most likely to have fairly uniform concentrations throughout an area. Exposure is to criteria air pollutants in ambient air. Due to weather fluctuations, multiyear averages may be the most appropriate way to monitor progress toward this objective.

11.6 Increase to at least 40 percent the proportion of homes in which homeowners/occupants have tested for radon concentrations and that have either been found to pose minimal risk or have been modified to reduce risk to health. (Baseline: Less than 5 percent of homes had been tested in 1989)

Special Population Targets

	Testing and Modification As Necessary	*Baseline*	*2000 Target*
11.6a	Homes with smokers and former smokers	—	50%
11.6b	Homes with children	—	50%

11.7 Reduce human exposure to toxic agents by decreasing the release of hazardous substances from industrial facilities: 65 percent decrease in the substances on the Department of Health and Human Services list of carcinogens, and a 50 percent reduction in the substances on the Agency for Toxic Substances and Disease Registry (ATSDR) priority list of the most toxic chemicals. (Baseline: 0.36 billion pounds on the Department of Health and Human Services list of carcinogens, and 1.93 billion pounds on the ATSDR list of the most toxic chemicals in 1988)

11.8 Reduce human exposure to solid waste-related water, air, and soil contamination, as measured by a reduction in average pounds of municipal solid waste produced per person each day to no more than 4.3 pounds before recovery and 3.2 pounds after recovery. (Baseline: 4.0 pounds per person each day in 1988)

Exposure to Solid Waste-Contamination (Average Pounds Per Person Each Day)	*1988 Baseline*	*2000 Target*
Total population	4.0	4.3
After recovery (recycling & composting)	3.5	3.2

Source: Characterization of Municipal Solid Waste in the United States, *EPA.*

11.9 Increase to at least 85 percent the proportion of people who receive a supply of drinking water that meets the safe drinking water standards established by the Environmental Protection Agency. (Baseline: 74 percent of 58,099 community water systems serving approximately 80 percent of the population in 1988)

Note: Compliance with the Safe Drinking Water Act includes monitoring and reporting as well as providing water that meets the Maximum Contaminant Level (MCL) standards set by the Environmental Protection Agency which define acceptable levels of contaminants. See Objective 11.3 for definition of community water systems.

11.10 Reduce potential risks to human health from surface water, as measured by an increase in the proportion of assessed rivers, lakes, and estuaries that support beneficial uses, such as consumable fish and recreational activities.

Note: Designated beneficial uses, such as aquatic life support, contact recreation (swimming), and water supply, are designated by each State and approved by the Environmental Protection Agency. Support of beneficial use is a proxy measure of risk to human health, as many pollutants causing impaired water uses do not have human health effects (e.g., siltation, impaired fish habitat).

Water Supporting Beneficial Use	*1992 Baseline*	*2000 Target*
Rivers supporting:		
Consumable fish	89%	94%
Recreational activities	71%	85%
Lakes supporting:		
Consumable fish	64%	82%
Recreational activities	77%	88%
Estuaries supporting:		
Consumable fish	94%	97%
Recreational activities	83%	91%

Source: National Water Quality Inventory, 1992 Preliminary Report, EPA.

Services and Protection Objectives

11.11 Perform testing for lead-based paint in at least 50 percent of homes built before 1950. (Baseline: 5 percent in 1991)

11.12 Expand to at least 35 the number of States in which at least 75 percent of local jurisdictions have adopted construction standards and techniques that minimize elevated indoor radon levels in those new building areas locally determined to have elevated radon levels. (Baseline: 1 State in 1989)

Note: Since construction codes are frequently adopted by local jurisdictions rather than States, progress toward this objective also may be tracked using the proportion of cities and counties that have adopted such construction standards.

11.13 Increase to at least 30 the number of States requiring that prospective buyers be informed of the presence of lead-based paint and radon concentrations in all buildings offered for sale. (Baseline: 2 States required disclosure of lead-based paint in 1989; 1 State required disclosure of radon concentrations in 1989; 2 additional States required disclosure that radon has been found in the State and that testing is desirable in 1989)

11.14 Eliminate significant health risks from National Priority List hazardous waste sites, as measured by performance of clean-up at these sites sufficient to eliminate immediate and significant health threats as specified in health assessments completed at all sites. (Baseline: 1,082 sites were on the list in March of 1990; of these, health assessments have been conducted for approximately 1,000)

Note: The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 required the Environmental Protection Agency to develop criteria for determining priorities among hazardous waste sites and to develop and maintain a list of these priority sites. The resulting list is called the National Priorities List (NPL).

11.15 Establish curbside recycling programs that serve at least 50 percent of the U.S. population and continue to increase household hazardous waste collection programs.

Recyclable Materials and Household Hazardous Waste Programs	*1988 Baseline*	*2000 Target*
Percentage of population served by curbside recycling programs	26%	50%
Permanent and temporary household hazardous waste collection events		
Permanent	96	215
Temporary	706	1,314
Total	**802**	**1,529**

Sources: Recycling data from Biocycle Journal of Waste Recycling. *Household hazardous waste collection data from the Waste Watch Center.*

11.16 Establish and monitor in at least 35 States plans to define and track sentinel environmental diseases. (Baseline: 0 States in 1990)

Note: Sentinel environmental diseases include lead poisoning, other heavy metal poisoning (e.g., cadmium, arsenic, and mercury), pesticide poisoning, carbon monoxide poisoning, heatstroke, hypothermia, acute chemical poisoning, methemoglobinemia, and respiratory diseases triggered by environmental factors (e.g., asthma).

1995 Addition

Risk Reduction Objective

11.17* Reduce to no more than 20 percent the proportion of children aged 6 and younger who are regularly exposed to tobacco smoke at home. (Baseline: More than 39 percent in 1986, as 39 percent of households with one or more children aged 6 or younger had a cigarette smoker in the household)

Note: Regular exposure to tobacco smoke at home is defined as the occurrence of tobacco smoking anywhere in the home on more than 3 days each week.

Food and Drug Safety

Health Status Objectives

12.1 Reduce infections caused by key foodborne pathogens to incidences of no more than:

Disease (per 100,000)	*1987 Baseline*	*2000 Target*
Salmonella species	18.0	16.0
Campylobacter jejuni	50.0	25.0
Escherichia coli O157:H7	8.0	4.0
Listeria monocytogenes	0.7	0.5

12.2 Reduce outbreaks of infections due to *Salmonella enteritidis* to fewer than 25 outbreaks yearly. (Baseline: 77 outbreaks in 1989)

Risk Reduction Objective

12.3 Increase to at least 75 percent the proportion of households in which principal food preparers routinely refrain from leaving perishable food out of the refrigerator for over 2 hours and wash cutting boards and utensils with soap after contact with raw meat and poultry. (Baseline: For refrigeration of perishable foods, 70 percent; for washing cutting boards with soap, 66 percent; and for washing utensils with soap, 55 percent, in 1988)

Services and Protection Objectives

12.4 Extend to at least 70 percent the proportion of States and territories that have implemented *Food Code 1993* for institutional food operations and to at least 70 percent the proportion that have adopted the new uniform food protection code that sets recommended standards for regulation of all food operations. (Baseline: 0 percent in 1994)

12.5 Increase to at least 75 percent the proportion of pharmacies and other dispensers of prescription medications that use linked systems to provide alerts to potential adverse drug reactions among medications dispensed by different sources to individual patients. (Baseline: 95 percent of pharmacies utilized computer systems in 1993)

12.6 Increase to at least 75 percent the proportion of primary care providers and other dispensers of medicine who routinely review with their patients aged 65 and older all prescribed and over-the-counter medicines taken by their patients each time a new medication is prescribed or dispensed. (Baseline: percentage of clinicians who routinely provide service—nurse practitioners, 55 percent; obstetricians/ gynecologists, 64 percent; internists, 84 percent; and family physicians, 63 percent of patients in 1992)

1995 Additions

Services and Protection Objectives

12.7 Increase to at least 75 percent the proportion of the total number of adverse event reports voluntarily sent directly to FDA that are regarded as serious. (Baseline: 69 percent based on first 7 months in 1993)

Source: FDA, MedWatch

Commentary:

On June 3, 1993, FDA announced MedWatch, the new FDA Medical Products Reporting Program. MedWatch is an outreach program to the health care professional community that will enable FDA to discover more quickly the adverse reactions and interactions that Drug Utilization Review, through the use of linked data bases, seeks to avoid. The expanded definition of serious being promoted by MedWatch includes "life-threatening" and "requires intervention to prevent permanent impairment or damage" as well as death, hospitalization, disability and congenital anomaly. Sixty-nine percent of adverse drug event reports submitted to the MedWatch program during its first 7 months have been serious.

MedWatch is an educational initiative for health professionals about the importance of reporting adverse events with medical products and to facilitate reporting. Increasing the percentage of serious adverse event reports results in a greater likelihood of receiving information that would be a significant contribution for safety data analysis and of decreasing the amount of less significant information that would congest the system. Increasing the percentage of serious reports increases the efficiency of the system and is also a measure of the success of educational messages sent to health professionals.

12.8 Increase to at least 75 percent the proportion of people who receive useful information verbally and in writing for new prescriptions from prescribers or dispensers. (Baseline: for written information, 14 percent from prescribers and 25 percent from dispensers in 1992)

Source: FDA national random telephone survey of adults, 1992

Commentary:

This objective measures what information patients state they receive, rather than relying on reports of health care providers. The research literature in patient education consistently shows that it is not what health professionals say or do, it is what patients know and understand that makes a difference in patient behavior and their health status. The research also indicates that patients make use of many different sources of health information besides health professionals, depending on their learning styles and motivations, and that multiple channels of exposure to information prove most effective in educating patients.

In order to obtain baseline data, FDA conducted a national random telephone survey of 1,023 adult respondents who had received a prescription within the previous 4 weeks. In the survey, FDA asked whether various types of information were received from a physician, such as how much of the medication to take, how often to take it, precautions to be aware of, and information associated with side effects. These data show that 14 percent of the respondents reported receiving written medication information from their physician. Baseline data for counseling on various drug information topics ranged from 29 percent to 55 percent for physicians and between 13 percent to 32 percent for pharmacists.

Prescribers are people who are authorized to prescribe, including physicians, nurse practitioners, and physician assistants depending on State law. Dispensers are authorized to dispense prescription medications and include physicians and pharmacists.

Oral Health

Health Status Objectives

13.1 Reduce dental caries (cavities) so that the proportion of children with one or more caries (in permanent or primary teeth) is no more than 35 percent among children aged 6–8 and no more than 60 percent among adolescents aged 15. (Baseline: 54 percent of children aged 6–8 in 1986–87; 78 percent of adolescents aged 15 in 1986–87)

Special Population Targets

	Dental Caries Prevalence	*1986–87 Baseline*	*2000 Target*
13.1a	Children aged 6–8 whose parents have less than high school education	70%	45%
13.1b	American Indian/Alaska Native children aged 6–8	92%[†] 52%[‡]	45%
13.1c	Black children aged 6–8	56%	40%
13.1d	American Indian/Alaska Native adolescents aged 15	93%[‡]	70%

[†]In primary teeth in 1983–84 [‡]In permanent teeth in 1983–84

13.2 Reduce untreated dental caries so that the proportion of children with untreated caries (in permanent or primary teeth) is no more than 20 percent among children aged 6–8 and no more than 15 percent among adolescents aged 15. (Baseline: 28 percent of children aged 6–8 in 1986; 24 percent of adolescents aged 15 in 1986–87)

Special Population Targets

	Untreated Dental Caries Among:	*1986–87 Baseline*	*2000 Target*
13.2a	Children aged 6–8 whose parents have less than high school education	43%	30%
13.2b	American Indian/Alaska Native children aged 6–8	64%[†]	35%
13.2c	Black children aged 6–8	36%	25%
13.2d	Hispanic children aged 6–8	36%[‡]	25%
	Among:		
13.2e	Adolescents aged 15 whose parents have less than a high school education	41%	25%
13.2f	American Indian/Alaska Native adolescents aged 15	84%[†]	40%
13.2g	Black adolescents aged 15	38%	20%
13.2h	Hispanic adolescents aged 15	31–47%[‡]	25%

[†]1983–84 baseline [‡]1982–84 baseline

13.3 Increase to at least 45 percent the proportion of people aged 35–44 who have never lost a permanent tooth due to dental caries or periodontal diseases.$ (Baseline: 31 percent of employed adults had never lost a permanent tooth for any reason in 1985–86)

Note:$ Never lost a permanent tooth is having 28 natural teeth exclusive of third molars.

13.4 Reduce to no more than 20 percent the proportion of people aged 65 and older who have lost all of their natural teeth.$ (Baseline:$ 36 percent in 1986)

Special Population Targets

	Complete Tooth Loss Prevalence	*1986 Baseline*	*2000 Target*
13.4a	Low-income people (annual family income <$15,000)	46%	25%
		1991 Baseline	*2000 Target*
13.4b	American Indians/Alaska Natives	42%	20%

13.5 Reduce the prevalence of gingivitis among people aged 35–44 to no more than 30 percent.$ (Baseline:$ 41 percent in 1985–86)

Special Population Targets

	Gingivitis Prevalence	*1985 Baseline*	*2000 Target*
13.5a	Low-income people (annual family income <$12,500)	50%	35%
13.5b	American Indians/Alaska Natives	95%†	50%
13.5c	Hispanics	50%	
	Mexican Americans	74%‡	
	Cubans	79%‡	
	Puerto Ricans	82%‡	

†1983–84 baseline$ ‡1982–84 baseline

13.6 Reduce destructive periodontal diseases to a prevalence of no more than 15 percent among people aged 35–44.$ (Baseline:$ 25 percent in 1985–86)

Note:$ Destructive periodontal disease is one$or more sites with 4 millimeters or greater loss of tooth attachment.

13.7* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline:$ 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

Special Population Targets

	Oral Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
13.7a	Black males aged 45–74	29.4	26.0
13.7b	Black females aged 45–74	6.9	6.9

Risk Reduction Objectives

13.8 Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth. (Baseline: 11 percent of children aged 8 and 8 percent of adolescents aged 14 in 1986–87)

Note: Progress toward this objective will be monitored based on prevalence of sealants in children at age 8 and at age 14, when the majority of first and second molars, respectively, are erupted.

Special Population Targets

	Dental Sealants	*1989 Baseline*	*2000 Target*
13.8a	Blacks aged 8	5%	50%
13.8b	Blacks aged 14	4%	50%
13.8c	Hispanics aged 8	8%	50%
13.8d	Hispanics aged 14	4%	50%

13.9 Increase to at least 75 percent the proportion of people served by community water systems providing optimal levels of fluoride. (Baseline: 61 percent in 1989)

Note: Optimal levels of fluoride are determined by the mean maximum daily air temperature over a 5-year period and range between 0.7 and 1.2 parts of fluoride per one million parts of water (ppm).

13.10 Increase use of professionally or self-administered topical or systemic (dietary) fluorides to at least 85 percent of people not receiving optimally fluoridated public water. (Baseline: An estimated 50 percent in 1989)

13.11* Increase to at least 75 percent the proportion of parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline: 55 percent of parents and caregivers of children 6–23 months of age in 1991)

Special Population Targets

	Appropriate Feeding Practices	*1991 Baseline*	*2000 Target*
13.11a	Parents and caregivers with less than high school education	36%	65%
13.11b	American Indian/Alaska Native parents and caregivers	74%†	65%
13.11c	Black parents and caregivers	48%	65%
13.11d	Hispanic parents and caregivers	39%	65%

† 1985–89 data in four IHS Service Areas in a pilot study

Note: Percentage of parents and caregivers of children 6–23 months of age. Appropriate feeding practices are that the child no longer uses a bottle during the past 2 weeks or if the child still uses a bottle that no bottle was given at bedtime, excluding bottles with plain water, during the past 2 weeks.

Services and Protection Objectives

13.12 Increase to at least 90 percent the proportion of all children entering school programs for the first time who have received an oral health screening, referral, and followup for necessary diagnostic, preventive, and treatment services. (Baseline: 66 percent of children aged 5 visited a dentist during the previous year in 1986)

Special Population Targets

	Percentage of Children Visiting a Dentist	*1991 Baseline*	*2000 Target*
13.12a	Blacks aged 5	51%	90%
13.12b	Hispanics aged 5	51%	90%

Note: School programs include Head Start, prekindergarten, kindergarten, and first grade.

13.13 Extend to all long-term institutional facilities the requirement that oral examinations and services be provided no later than 90 days after entry into these facilities. (Baseline: Nursing facilities receiving Medicaid or Medicare reimbursement will be required to provide for oral examinations within 90 days of patient entry beginning in 1990; baseline data unavailable for other institutions)

Note: Long-term institutional facilities include nursing homes, prisons, juvenile homes, and detention facilities.

13.14 Increase to at least 70 percent the proportion of people aged 35 and older using the oral health care system during each year. (Baseline: 54 percent in 1986)

Special Population Targets

	Proportion Using Oral Health Care System During Each Year	*1986 Baseline*	*2000 Target*
13.14a	Edentulous people	11%	50%
13.14b	People aged 65 and older	42%	60%
		1991 Baseline	*2000 Target*
13.14c	Blacks aged 35 and older	43%	60%
13.14d	Mexican Americans aged 35 and older	38%	60%
13.14e	Puerto Ricans aged 35 and older	51%	60%

13.15 Increase to at least 40 the number of States that have an effective system for recording and referring infants with cleft lips and/or palates to craniofacial anomaly teams. (Baseline: In 1988, approximately 25 States had a central recording mechanism for cleft lip and/or palate, and approximately 25 States had an organized referral system to craniofacial anomaly teams)

13.15	*Identification and Referral of Infants With Clefts*	*1989 Baseline*	*2000 Target*
	States with system to identify clefts	25	40
	States with system to refer for care	20	40
	States with system to follow-up	27†	40
	States with system to identify and refer	11	40

†1993 Illinois Department of Health Survey

13.16* Extend requirement of the use of effective head, face, eye, and mouth protection to all organizations, agencies, and institutions sponsoring sporting and recreation events that pose risks of injury. (Baseline: National Collegiate Athletic Association football, hockey, and lacrosse; high school football; amateur boxing; and amateur ice hockey in 1988)

1995 Addition

Risk Reduction Objective

13.17* Reduce smokeless tobacco use by males aged 12–24 to a prevalence of no more than 4 percent. (Baseline: 6.6 percent among males aged 12–17 in 1988; 8.9 percent among males aged 18–24 in 1987)

Special Population Target

	Smokeless Tobacco Use	*1986–87 Baseline*	*2000 Target*
13.17a	American Indian/Alaska Native youth	18–64%	10%

Note: For males aged 12–17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18–24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.

Maternal and Infant Health

Health Status Objectives

14.1 Reduce the infant mortality rate to no more than 7 per 1,000 live births. (Baseline: 10.1 per 1,000 live births in 1987)

Special Population Targets

	Infant Mortality (per 1,000 live births)	*1987 Baseline*	*2000 Target*
14.1a	Blacks	18.8	11.0
14.1b	American Indians/Alaska Natives	13.4†	8.5
14.1c	Puerto Ricans	12.9†	8.0

Type-Specific Targets

	Neonatal and Postneonatal Mortality (per 1,000 live births)	*1987 Baseline*	*2000 Target*
14.1d	Neonatal mortality	6.5	4.5
14.1e	Neonatal mortality among blacks	12.3	7.0
14.1f	Neonatal mortality among Puerto Ricans	8.6†	5.2
14.1g	Postneonatal mortality	3.6	2.5
14.1h	Postneonatal mortality among blacks	6.4	4.0
14.1i	Postneonatal mortality among American Indians/Alaska Natives	7.0†	4.0
14.1j	Postneonatal mortality among Puerto Ricans	4.3†	2.8

†1984 baseline

Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.

14.2 Reduce the fetal death rate (20 or more weeks of gestation) to no more than 5 per 1,000 live births plus fetal deaths. (Baseline: 7.6 per 1,000 live births plus fetal deaths in 1987)

Special Population Target

	Fetal Deaths	*1987 Baseline*	*2000 Target*
14.2a	Blacks	13.1‡	7.5‡

‡ Per 1,000 live births plus fetal deaths

14.3 Reduce the maternal mortality rate to no more than 3.3 per 100,000 live births. (Baseline: 6.6 per 100,000 in 1987)

Special Population Target

	Maternal Mortality (Per 100,000 live births)	*1987 Baseline*	*2000 Target*
14.3a	Blacks	14.9	5.0

Note: The objective uses the maternal mortality rate as defined by the National Center for Health Statistics. However, if other sources of maternal mortality data are used, a 50-percent reduction in maternal mortality is the intended target.

14.4 Reduce the incidence of fetal alcohol syndrome to no more than 0.12 per 1,000 live births. (Baseline: 0.22 per 1,000 live births in 1987)

		Special Population Targets	
	Fetal Alcohol Syndrome (per 1,000 live births)	*1987 Baseline*	*2000 Target*
14.4a	American Indians/Alaska Natives	4.0	2.0
14.4b	Blacks	0.8	0.4

Risk Reduction Objectives

14.5 Reduce low birthweight to an incidence of no more than 5 percent of live births and very low birthweight to no more than 1 percent of live births. (Baseline: 6.9 and 1.2 percent, respectively, in 1987)

		Special Population Targets	
	Low Birthweight	*1987 Baseline*	*2000 Target*
14.5a	Blacks	13.0%	9%
	Very Low Birthweight		
14.5b	Blacks	2.8%	2%
	Low Birthweight	*1990 Baseline*	*2000 Target*
14.5c	Puerto Ricans	9.0%	6%
	Very Low Birthweight		
14.5d	Puerto Ricans	1.6%	1%

Note: Low birthweight is weight at birth of less than 2,500 grams; very low birthweight is weight at birth of less than 1,500 grams.

14.6 Increase to at least 85 percent the proportion of mothers who achieve the minimum recommended weight gain during their pregnancies. (Baseline: 67 percent of married women in 1980)

Note: Recommended weight gain is pregnancy weight gain recommended in the 1990 National Academy of Science's report, Nutrition During Pregnancy.

14.7 Reduce severe complications of pregnancy to no more than 15 per 100 deliveries. (Baseline: 22 hospitalizations (prior to delivery) per 100 deliveries in 1987)

		Special Population Target	
	Pregnancy Complications (per 100 deliveries)	*1991 Baseline*	*2000 Target*
14.7a	Blacks	28	16

Note: Severe complications of pregnancy will be measured using hospitalizations due to pregnancy-related complications.

14.8 Reduce the cesarean delivery rate to no more than 15 per 100 deliveries. (Baseline: 24.4 per 100 deliveries in 1987)

Type-Specific Targets

	Cesarean Delivery (per 100 deliveries)	*1987 Baseline*	*2000 Target*
14.8a	Primary (first time) cesarean delivery	17.4	12
14.8b	Repeat cesarean deliveries	91.2†	65†

†Among women who had a previous cesarean delivery

14.9* Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 54 percent during early postpartum and 21 percent who are still breastfeeding at 5 to 6 months in 1988)

Special Population Targets

	Mothers Breastfeeding Their Babies:	*1988 Baseline*	*2000 Target*
	During Early Postpartum Period:		
14.9a	Low-income mothers	32%	75%
14.9b	Black mothers	25%	75%
14.9c	Hispanic mothers	51%	75%
14.9d	American Indian/Alaska Native mothers	47%	75%
	At Age 5–6 Months:		
14.9e	Low-income mothers	9%	50%
14.9f	Black mothers	8%	50%
14.9g	Hispanic mothers	16%	50%
14.9h	American Indian/Alaska Native mothers	28%	50%

Note: The definition used for breastfeeding includes exclusive use of human milk or the use of human milk with a supplemental bottle of formula or cow's milk.

14.10 Increase abstinence from tobacco use by pregnant women to at least 90 percent and increase abstinence from alcohol, cocaine, and marijuana by pregnant women by at least 20 percent. (Baseline: 75 percent of pregnant women abstained from tobacco use in 1985)

	1988 Baseline	*2000 Target*
Tobacco	78%†	90%
Alcohol	79%	95%
Cocaine	99%	100%
Marijuana	98%	100%

†1987 data

Services and Protection Objectives

14.11 Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy. (Baseline: 76 percent of live births in 1987)

Special Population Targets

	Proportion of Pregnant Women Receiving Early Prenatal Care (Percent of live births)	*1987 Baseline*	*2000 Target*
14.11a	Black women	60.8%	90%
14.11b	American Indian/Alaska Native women	57.6%	90%
14.11c	Hispanic women	61.0%	90%

14.12* Increase to at least 60 percent the proportion of primary care providers who provide age-appropriate preconception care and counseling. (Baseline: 18–65 percent of pediatricians, nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

14.13 Increase to at least 90 percent the proportion of women enrolled in prenatal care who are offered screening and counseling on prenatal detection of fetal abnormalities. (Baseline: 29 percent in 1988)

14.14 Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care. (Baseline data unavailable)

14.15 Increase to at least 95 percent the proportion of newborns screened by State-sponsored programs for genetic disorders and other disabling conditions and to 90 percent the proportion of newborns testing positive for disease who receive appropriate treatment. (Baseline: For sickle cell anemia, with 20 States reporting, approximately 33 percent of live births screened [57 percent of black infants]; for galactosemia, with 38 States reporting, approximately 70 percent of live births screened)

Note: As measured by the proportion of infants served by programs for sickle cell anemia and galactosemia. Screening programs should be appropriate for State demographic characteristics.

14.16 Increase to at least 90 percent the proportion of babies aged 18 months and younger who receive recommended primary care services at the appropriate intervals. (Baseline data unavailable)

1995 Addition

Health Status Objective

14.17 Reduce the incidence of spina bifida and other neural tube defects to 3 per 10,000 live births. (Baseline: 6 per 10,000 in 1990)

Source: Birth Defect Monitoring System, CDC.

Commentary:

Spina bifida and anencephaly are common and serious birth defects known as neural tube defects (NTDs). Anencephaly is invariably fatal, whereas about 80 percent of babies with spina bifida survive. Persons with spina bifida usually have lower body paralysis with bowel and bladder incontinence. There are about 4,000 NTD-affected pregnancies in the United States each year. Between 2,000 and 3,000 of these pregnancies result in term births, while the remainder are identified prenatally and terminated by induced abortion.

In 1991, a British-funded randomized clinical trial of women who had a previous pregnancy affected with spina bifida or other NTD showed that folic acid reduced the risk of having a subsequent affected pregnancy by about 70 percent.[1] In 1992, a second randomized clinical trial conducted in Hungary among women with no history of NTD also showed a statistically significant reduction in risk.[2] Three major case control studies in the United States have documented that the risk of NTD-affected pregnancy among women who consume 400 µg of folic acid daily in a vitamin supplement is less than half the risk among women who consume folate from only dietary sources (on average 200 µg per day).[3–5] The results of these and other studies led to consensus among agencies of the U.S. Public Health Service (PHS) that folic acid prevents NTD. In September 1992, the PHS published a recommendation that all women capable of becoming pregnant should continue 400 µg folic acid per day for the purpose of reducing the risk of spina bifida and other neural tube defects.

The reason for recommending daily use of folic acid is that the crucial time to consume folic acid for the purpose of preventing NTD-affected pregnancies is from about 1 month before conception and throughout early pregnancy. Since it has been estimated that 50 percent of pregnancies in the United States are not planned,[7] to maximize NTD prevention it is necessary to recommend that all women who are capable of becoming pregnant consume 400 µg of folic acid daily. Educational efforts are underway to increase the awareness of the folic acid NTD prevention among the general population. PHS is also considering the possibility of fortifying cereal grain products with folic acid.

Based on a synthesis of information from several studies including those which used multivitamins containing folic acid at a daily dose level of at least 0.4 mg, it was inferred that folic acid alone at levels of 0.4 mg per day will reduce the risk of NTDs. The protective effect found in the studies of lower-dose folic acid, measured

by the reduction in NTD incidence, ranged from none to substantial; a reasonable estimate of the expected reduction in the United States is 50 percent.[6]

A trend of decreasing birth prevalence of neural tube defects (spina bifida and anencephaly) has been observed over the past 25 years by the CDC Birth Defects surveillance program. It is possible that at least some of this decrease has been the result of increased regular use of supplements containing folic acid by women of childbearing age.[8]

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Heart Disease and Stroke

Health Status Objectives

15.1* Reduce coronary heart disease deaths to no more than 100 per 100,000 people. (Age-adjusted baseline: 135 per 100,000 in 1987)

		Special Population Target	
	Coronary Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
15.1a	Blacks	168	115

15.2* Reduce stroke deaths to no more than 20 per 100,000 people. (Age-adjusted baseline: 30.4 per 100,000 in 1987)

		Special Population Target	
	Stroke Deaths (per 100,000)	*1987 Baseline*	*2000 Target*
15.2a	Blacks	52.5	27

15.3 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: 14.4 per 100,000 in 1987)

		Special Population Target	
	ESRD Incidence (per 100,000)	*1987 Baseline*	*2000 Target*
15.3a	Blacks	34.0	30

Risk Reduction Objectives

15.4* Increase to at least 50 percent the proportion of people with high blood pressure whose blood pressure is under control. (Baseline: 11 percent controlled among people aged 18–74 in 1976–80)

		Special Population Target	
	High Blood Pressure Control	*1976–80 Baseline*	*2000 Target*
15.4a	Men with high blood pressure	6%	40%
		1988–91 Baseline	*2000 Target*
15.4b	Mexican Americans	14%	50%
15.4c	Women 70 years and older	19%	50%

Note: People with high blood pressure have blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or take antihypertensive medication. Blood pressure control is defined as maintaining a blood pressure less than 140 mm Hg systolic and 90 mm Hg diastolic. Control of hypertension does not include nonpharmacologic treatment.

15.5 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)

Special Population Targets

	Taking Action to Control Blood Pressure	*1985 Baseline*	*2000 Target*
15.5a	White hypertensive men aged 18–34	51%†	80%
15.5b	Black hypertensive men aged 18–34	63%†	80%

†Baseline for aware hypertensive men

Note: People with high blood pressure are defined in the National Health Interview Survey as those who are told on two or more occasions by a physician or other health professional that they had blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or taking antihypertensive medication. Actions to control blood pressure include taking medication, dieting to lose weight, cutting down on salt, and exercising.

15.6* Reduce the mean serum cholesterol level among adults to no more than 200 mg/dL. (Baseline: 213 mg/dL among people aged 20–74 in 1976–80, 211 mg/dL for men and 215 mg/dL for women)

15.7* 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 20–74 in 1976–80, 29 percent for women and 25 percent for men)

15.8 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: 30 percent of people with high blood cholesterol were aware that their blood cholesterol level was high in 1988)

Note: "High blood cholesterol" means a level that requires diet and, if necessary, drug treatment. Actions to control high blood cholesterol include keeping medical appointments, making recommended dietary changes (e.g., reducing saturated fat, total fat, and dietary cholesterol), and, if necessary, taking prescribed medication.

15.9* 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: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of

less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 21 percent met the goal for fat and 21 percent met the goal for saturated fat based on 2-day dietary data from the 1989–91 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

15.10* 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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

	Overweight Prevalence	*1976–80 Baseline*†	*2000 Target*
15.10a	Low-income women aged 20 and older	37%	25%
15.10b	Black women aged 20 and older	44%	30%
15.10c	Hispanic women aged 20 and older		25%
	Mexican-American women	39%‡	
	Cuban women	34%‡	
	Puerto Rican women	37%‡	
15.10d	American Indians/Alaska Natives	29–75%§	30%
15.10e	People with disabilities	36%††	25%
15.10f	Women with high blood pressure	50%	41%
15.10g	Men with high blood pressure	39%	35%
15.10h	Mexican-American men	30%‡	25%

†Baseline for people aged 20–74 ‡1982–84 baseline for Hispanics aged 20–74 §1984–88 estimates for different tribes ††1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

15.11* 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. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes 5 or more times per week and 16 percent were active 7 or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	*1991 Baseline*	*2000 Target*
15.11a	Hispanics 18 years and older 5 or more times per week	20%	25%

Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.

15.12* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 percent for men and 27 percent for women.)

Special Population Targets

	Cigarette Smoking Prevalence	*1987 Baseline*	*2000 Target*
15.12a	People with a high school education or less aged 20 and older	34%	20%
15.12b	Blue-collar workers aged 18 and older	41%	20%
15.12c	Military personnel	42%†	20%
15.12d	Blacks aged 18 and older	33%	18%
15.12e	Hispanics aged 18 and older	24%	15%
15.12f	American Indians/Alaska Natives	42–70%‡	20%
15.12g	Southeast Asian men	55%§	20%
15.12h	Women of reproductive age	29%††	12%
15.12i	Pregnant women	25%‡‡	10%
15.12j	Women who use oral contraceptives	36%§§	10%

†1988 baseline ‡1979–87 estimates for different tribes §1984–88 baseline ††Baseline for women aged 18–44 ‡‡1985 baseline §§1983 baseline

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes. Since 1992, estimates include some-day (intermittent) smokers.

Services and Protection Objectives

15.13 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)

Note: A blood pressure measurement within the preceding 2 years refers to a measurement by a health professional or other trained observer.

Special Population Target

	Blood Pressure Checked	*1991 Baseline*	*2000 Target*
15.13a	Mexican-American men	69%	90%

15.14 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)

Special Population Targets

	Blood Cholesterol Checked	*1991 Baseline*	*2000 Target*
	Ever checked		
15.14a	Blacks	56%	75%
15.14b	Mexican Americans	42%	75%
15.14c	American Indians/Alaska Natives	46%	75%
	Past two years		
15.14d	Mexican Americans	33%	75%
15.14e	American Indians/Alaska Natives	38%	75%
15.14f	Asians/Pacific Islanders	45%	75%

15.15 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: Median cholesterol level, 240–259 mg/dL, when diet therapy is initiated; median cholesterol level, 300–319 mg/dL drug therapy is initiated.)

Note: Treatment recommendations at baseline are outlined in detail in the Report of the Expert Panel on the Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults, *released by the National Cholesterol Education Program in 1987. Current treatment recommendations are described in the* Second Report of the Expert Panel on Detection, Evaluation and Treatment of High Blood Cholesterol in Adults *released in 1993. Treatment recommendations are likely to be refined over time. Thus, for the year 2000, "current" means whatever recommendations are then in effect.*

15.16 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: 35 percent offered high blood pressure and/or cholesterol programs in 1992)

15.17 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)

Cancer

Health Status Objectives

Note: In its publications, the National Cancer Institute age-adjusts cancer death rates to the 1970 U.S. population. Using the 1970 standard, the equivalent baseline and target values for the health status objectives differ from those presented here.

16.1* Reverse the rise in cancer deaths to achieve a rate of no more than 130 per 100,000 people. (Age-adjusted baseline: 134 per 100,000 in 1987)

Special Population Target

	Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.1a	Blacks	182	175

16.2* Slow the rise in lung cancer deaths to achieve a rate of no more than 42 per 100,000 people. (Age-adjusted baseline: 38.5 per 100,000 in 1987)

Special Population Targets

	Lung Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.2a	Females	25.6	27
16.2b	Black males	86.1	91

16.3 Reduce breast cancer deaths to no more than 20.6 per 100,000 women. (Age-adjusted baseline: 23.0 per 100,000 in 1987)

Special Population Target

	Breast Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.3a	Black females	27.5	25

16.4 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)

Special Population Targets

	Cervical Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.4a	Black females	5.9	3
16.4b	Hispanic females	3.6†	2

†NIH, Surveillance, Epidemiology, and End Results (SEER) 1977–83, age-adjusted to 1940

16.5* Reduce colorectal cancer deaths to no more than 13.2 per 100,000 people. (Age-adjusted baseline: 14.7 per 100,000 in 1987)

Special Population Target

	Colorectal Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.5a	Blacks	18.1	16.5

Risk Reduction Objectives

16.6* Reduce cigarette smoking to a prevalence of no more than 15 percent among people aged 18 and older. (Baseline: 29 percent in 1987, 31 percent for men and 27 percent for women.)

Special Population Targets

	Cigarette Smoking Prevalence	*1987 Baseline*	*2000 Target*
16.6a	People with a high school education or less aged 20 and older	34%	20%
16.6b	Blue-collar workers aged 18 and older	41%	20%
16.6c	Military personnel	42%†	20%
16.6d	Blacks aged 18 and older	33%	18%
16.6e	Hispanics aged 18 and older	24%	15%
16.6f	American Indians/Alaska Natives	42–70%‡	20%
16.6g	Southeast Asian men	55%§	20%
16.6h	Women of reproductive age	29%††	12%
16.6i	Pregnant women	25%‡‡	10%
16.6j	Women who use oral contraceptives	36%§§	10%

†1988 baseline ‡1979–87 estimates for different tribes §1984–88 baseline ††Baseline for women aged 18–44 ‡‡1985 baseline §§1983 baseline

Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes. Since 1992, estimates include same-day (intermittent) smokers.

16.7* 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: for people aged 2 and older: 36 percent of calories from total fat and 13 percent of calories from saturated fat based on 1-day dietary data from the 1976–80 NHANES II; 34 percent of calories from total fat and 12 percent from saturated fat based on 1-day dietary data from the 1989–91 Continuing Survey of Food Intakes by Individuals [(CSFII]). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of no more than 30 percent of calories from fat, and increase to at least 50 percent the proportion of people aged 2 and older who meet the average daily goal of less than 10 percent of calories from saturated fat. (Baseline for people aged 2 and older: 21 percent met the goal for fat and 21 percent met the goal for saturated fat based on 2-day dietary data from the 1989–91 NHANES; 22 percent met the goal for fat and 21 percent met the goal for saturated fat based on the 3-day dietary data from 1989–91 CSFII)

16.8* Increase complex carbohydrate and fiber-containing foods in the diets of people aged 2 and older to an average of 5 or more daily servings for vegetables (including legumes) and fruits, and to an average of 6 or more daily servings for grain products. (Baseline: 4.1 servings of vegetables and fruits and 5.8 servings of grain products for people aged 2 and older based on 3-day dietary data from the

1989–91 CSFII). In addition, increase to at least 50 percent the proportion of people aged 2 and older who meet the *Dietary Guidelines*' average daily goal of 5 or more servings of vegetables/fruits, and increase to at least 50 percent the proportion who meet the goal of 6 or more servings of grain products. (Baseline: 29 percent met the goal for fruits and vegetables and 40 percent met the goal for grain products for people aged 2 and older based on 3-day dietary data in the 1989–91 CSFII).

Note: The definition of vegetables, fruits, and grain products and serving size designations are derived from The Food Guide Pyramid*. Vegetable, fruit, and grain ingredients from mixtures are included in the total, and fractions of servings are counted.*

Services and Protection Objectives

16.9 Increase to at least 60 percent the proportion of people of all ages who limit sun exposure, use sunscreens and protective clothing when exposed to sunlight, and avoid artificial sources of ultraviolet light (e.g., sun lamps, tanning booths). (Baseline: 31 percent limited sun exposure, 28 percent used sunscreen, and 28 percent wore protective clothing in 1992)

16.10 Increase to at least 75 percent the proportion of primary care providers who routinely counsel patients about the following: tobacco use cessation, diet modification, and cancer screening recommendations, which includes providing information on the potential benefit or harm attributed to the various screening modalities and discussion of risk factors associated with breast, prostate, cervical, colorectal, and lung cancers. (Baseline: About 52 percent of internists reported counseling more than 75 percent of their smoking patients about smoking cessation in 1986)

16.11 Increase to at least 60 percent those women aged 50 and older who have received a clinical breast examination and a mammogram within the preceding 1–2 years. (Baseline: 25 percent of women aged 50 and older within the preceding 2 years in 1987)

Special Population Targets

	Clinical Breast Exam & Mammogram Received Within Preceding 2 Years:	*1987 Baseline*	*2000 Target*
16.11a	Hispanic women aged 50 and older	18%	60%
16.11b	Low-income women aged 50 and older (annual family income <$10,000)	15%	60%
16.11c	Women aged 50 and older with less than high school education	16%	60%
16.11d	Women aged 70 and older	18%	60%
16.11e	Black women aged 50 and older	19%	60%

16.12 Increase to at least 95 percent the proportion of women aged 18 and older who have ever received a Pap test, and to at least 85 percent those who received a Pap test within the preceding 1–3 years. (Baseline: 88 percent "ever" and 75 percent "within the preceding 3 years" in 1987)

16.13 Increase to at least 50 percent the proportion of people aged 50 and older who have received fecal occult blood testing within the preceding 1–2 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)

16.14 Increase to at least 40 percent the proportion of people aged 50 and older visiting a primary care provider in the preceding year who have received oral, skin, and digital rectal examinations during one such visit. (Baseline: An estimated 27 percent received a digital rectal exam during a physician visit within the preceding year in 1987)

16.15 Ensure that Pap tests meet quality standards by monitoring and certifying all cytology laboratories. (Baseline data unavailable)

16.16 Ensure that mammograms meet quality standards by inspecting and certifying 100 percent according to the requirements of the Mammography Quality Standards Act. (Baseline: An estimated 18–21 percent certified by the American College of Radiology as of June 1990)

1995 Addition

Health Status Objective

16.17* Reduce deaths due to cancer of the oral cavity and pharynx to no more than 10.5 per 100,000 men aged 45–74 and 4.1 per 100,000 women aged 45–74. (Baseline: 13.6 per 100,000 men and 4.8 per 100,000 women in 1987)

Special Population Targets

	Oral Cancer Deaths (per 100,000)	*1990 Baseline*	*2000 Target*
16.17a	Black males aged 45–74	29.4	26.0
16.17b	Black females aged 45–74	6.9	6.9

Diabetes and Chronic Disabling Conditions

Health Status Objectives

17.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	*1990 Baseline*	*2000 Target*
17.1a	Blacks	56.0	60
17.1b	Hispanics	64.8	65
17.1c	People aged 65 and older	11.9†	14†

†Years of healthy life remaining at age 65

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure.

17.2 Reduce to no more than 8 percent the proportion of people who experience a limitation in major activity due to chronic conditions. (Baseline: 9.4 percent in 1988)

Special Population Targets

	Prevalence of Disability	*1988 Baseline*	*2000 Target*
17.2a	Low-income people (annual family income <$10,000 in 1988)	18.9%	15%
17.2b	American Indians/Alaska Natives	13.4%†	11%
17.2c	Blacks	11.2%	9%

†1983–85 baseline

		1991 Baseline	*2000 Target*
17.2d	Puerto Ricans	11.7%	10%

Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.

17.3 Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities, thereby preserving independence. (Baseline: 111 per 1,000 in 1984–85)

Special Population Targets

	Difficulty Performing Self-care Activities (per 1,000)	*1984–85 Baseline*	*2000 Target*
17.3a	People aged 85 and older	371	325
17.3b	Blacks aged 65 and older	112	98

Note: Personal care activities are bathing, dressing, using the toilet, getting in and out of bed or chair, and eating.

17.4 Reduce to no more than 10 percent the proportion of people with asthma who experience activity limitation. (Baseline: Average of 19.4 percent during 1986–88)

Special Population Target

	Asthmatics with Activity Limitations	*1989–1991 Baseline*	*2000 Target*
17.4a	Blacks	30.5%	19%
17.4b	Puerto Ricans	51.5%	22%

Note: Activity limitation refers to any self-reported limitation in activity attributed to asthma.

17.5 Reduce activity limitation due to chronic back conditions to a prevalence of no more than 19 per 1,000 people. (Baseline: Average of 21.9 per 1,000 during 1986–88)

Note: Chronic back conditions include intervertebral disk disorders, curvature of the back or spine, and other self-reported chronic back impairments such as permanent stiffness or deformity of the back or repeated trouble with the back. Activity limitation refers to any self-reported limitation in activity attributed to a chronic back condition.

17.6 Reduce significant hearing impairment to a prevalence of no more than 82 per 1,000 people. (Baseline: Average of 88.9 per 1,000 during 1986–88)

Special Population Target

	Hearing Impairment (per 1,000)	*1986–88 Baseline*	*2000 Target*
17.6a	People aged 45 and older	203	180

Note: Hearing impairment covers the range of hearing deficits from mild loss in one ear to profound loss in both ears. Generally, inability to hear sounds at levels softer (less intense) than 20 decibels (dB) constitutes abnormal hearing. Significant hearing impairment is defined as having hearing thresholds for speech poorer than 25 dB. However, for this objective, self-reported hearing impairment (i.e., deafness in one or both ears or any trouble hearing in one or both ears) will be used as a proxy measure for significant hearing impairment.

17.7 Reduce significant visual impairment to a prevalence of no more than 30 per 1,000 people. (Baseline: Average of 34.5 per 1,000 during 1986–88)

Special Population Target

	Visual Impairment (per 1,000)	*1986–88 Baseline*	*2000 Target*
17.7a	People aged 65 and older	87.7	70

Note: Significant visual impairment is generally defined as a permanent reduction in visual acuity and/or field of vision which is not correctable with eyeglasses or contact lenses. Severe visual impairment is defined as inability to read ordinary newsprint even with corrective lenses. For this objective, self-reported blindness in one or both eyes and other self-reported visual impairments (i.e., any trouble seeing with one or both eyes even when wearing glasses or colorblindness) will be used as a proxy measure for significant visual impairment.

17.8* Reduce the prevalence of serious mental retardation among school-aged children to no more than 2 per 1,000 children. (Baseline: 2.7 per 1,000 children aged 10 in 1985–88)

Note: Serious mental retardation is defined as an Intelligence Quotient (I.Q.) less than 50. This includes individuals defined by the American Association of Mental Retardation as profoundly retarded (I.Q. of 20 or less), severely retarded (I.Q. of 21–35), and moderately retarded (I.Q. of 36–50).

17.9 Reduce diabetes-related deaths to no more than 34 per 100,000 people. (Age-adjusted baseline: 38 per 100,000 in 1986)

Special Population Targets

	Diabetes-Related Deaths (per 100,000)	*1986 Baseline*	*2000 Target*
17.9a	Blacks	67.0	58
17.9b	American Indians/Alaska Natives	46.0	41
		1990 Baseline	*2000 Target*
17.9c	Mexican Americans	55.9	50
17.9d	Puerto Ricans	47.0	42

Note: Diabetes-related deaths refer to deaths from diabetes as an underlying or contributing cause.

17.10 Reduce the most severe complications of diabetes as follows:

Complications Among People With Diabetes	*1988 Baseline*	*2000 Target*
End-stage renal disease	1.5/1,000†	1.4/1,000
Blindness	2.2/1,000	1.4/1,000
Lower extremity amputation	8.2/1,000†	4.9/1,000
Perinatal mortality‡	5%	2%
Major congenital malformations‡	8%	4%

†1987 baseline ‡Among infants of women with established diabetes

Special Population Targets for ESRD

	ESRD Due to Diabetes (per 1,000)	*1983–86 Baseline*	*2000 Target*
17.10a	Blacks with diabetes	2.2	2.0
17.10b	American Indians/Alaska Natives with diabetes	2.1	1.9

Special Population Target for Amputations

	Lower Extremity Amputations Due to Diabetes (per 1,000)	*1984–87 Baseline*	*2000 Target*
17.10c	Blacks with diabetes	10.2	6.1

Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.

17.11* Reduce diabetes to an incidence of no more than 2.5 per 1,000 people and a prevalence of no more than 25 per 1,000 people. (Baselines: 2.9 per 1,000 in 1987; 28 per 1,000 in 1987)

Special Population Targets

	Prevalence of Diabetes (per 1,000)	*1982–84 Baseline*†	*2000 Target*
17.11a	American Indians/Alaska Natives	69‡	62
17.11b	Puerto Ricans	55	49
17.11c	Mexican Americans	54	49
17.11d	Cuban Americans	36	32
17.11e	Blacks	36§	32

†1982–84 baseline for people aged 20–74 ‡1987 baseline for American Indians/Alaska Natives aged 15 and older §1987 baseline for blacks of all ages

Risk Reduction Objectives

17.12* 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 12–19. (Baseline: 26 percent for people aged 20–74 in 1976–80, 24 percent for men and 27 percent for women; 15 percent for adolescents aged 12–19 in 1976–80)

Special Population Targets

	Overweight Prevalence	*1976–80 Baseline*†	*2000 Target*
17.12a	Low-income women aged 20 and older	37%	25%
17.12b	Black women aged 20 and older	44%	30%
17.12c	Hispanic women aged 20 and older		25%
	Mexican-American women	39%‡	
	Cuban women	34%‡	
	Puerto Rican women	37%‡	
17.12d	American Indians/Alaska Natives	29–75%§	30%
17.12e	People with disabilities	36%§	25%
17.12f	Women with high blood pressure	50%	41%
17.12g	Men with high blood pressure	39%	35%
17.12h	Mexican-American men	30%‡	25%

†Baseline for people aged 20–74 ‡1982–84 baseline for Hispanics aged 20–74 §1984–88 estimates for different tribes ††1985 baseline for people aged 20–74 who report any limitation in activity due to chronic conditions derived from self-reported height and weight

Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12–14, 24.3 for males aged 15–17, 25.8 for males aged 18–19, 23.4 for females aged 12–14, 24.8 for females aged 15–17, and 25.7 for females aged 18–19. The values for adults are the gender-specific 85th percentile values of the 1976–80 National Health and

Nutrition Examination Survey (NHANES II), reference population 20–29 years of age. For adolescents, overweight was defined using BMI cutoffs based on modified age- and gender-specific 85th percentile values of the NHANES II. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.

17.13* 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. (Baseline: 22 percent of people aged 18 and older were active for at least 30 minutes five or more times per week, and 16 percent were active seven or more times per week in 1985)

Special Population Target

	Moderate Physical Activity	*1991 Baseline*	*2000 Target*
17.13a	Hispanics 18 years and older five or more times per week	20%	25%

Note: Light to moderate physical activity requires sustained, rhythmic muscular movements, is at least equivalent to sustained walking, and is performed at less than 60 percent of maximum heart rate for age. Maximum heart rate equals roughly 220 beats per minute minus age. Examples may include walking, swimming, cycling, dancing, gardening and yardwork, various domestic and occupational activities, and games and other childhood pursuits.

Services and Protection Objectives

17.14 Increase to at least 40 percent the proportion of people with chronic and disabling conditions who receive formal patient education including information about community and self-help resources as an integral part of the management of their condition. (Baseline data unavailable)

Type-Specific Targets

	Patient Education	*1983–84 Baseline*	*2000 Target*
17.14a	People with diabetes	32% (classes) 68% (counseling)	75%
		1991 Baseline	*2000 Target*
17.14b	People with asthma	9%	50%
17.14c	Blacks with diabetes	34% (classes)	75%
17.14d	Hispanics with diabetes	27% (classes)	75%

17.15 Increase to at least 80 percent the proportion of providers of primary care for children who routinely refer or screen infants and children for impairments of vision, hearing, speech and language, and assess other developmental milestones as part of well-child care. (Baseline: 19–72 percent of pediatricians, nurse practitioners, and family physicians reported routinely providing services to patients in 1992)

17.16 Reduce the average age at which children with significant hearing impairment are identified to no more than 12 months. (Baseline: Estimated as 24 to 30 months in 1988)

		Special Population Target	
	Hearing Impairment	*1991 Baseline*	*2000 Target*
17.16a	Blacks	36	12

17.17 Increase to at least 60 percent the proportion of providers of primary care for older adults who routinely evaluate people aged 65 and older for urinary incontinence and impairments of vision, hearing, cognition, and functional status. (Baseline: 3–63 percent of nurse practitioners, obstetricians/gynecologists, internists, and family physicians reported routinely providing services to patients in 1992)

17.18 Increase to at least 90 percent the proportion of perimenopausal women who have been counseled about the benefits and risks of estrogen replacement therapy (combined with progestin, when appropriate) for prevention of osteoporosis. (Baseline data unavailable)

17.19 Increase to at least 75 percent the proportion of worksites with 50 or more employees that have a policy or program for the hiring of people with disabilities. (Baseline: 37 percent of medium and large companies in 1986)

Note: Mandated by the Americans with Disabilities Act.

17.20 Increase to 50 the number of States that have service systems for children with or at risk of chronic and disabling conditions, as required by Public Law 101-239. (Baseline data unavailable)

Note: Children with or at risk of chronic and disabling conditions, often referred to as children with special health care needs, include children with psychosocial as well as physical problems. This population encompasses children with a wide variety of actual or potential disabling conditions, including children with or at risk for cerebral palsy, mental retardation, sensory deprivation, developmental disabilities, spina bifida, hemophilia, other genetic disorders, and health-related educational and behavioral problems. Service systems for such children are organized networks of comprehensive, community-based, coordinated, and family-centered services.

1995 Additions

Health Status Objectives

17.21 Reduce the prevalence of peptic ulcer disease to no more than 18 per 1,000 people aged 18 and older by preventing its recurrence. (Baseline: 19.9 per 1,000 in 1991)

Source: National Health Interview Survey, CDC

Commentary:

The National Statistics of Peptic Ulcer Disease show that in the United States, gastrointestinal diseases lead all other conditions in office visits to physicians and are among the front-running causes for hospitalization. Digestive diseases cost the Nation more than $50 billion annually and in chronic form effect about 37 million individuals. Of these, 11 percent—4 million patients, 19 years or older—are under treatment for peptic ulcer and have seen a physician during the past year. These patients account for most of the 2.1 million office visits per year for gastritis and duodenitis and 2.5 million office visits for abdominal pain. An additional 2.3 million individuals have had medically diagnosed ulcers within the past year but are not under active treatment at the moment. This totals about 6 million known peptic ulcer patients in a given year, each of whom, on the average, spend about 2 1/2 weeks under restricted activity (1 week of this in bed). About 240,000 patients are hospitalized each year with peptic ulcers. The average time of hospitalization is 1 week, amounting to a total of 1.7 million hospital days each year.

In the general population in the United States, the lifetime prevalence of peptic ulcer is 11 percent for men and 10 percent for women. The annual prevalence is 15 per 1,000 according to the 1991 National Health Interview Survey conducted by the CDC/National Center for Health Statistics.

Most peptic ulcers have a chronic, recurring course. The nature and severity of symptoms vary with their location, the patient's age, and other factors. Conventionally treated peptic ulcers usually heal but tend to recur (in most cases in intervals of between 10 and 18 months) and demand costly treatment for the lifetime of the patient. Some patients will have pain as the main presenting symptom; others report the presence of an ulcer for the first time when an acute complication—hemorrhage, gastrointestinal perforation, or obstruction develops. These are serious and may be life-threatening.

An effective new therapy now prevents the usual recurrence of the disease—the periodic development of new, active ulcers ("primary prevention")—and the progressive generation of the serious, surgery-requiring complications ("secondary prevention").

The costs of peptic ulcer disease to society are high in terms of human suffering as well as in direct and indirect economic costs. Among the direct costs are those related to these surgery, office and clinic visits, physician care, diagnostic tests, and significant expenditures for drugs. Indirect costs include loss of productivity due to absenteeism from work and loss of potential productivity due to premature death. Much of these costs and the considerable human suffering and disability have recently become avoidable.

In 1982, a bacterium, *Helicobacter pylori,* was cultured from the human stomach. Since then, it has been shown that this organism is associated with chronic gastritis and peptic ulcer disease. Data from throughout the world indicate that persistent infection with this organism accounts for the high recurrence rate and chronicity of peptic ulcer disease. New therapeutic regimens have been developed to eradicate the organism effectively in ulcer patients. These combination drug treatments, in addition to healing the acute ulcer, eradicate the organism and prevent ulcer recurrence and lifelong chronicity in the overwhelming majority of patients. With this new treatment, the potentially realizable cost saving in peptic ulcer care have been very conservatively estimated at $760 million per year—an important, timely consideration. Under these new conditions, objectives calling for 1) reduced prevalence, 2) reduction of long-term complications of the disease, and 3) a diminution in direct and indirect cost to society are likely to show progress within a 10-year period.

17.22* Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline data unavailable)

Note: Disease prevention and health promotion data include disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.

Services and Protection Objective

17.23 Increase to 70 percent the proportion of people with diabetes who have an annual dilated eye exam. (Baseline: 49 percent for people aged 18 and older in 1989)

Source: Supplement to the National Health Interview Survey; Brechner, et al. JAMA, *1993.*

Followup source: Supplement to the National Health Interview Survey and the Diabetes Supplement to the Behavioral Risk Factor Surveillance System.

Commentary:

Diabetes mellitus is the leading cause of blindness among working age Americans. Data indicate that approximately 90 percent of blindness due to diabetes could be prevented by secondary and tertiary prevention efforts. Regarding tertiary strategies, dilated eye exams are necessary to detect treatable retinopathy. It is recommended that by the year 2000 at least 70 percent of people with diabetes have an annual dilated eye exam by a qualified eye care specialist.

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HIV Infection

Health Status Objectives

18.1 Confine annual incidence of diagnosed AIDS cases to no more than 43 per 100,000 population. (Baseline: 17.0 per 100,000 in 1989)

	Rates of AIDS Cases (per 100,000)	*1989 Baseline*	*2000 Target*
18.1a	Men who have sex with men (number of cases)	27,000	No more than 48,000
18.1b	Blacks	44.4	No more than 136 per 100,000
18.1c	Hispanics	34.9	No more than 76 per 100,000
18.1d	Women	3.5	No more than 13 per 100,000
18.1e	Injecting drug users (number of cases)	10,300	No more than 25,000

Note: Cases are by year of diagnosis and are corrected for delays in reporting and underreporting.

18.2 Confine the prevalence of HIV infection to no more than 400 per 100,000 people. (Baseline: An estimated 400 per 100,000 in 1989)

		Special Population Targets	
	Estimated Prevalence of HIV Infection (per 100,000)	*1989 Baseline*	*2000 Target*
18.2a	Men who have sex with men	2,000–42,000[†]	20,000
18.2b	Injecting drug users	30,000–40,000[‡]	40,000
18.2c	Women giving birth to live infants	160	100

[†]Per 100,000 men who have sex with men aged 15–24 based on men tested in selected sexually transmitted disease clinics in unlinked surveys; most studies find HIV prevalence of between 2,000 and 21,000 per 100,000 [‡]Per 100,000 injecting drug users aged 15–24 in the New York City vicinity; in areas other than major metropolitan centers, infection rates in people entering selected drug treatment programs tested in unlinked surveys are often under 500 per 100,000

Note: The year 2000 target has been revised to reflect new CDC estimates of the prevalence of HIV infection.

Risk Reduction Objectives

18.3[*] Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline 27 percent of females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17; reported in 1988)

Special Population Targets

	Adolescents Engaged in Sexual Intercourse	*1988 Baseline*	*2000 Target*
18.3a	Black males aged 15	69%	15%
18.3b	Black males aged 17	90%	40%
18.3c	Black females aged 17	66%	40%

18.4* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15–44 reported that their partners used a condom at last sexual intercourse in 1988)

Special Population Targets

	Use of Condoms	*1988 Baseline*	*2000 Target*
18.4a	Sexually active young women aged 15–19 (by their partners)	26%	60%
18.4b	Sexually active young men aged 15–19	57%	75%
18.4c	Injecting drug users	34%†	75%
18.4d	Black women aged 15–44	12.4%	75%

† 1992 Baseline

18.5 Increase to at least 50 percent the estimated proportion of all injecting drug users who are in drug abuse treatment programs. (Baseline: An estimated 11 percent of opiate abusers were in treatment in 1989)

Note: An injecting drug user is anyone who within the past 12 months has injected drugs not prescribed by a physician. The definition of "drug abuse treatment" must include more than contact for treatment and must be sustained to be effective. Therefore, contacts for treatment do not represent treatment.

18.6 Increase to at least 75 percent the proportion of active injecting drug users who use only new or properly decontaminated syringes, needles and other drug paraphernalia ("works"). (Baseline: 30.8 percent in 1991)

18.7 Reduce to no more than 1 per 250,000 units of blood and blood components the risk of transfusion-transmitted HIV infection. (Baseline: 1 per 40,000 to 150,000 units in 1989)

Services and Protection Objectives

18.8 Increase to at least 80 percent the proportion of HIV-infected people who know their serostatus. (Baseline: 72.5 percent in 1990)

Note: This objective will be tracked by the percentage of positive tests at public counseling and testing sites to which people returned for posttest counseling.

18.9* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide appropriate counseling† on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987)

Special Population Targets

	Counseling on HIV and STD Prevention	*1987 Baseline*	*2000 Target*
18.9a	Providers practicing in high-incidence areas	—	90%
		1992 Baseline	*2000 Target*
18.9b	Family Physicians	27%	75%
18.9c	Internists	30%	75%
18.9d	Nurse Practitioners	50%	75%
18.9e	Obstetricians/gynecologists	46%	75%
18.9f	Pediatricians	46%	75%
18.9g	Mental Health Care Providers	—	75%

† Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Primary care providers include physicians, nurses, nurse practitioners, and physician assistants. Mental health care providers include psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

18.10* Increase to at least 95 percent the proportion of schools that provide appropriate† HIV and other STD education curricula for students in 4th–12th grade, preferably as part of comprehensive school health education, based upon scientific information that includes the way HIV and other STDs are prevented and transmitted. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as a part of their standard curricula in 1988)

† An appropriate curriculum is defined as one that is sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens. HIV and STD education should include information about primary transmission routes and should increase students' skills in avoiding infection.

18.11* Increase to at least 90 percent the proportion of students who received HIV and other STD information, education, or counseling on their college or university campus. (Baseline data unavailable)

18.12 Increase to at least 90 percent the proportion of cities with populations over 100,000 that have outreach programs to contact injecting drug users (particularly injecting drug users) to deliver HIV risk reduction messages. (Baseline: 35 percent in 1991)

Note: HIV risk reduction messages include messages about reducing or eliminating drug use, entering drug treatment, disinfection of injection equipment if still injecting drugs, and safer sex practices.

18.13* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide onsite primary prevention and provide or refer for secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

18.14 Extend to all facilities where workers are at risk for occupational transmission of HIV regulations to protect workers from exposure to bloodborne infections, including HIV infection. (Baseline: 100 percent in 1992)

1995 Additions

Risk Reduction Objective

18.15* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse for the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 and 33 percent of sexually active males aged 15–17 in 1988)

Commentary for shared objective:

The risks of early sexual intercourse include not only unwanted pregnancy, but also infection by sexually transmitted diseases, including HIV.

For young adolescents the most effective means of preventing possible physical and psychological problems related to sexual intercourse is to delay or stop sexual activity. But teenage sexual activity is a complex issue, embedded in family, social, and economic factors. Peers of the same gender are a major influence on adolescent attitudes about sexual activity. The proportion of their same sex peers that teenagers believe are sexually active and how sexually active they believe them to be are powerful predictors of sexual experience among adolescent boys and girls.

Young people who choose abstinence should be supported in this choice. Counselors and educators should be trained in building skills to help young people who choose abstinence to sustain their choice. Educational and counseling materials should give

credence and support to this choice and should promote virginity and abstinence as healthy choices. Peer groups advocating abstinence as an acceptable choice should be encouraged.

Interventions to prevent associated negative health outcomes from early sexual activity cannot be successful without the full support and involvement of parents and others who serve in advisory and role model capacities with teenagers.

Services and Protection Objectives

18.16 Increase to at least 50 percent the proportion of large businesses and to 10 percent the proportion of small businesses that implemented a comprehensive HIV/AIDS workplace program. (Baseline data unavailable)

Comprehensive Programs	*1995 Baseline*	*2000 Target*
Federal Government departments and agencies	80%	100%

Source: CDC

Note: An HIV/AIDS workplace program consists of (1) an HIV/AIDS written policy, (2) managerial training about the policy and its application and (3) HIV/AIDS employee education.

Commentary:

Workplace health promotion has long been seen as an effective activity to promote good health and prevent illness. The workplace provides access to an adult population at risk for many health problems and is an appropriate classroom for teaching employees how to reduce personal risk.

Seventy-six percent of AIDS cases are in people ages 25–44 and over 50 percent of the workforce is in this same age group. These workers are also the parents of the nation's youth where HIV infection is rapidly increasing. Employers provide a highly credible source of information to employees. Today's workplace offers access to people of every race, gender, sexual orientation, age, and ethnic group since all these segments of the population are found in the workplace.

In June 1993, the National Commission on AIDS recommended expansion of workplace education. On September 30, 1993, the President of the United States mandated HIV/AIDS education for all Federal employees providing leadership on this issue for the rest of the Nation's employers.

18.17 Increase to at least 40 percent the number of federally funded primary care clinics that have formal established linkages with substance abuse treatment programs and increase to at least 40 percent the number of federally funded substance abuse treatment programs that have formal established linkages with primary care clinics. (Baseline data unavailable)

Commentary:

In 1991, more than one-third of all AIDS cases were attributable to injecting drug use. AIDS cases in women are frequently correlated with both non-injecting drug and alcohol use and sex with injecting drug users.

Substance abuse treatment and primary health care have been historically separate systems of care that are now being forced together because of HIV-related disease. To meet the needs of substance-involved individuals, coordination and integration of specialized substance abuse services with the primary health care, mental health, and HIV/AIDS service systems are needed at State and local levels in both the public and private sectors. Access to an integrated array of general and specialized health and social services will promote better treatment outcomes and sustained recovery for injecting and non-injecting drug users and provide the best strategy for lowering the rates of HIV transmission within the drug-using community.

Sexually Transmitted Diseases

Health Status Objectives

19.1 Reduce gonorrhea to an incidence of no more than 100 cases per 100,000 people. (Baseline: 300 per 100,000 in 1989)

Special Population Targets

	Gonorrhea Incidence (per 100,000)	*1989 Baseline*	*2000 Target*
19.1a	Blacks	1,990	650
19.1b	Adolescents aged 15–19	1,123	375
19.1c	Women aged 15–44	501	175

19.2 Reduce the prevalence of *Chlamydia trachomatis* infections among young women (under the age of 25 years) to no more than 5 percent. (Baseline: 8.5 percent in women 20–24 and 12.2 percent in females 19 and younger in 1988)

Note: As measured by a decrease in the prevalence of chlamydia infection among family planning clients <25 years old at their initial visit.

19.3 Reduce primary and secondary syphilis to an incidence of no more than 4 cases per 100,000 people. (Baseline: 18.1 per 100,000 in 1989)

Special Population Target

	Primary and Secondary Syphilis Incidence (per 100,000)	*1989 Baseline*	*2000 Target*
19.3a	Blacks	118	30

19.4 Reduce congenital syphilis to an incidence of no more than 40 cases per 100,000 live births. (Baseline: 91.0 per 100,000 live births in 1990)

Special Population Targets

	Congenital syphilis (per 100,000)	*1992 Baseline*	*2000 Target*
19.4a	Blacks	427	175
19.4b	Hispanics	135	50

19.5 Reduce genital herpes and genital warts, as measured by a reduction to 138,500 and 246,500, respectively, in the annual number of first-time consultations with a physician for the conditions. (Baseline: 163,000 and 290,000 in 1988)

19.6 Reduce the incidence of pelvic inflammatory disease, as measured by a reduction in hospitalizations for pelvic inflammatory disease to no more than 100 per 100,000 women aged 15–44 and a reduction in the number of initial visits to physicians for pelvic inflammatory disease to no more than 290,000. (Baseline: 311 per 100,000 in 1988 and 430,800 visits in 1988)

Special Population Targets

	Hospitalizations for PID (per 100,000)	*1988 Baseline*	*2000 Target*
19.6a	Blacks	655	150
19.6b	Adolescents (aged 15–19)	342	110

19.7 Reduce sexually transmitted hepatitis B infection to no more than 30,500 cases. (Baseline: 47,593 cases in 1987)

19.8 Reduce the rate of repeat gonorrhea infection to no more than 15 percent within the previous year. (Baseline: 20 percent in 1987)

Note: As measured by a reduction in the proportion of gonorrhea patients who, within the previous year, were treated for a separate case of gonorrhea.

Special Population Target

	Repeat Gonorrhea	*1992 Baseline*	*2000 Target*
19.8a	Blacks†	21.3%	17%

†Proportion of male gonorrhea patients with one or more gonorrhea infections within the previous 12 months.

Risk Reduction Objectives

19.9* Reduce the proportion of adolescents who have engaged in sexual intercourse to no more than 15 percent by age 15 and no more than 40 percent by age 17. (Baseline: 27 percent of females and 33 percent of males by age 15; 50 percent of females and 66 percent of males by age 17 reported in 1988)

Special Population Targets

	Adolescents Engaged In Sexual Intercourse	*1988 Baseline*	*2000 Target*
19.9a	Black males aged 15	69%	15%
19.9b	Black males aged 17	90%	40%
19.9c	Black females aged 17	66%	40%

19.10* Increase to at least 50 percent the proportion of sexually active, unmarried people who used a condom at last sexual intercourse. (Baseline: 19 percent of sexually active, unmarried women aged 15–44 reported that their partners used a condom at last sexual intercourse in 1988)

Special Population Targets

	Use of Condoms	*1988 Baseline*	*2000 Target*
19.10a	Sexually active young women aged 15–19 (by their partners)	26.0%	60%
19.10b	Sexually active young men aged 15–19	57.0%	75%
19.10c	Injecting drug users	34.0%†	75%
19.10d	Black women aged 15–44	12.4%	75%

† 1992 Baseline

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens who are not yet sexually active.

Services and Protection Objectives

19.11* Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics, drug treatment centers, and primary care clinics that provide onsite primary and secondary prevention services for HIV infection and bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) to high-risk individuals and their sex or needle-sharing partners. (Baseline: 40 percent of family planning clinics for bacterial sexually transmitted diseases in 1989)

19.12* Increase to at least 95 percent the proportion of schools that provide appropriate† HIV and other STD education curricula for students in 4th–12th grade, preferably as part of comprehensive school health education, based upon scientific information that includes the way HIV infection and other STDs are prevented and transmitted. (Baseline: 95 percent of schools reported offering at least one class on sexually transmitted diseases as part of their standard curricula in 1988)

† An appropriate curriculum is defined as one that is sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Strategies to achieve this objective must be undertaken sensitively to avoid indirectly encouraging or condoning sexual activity among teens. HIV and STD education should include information about primary transmission routes and should increase students' skills in avoiding infection.

19.13 Increase to at least 90 percent the proportion of primary care providers treating patients with sexually transmitted diseases who correctly manage cases, as measured by their use of appropriate types and amounts of therapy. (Baseline: 70 percent in 1988)

19.14* Increase to at least 75 percent the proportion of primary care and mental health care providers who provide appropriate counseling† on the prevention of HIV and other sexually transmitted diseases. (Baseline: 10 percent of physicians reported that they regularly assessed the sexual behaviors of their patients in 1987)

Special Population Targets

	Counseling on HIV and STD Prevention	*1987 Baseline*	*2000 Target*
19.14a	Providers practicing in high-incidence areas	—	90%
		1992 Baseline	*2000 Target*
19.14b	Family Physicians	27%	75%
19.14c	Internists	30%	75%
19.14d	Nurse Practitioners	50%	75%
19.14e	Obstetricians/gynecologists	46%	75%
19.14f	Pediatricians	46%	75%
19.14g	Mental Health Care Providers	—	75%

† Appropriate counseling is defined as counseling that is client centered and sensitive to issues of age or developmental stage, gender, race, ethnicity, culture, language, and sexual orientation.

Note: Primary care providers include physicians, nurses, nurse practitioners and physician assistants. Mental health care providers include psychiatrists, psychologists, social workers, psychiatric nurses, and mental health counselors. Areas of high AIDS and sexually transmitted disease incidence are cities and States with incidence rates of AIDS cases, HIV seroprevalence, gonorrhea, or syphilis that are at least 25 percent above the national average.

19.15 Increase to at least 50 percent the proportion of all patients with bacterial sexually transmitted diseases (gonorrhea, syphilis, and chlamydia) who are offered provider referral services. (Baseline: 20 percent of those treated in sexually transmitted disease clinics in 1988)

Note: Provider referral (previously called contact tracing) is the process whereby health department personnel directly notify the sexual partners of infected individuals of their exposure to an infected individual for the purpose of education, counseling, and referral to health care services.

1995 Additions

Risk Reduction Objective

19.16* Increase to at least 40 percent the proportion of ever sexually active adolescents aged 17 and younger who have not had sexual intercourse for the previous 3 months. (Baseline: 23.6 percent of sexually active females aged 15–17 in 1988; 33 percent of sexually active males aged 15–17 in 1988)

Services and Protection Objective

19.17* Increase to at least 90 percent the proportion of students who received HIV and other STD information, education, or counseling on their college or university campus. (Baseline data unavailable)

Immunization and Infectious Diseases

Health Status Objectives

20.1 Reduce indigenous cases of vaccine-preventable diseases as follows:

Disease	*1988 Baseline*	*2000 Target*
Diphtheria among people aged 25 and younger	1	0
Tetanus among people aged 25 and younger	3	0
Polio (wild-type virus)	0	0
Measles	3,058	0
Rubella	225	0
Congenital Rubella Syndrome	6	0
Mumps	4,866	500
Pertussis	3,450	1,000

20.2 Reduce epidemic-related pneumonia and influenza deaths among people aged 65 and older to no more than 15.9 per 100,000. (Baseline: Average of 19.9 per 100,000 during 1979–1987. This represents the average of the eight seasons from the 1979–80 season through the 1986–87 season.)

Note: Epidemic-related pneumonia and influenza deaths are those that occur above and beyond the normal yearly fluctuations of mortality. Because of the extreme variability in epidemic-related deaths from year to year, it will be measured using a 3-year average.

20.3 Reduce viral hepatitis as follows:

(Per 100,000)	*1987 Baseline*	*2000 Target*
Hepatitis B	63.5	40.0
Hepatitis A	33.0	16.0
Hepatitis C	18.3	13.7

Special Population Targets

	Hepatitis B (Number of Cases)	*1987 Baseline*	*2000 Target*
20.3a	Injecting drug users	44,348	7,932
20.3b	Heterosexually active people	33,995	22,663
20.3c	Homosexual men	13,598	4,568
20.3d	Children of Asians/Pacific Islanders	10,817	1,500
20.3e	Occupationally exposed workers	3,090	623
20.3f	Infants (chronic infections)	6,012	1,111
20.3g	Alaska Natives (number of new carriers)	15	1
		1992 Baseline	*2000 Target*
20.3h	Blacks (cases per 100,000)	52.8	40
	Hepatitis A (cases per 100,000)		
20.3i	Hispanics	53.8	27
20.3j	American Indians/Alaska Natives	256.0	128
	Hepatitis C (cases per 100,000)		
20.3k	Hispanics	17.2	13

20.4 Reduce tuberculosis to an incidence of no more than 3.5 cases per 100,000 people. (Baseline: 9.1 per 100,000 in 1988)

Special Population Targets

	Tuberculosis Cases (per 100,000)	*1988 Baseline*	*2000 Target*
20.4a	Asians/Pacific Islanders	36.3	15
20.4b	Blacks	28.3	10
20.4c	Hispanics	18.3	5
20.4d	American Indians/Alaska Natives	18.1	5

20.5 Reduce by at least 10 percent the incidence of surgical wound infections and nosocomial infections in intensive care patients. (Baseline: Device-associated nosocomial infection rates (per 1,000 device days for bloodstream infections, urinary tract infections and pneumonia in medical/coronary ICUs, surgical/medical-surgical ICUs and pediatric ICUs in 1986–90 and surgical wound infection rates (per 100 operations), low-risk patients 1.1, medium low-risk patients 3.2, medium-high-risk patients 6.3, and high-risk patients 14.4 in 1986–90)

20.6 Reduce selected illness among international travelers as follows:

Number of Cases	*1987 Baseline*	*2000 Target*
Typhoid fever	280	140
Hepatitis A	4,475	1,119
Malaria	932	750

20.7 Reduce bacterial meningitis to no more than 4.7 cases per 100,000 people. (Baseline: 6.5 per 100,000 in 1986)

Special Population Target

	Bacterial Meningitis Cases (per 100,000)	*1987 Baseline*	*2000 Target*
20.7a	Alaska Natives	33	8

20.8 Reduce infectious diarrhea by at least 25 percent among children in licensed child care centers and children in programs that provide an Individualized Education Program (IEP) or Individualized Health Plan (IHP). (Baseline: 32 percent in children aged 0 to 6 years and 38 percent in children aged 0 to 3 years in 1991)

20.9 Reduce acute middle ear infections among children aged 4 and younger, as measured by days of restricted activity or school absenteeism, to no more than 105 days per 100 children. (Baseline: 135.4 days per 100 children in 1987)

20.10 Reduce pneumonia-related days of restricted activity as follows:

	1987 Baseline	*2000 Target*
People aged 65 and older (per 100 people)	19.1 days	15.1 days
Children aged 4 and younger (per 100 children)	29.4 days	24 days

Risk Reduction Objectives

20.11 Increase immunization levels as follows: Basic immunization series among children through age 2: at least 90 percent. (Baseline: revised to 54 to 64 percent in 1985)

Basic immunization series among children in licensed child care facilities and kindergarten through postsecondary education institutions: at least 95 percent. (Baseline: For licensed child care, 94–95 percent; 97–98 percent for children entering school for the 1987–1988 school year; and for postsecondary institutions, baseline data unavailable in 1992)

Hepatitis B immunization among high-risk populations, including infants of hepatitis B surface antigen-positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent; injecting drug users in drug treatment programs to at least 50 percent; and men who have sex with men to at least 50 percent. (Baseline: 40 percent of infants of surface antigen-positive mothers in 1991; 37 percent of occupationally exposed workers in 1989; and data are unavailable for injecting drug users and men who have sex with men)

Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people: at least 80 percent. (Baseline data unavailable)

Pneumococcal pneumonia and influenza immunization among noninstitutionalized, high-risk populations, as defined by the Immunization Practices Advisory Committee: at least 60 percent. (Baseline: 14 percent estimated for pneumococcal vaccine and 30 percent for influenza vaccine in 1989)

Special Population Targets

		Influenza Vaccines	*Pneumococcal Vaccines*	
	Percent Immunized	*1991 Baseline*	*1991 Baseline*	*2000 Target*
20.11a	Blacks 65 years and older	27%	14%	60%
20.11b	Hispanics 65 years and older	34%	12%	60%

20.12 Reduce postexposure rabies treatments to no more than 9,000 per year. (Baseline: 18,000 estimated treatments in 1987)

Services and Protection Objectives

20.13 Expand immunization laws for schools, preschools, and day care settings to all States for all antigens. (Baseline: 10–49 States and the District of Columbia depending on the antigen and setting in 1989)

20.14 Increase to at least 90 percent the proportion of primary care providers who provide information and counseling about immunizations and offer immunizations as appropriate for their patients. (Baseline: 68–89 percent of pediatricians, nurse practitioners, and family physicians reported routinely providing immunization services to children; and 4–49 percent of nurse practitioners, obstetricians/gynecologists, internists and family physicians reported routinely providing immunization services to adult patients in 1992)

20.15 Improve the financing and delivery of immunizations for children and adults so that virtually no American has a financial barrier to receiving recommended immunizations. (Baseline: Financial coverage for immunizations was included in 45 percent of employment-based insurance plans with conventional insurance plans; 62 percent with Preferred Provider Organization plans; and 98 percent with Health Maintenance Organization plans in 1989; Medicaid covered basic immunizations for eligible children, and Medicare covered pneumococcal immunization for eligible older adults in 1981 and influenza immunization in 1993)

20.16 Increase to at least 90 percent the proportion of public health departments that provide adult immunization for influenza, pneumococcal disease, hepatitis B, tetanus, and diphtheria. (Baseline: 37 to 70 percent in 1990)

20.17 Increase to at least 90 percent the proportion of local health departments that have ongoing programs for actively identifying cases of tuberculosis and latent infection in populations at high risk for tuberculosis. (Baseline data unavailable)

Note: Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.

20.18 Increase to at least 85 percent the proportion of people found to have tuberculosis infection who completed courses of preventive therapy. (Baseline: 89 health departments reported that 66.3 percent of 95,201 persons placed on preventive therapy completed their treatment in 1987)

20.19 Increase to at least 85 percent the proportion of tertiary care hospital laboratories and to at least 50 percent the proportion of secondary care hospital and health maintenance organization laboratories possessing technologies for rapid viral diagnosis of influenza. (Baseline: 52 percent of tertiary care hospitals; 45 percent of secondary care hospitals, and 69 percent of HMOs in 1993)

Clinical Preventive Services

Health Status Objective

21.1* Increase years of healthy life to at least 65 years. (Baseline: An estimated 64 years in 1990)

Special Population Targets

	Years of Healthy Life	*1990 Baseline*	*2000 Target*
21.1a	Blacks	56	60
21.1b	Hispanics	64.8	65
21.1c	People aged 65 and older	11.9†	14†

†Years of healthy life remaining at age 65

Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure.

Risk Reduction Objective

21.2 Increase the proportion of people who have received selected clinical preventive screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force.

Receipt of Selected Clinical Preventive and Counseling Services

Special and Type-Specific Targets

	1991 Baseline	*2000 Target*
Basic Immunization Series (4 DTP, 3 Polio, and 2 MMR)	55%‡	90%
Children 19–35 months:		
DTP (3 or more doses)	83%‡	
Polio (3 or more doses)	72%‡	
Measles/Mumps/Rubella (1 dose)	83%‡	
Haemophilus influenzae B (3 or more doses)	28%‡	
Hepatitis B (1 dose)	16%§	

Special Population Targets

	1991 Baseline	*2000 Target*
Routine check-up†	74%	91%
People 65 years and over	67%	
*Cholesterol checked in last 5 years**	60%§	75%
*Cholesterol ever checked**	63%	75%
Low-income people	46%	
Blacks*	56%	
Hispanics	51%	
American Indians/Alaska Natives*	46%	

	1991 Baseline	*2000 Target*
Cholesterol checked in last 2 years	50%	75%
Low-income people	37%	
Hispanics	42%	
Asians/Pacific Islanders	45%	
American Indians/Alaska Natives	38%	
Tetanus booster in last 10 years	52%	62%
People 65 years and over	29%	
Hispanics	45%	
Asians/Pacific Islanders	40%	
People with disabilities	47%	
Pneumococcal vaccine in lifetime (Aged 65 and over)	21%	60%
Low-income people	17%	
Blacks*	14%	
Hispanics*	12%	
Asians/Pacific Islanders	15%	
*Influenza vaccine in last year (Aged 65 and over)**	42%	60%
Low-income people	36%	
Blacks*	27%	
Hispanics*	34%	
Asians/Pacific Islanders	29%	
Pap test in last 3 years		
Women aged 18 and over	74%‡	85%
Women aged 65 and over	51%‡	
Asians/Pacific Islanders	62%‡	
American Indians/Alaska Natives	64%‡	
Women with disabilities	65%‡	
Breast exam and mammogram in past 2 years		
Women 50 years and over	51%‡	60%
Women aged 65 and over	43%‡	
Low-income women	30%‡	
Asians/Pacific Islanders	38%‡	
American Indians/Alaska Natives	31%‡	
Women with disabilities	44%‡	
Counseling services††	56%	
People aged 65 and over	42%	80%
Asians/Pacific Islanders	51%	

Note: Baselines and targets for total population (18 years and over); special populations have more than a 10 percent disparity with the total population.

†In the last 3 years for people aged 18–64 and in the last year for people aged 65 and older ‡1992 data §1993 data ††For people aged 18–64, counseling is defined as a screening question on at least one of the following: diet, physical activity, tobacco use, alcohol use, drug use, sexually transmitted diseases, contraceptive use in the past 3 years. For people aged 65 and over, counseling on at least one of: diet, physical activity, tobacco use, alcohol use in the past year.

Services and Protection Objectives

21.3 Increase to at least 95 percent the proportion of people who have a specific source of ongoing primary care for coordination of their preventive and episodic health care. (Baseline: 80 percent in 1991)

Special Population Targets

	Percentage With Source of Care	*1991 Baseline*	*2000 Target*
21.3a	Hispanics	63%	95%
	Mexican Americans	57%	95%
21.3b	Blacks	78%	95%
21.3c	Low-income people	71%	95%
21.3d	American Indians/Alaska Natives	70%	95%
21.3e	Asians/Pacific Islanders	70%	95%

Note: Since 1991, the emergency room has not been counted as a regular source for primary care services. 21.3a breaks out only Mexican Americans since the rates for Puerto Ricans and Cubans are similar to the total population.

21.4 Improve financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline: 16 percent of people aged 65 and under in 1989)

Special Population Targets

	Proportion of People Without Health Care Coverage (People Under 65 Years)	*1989 Baseline*	*2000 Target*
21.4a	American Indians/Alaska Natives	36%	0%
21.4b	Hispanics	31%	0%
	Mexican Americans	38%	0%
	Puerto Ricans	21%	0%
	Cubans	21%	0%
21.4c	Blacks	22%	0%

21.5 Ensure that at least 90 percent of people for whom primary care services are provided directly by publicly funded programs are offered, at a minimum, the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline: 10–100 percent for screening recommendations; 40–100 percent or counseling recommendations; 10–96 percent for immunizations in 1991–92)

Note: Publicly funded programs that provide primary care services directly include federally funded programs such as the Maternal and Child Health Program, Community and Migrant Health Centers, and the Indian Health Service as well as primary care service settings funded by State and local governments. This objective does not include services covered indirectly through the Medicare and Medicaid programs.

21.6 Increase to at least 50 percent the proportion of primary care providers who provide their patients with the screening, counseling, and immunization services recommended by the U.S. Preventive Services Task Force. (Baseline: 4–96 percent of pediatricians, nurse practitioners, family physicians, internists, and obstetricians/gynecologists reported routinely providing recommended services to patients in 1992)

21.7 Increase to at least 90 percent the proportion of people who are served by a local health department that assesses and assures access to essential clinical preventive services. (Baseline: proportion of local health departments that assess the extent to which clinical preventive services are provided in jurisdiction—76 percent; proportion of local health departments that collect data to document the number of providers of clinical preventive services—45 percent; proportion of local health departments that evaluate the availability of and need for clinical preventive services—57 percent; of these, the proportion that provide programs to fill gaps—83 percent in 1992)

Note: Local health department refers to any local component of the public health system, defined as an administrative and service unit of local or State government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than a State.

21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

Degrees Awarded To	*1985–86 Baseline*	*2000 Target*
Blacks	5%	8.0%
Hispanics	3%	6.4%
American Indians/Alaska Natives	0.3%	0.6%

Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hispanics, and American Indians and Alaska Natives.

21.8a Increase the proportion of individuals from underrepresented racial and ethnic minority groups enrolled in U.S. schools of nursing.

Proportion Enrolled in fall Academic Year[*]	*1991–92 Baseline*	*2000 Target*
Blacks	9.1%	10%
Hispanic	3.1%	4%
Asians/Pacific Islanders[†]	2.9%	5%
American Indians/Alaska Natives	0.7%	1%

[*]Enrollment figures have been shown to be statistically predictive of graduating rates.

[†]The Asians/Pacific Islanders special population target is important because at this time the majority of Asian/Pacific Islander nurses in the United States is foreign-educated. Since this subobjective refers to preparing nurses in this country, it is appropriate to consider these nurses as an underrepresented minority.

Surveillance and Data Systems

Health Status Objectives

22.1 Develop a set of health status indicators appropriate for Federal, State, and local health agencies and establish use of the set in at least 40 States. (Baseline: Set developed in 1991)

22.2 Identify, and create where necessary, national data sources to measure progress toward each of the year 2000 national health objectives. (Baseline: 77 percent of the objectives have baseline data in 1990)

		Type-Specific Target	
		1995 Baseline	*2000 Target*
22.2a	Identify, and create where necessary, State level data for at least two-thirds of the objectives in State year 2000 plans	42 States	50 States

22.3 Develop and disseminate among Federal, State, and local agencies procedures for collecting comparable data for each of the year 2000 national health objectives and incorporate these into Public Health Service data collection systems. (Baseline: 12 percent of objectives in 1990)

22.4* Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline data unavailable)

Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.

22.5 Implement in all States periodic analysis and publication of data needed to measure progress toward objectives for at least 10 of the priority areas of the national health objectives. (Baseline: 20 States reported that they disseminate the analyses they use to assess State progress toward the health objectives to the public and to health professionals in 1989)

		Type-Specific Target	
		1992 Baseline	*2000 Target*
22.5a	Periodic analysis and publication of State progress toward the national or State-specific objectives for each racial or ethnic group that makes up at least 10 percent of the State population	19 States	50 States

Note: Periodic is at least once every 4 years. Objectives include, at a minimum, one from each objectives category: health status, risk reduction, and services and protection.

22.6 Expand in all States systems for the transfer of health information related to the national health objectives among Federal, State, and local agencies. (Baseline: 30 States reported that they have some capability for transfer of health data, tables, graphs, and maps to Federal, State, and local agencies that collect and analyze data in 1989)

Note: Information related to the national health objectives includes State and national level baseline data, disease prevention/health promotion evaluation results, and data generated to measure progress.

22.7 Achieve timely release of national surveillance and survey data needed by health professionals and agencies to measure progress toward the national health objectives. (Baseline: 65 percent of data released within 1 year of collection and 24 percent of data were released between 1 and 2 years of collection in 1994)

Note: Timely release (publication of provisional or final data or public use data tapes) should be based on the use of the data, but is at least within 1 year of the end of data collection.

Age-Related Objectives

*Reduce the death rate for children by 15 percent to no more than 28.6 per 100,000 children aged 1–14, and for infants by approximately 30 percent to no more than 7 per 1,000 live births. (Baseline: 33.7 per 100,000 for children in 1987 and 10.1 per 1,000 live births for infants in 1987)

Reduce the death rate for adolescents and young adults by 15 percent to no more than 83.1 per 100,000 people aged 15–24. (Baseline: 97.8 per 100,000 in 1987)

Reduce the death rate for adults by 20 percent to no more than 341.5 per 100,000 people aged 25–64. (Baseline: 426.9 per 100,000 in 1987)

*Reduce to no more than 90 per 1,000 people the proportion of all people aged 65 and older who have difficulty in performing two or more personal care activities (a reduction of about 19 percent), thereby preserving independence. (Baseline: 111 per 1,000 in 1984–85)