

Chapter 4

CHRONIC DISEASE

Chronic Disease

What is it?

A chronic disease or condition is one that lasts for a long time. Most chronic diseases cannot be prevented by vaccines or cured by medication.^{1,2} The National Center for Health Statistics defines chronic conditions as conditions not cured once acquired or conditions that have been present three months or longer.³ Chronic diseases require long term treatment and management since they do not go away. The most common chronic diseases in the United States are cardiovascular disease, cancer, and diabetes. All are more common among older people.^{4,5} Most chronic diseases are not caused by infection. However, some infectious diseases, such as HIV/AIDS, are also chronic because they are life-long conditions. The National Center for Chronic Disease Prevention and Health Promotion targets those chronic diseases that are preventable and carry a high cost to society in terms of death, disability, and health care dollars.⁴

Why is it important?

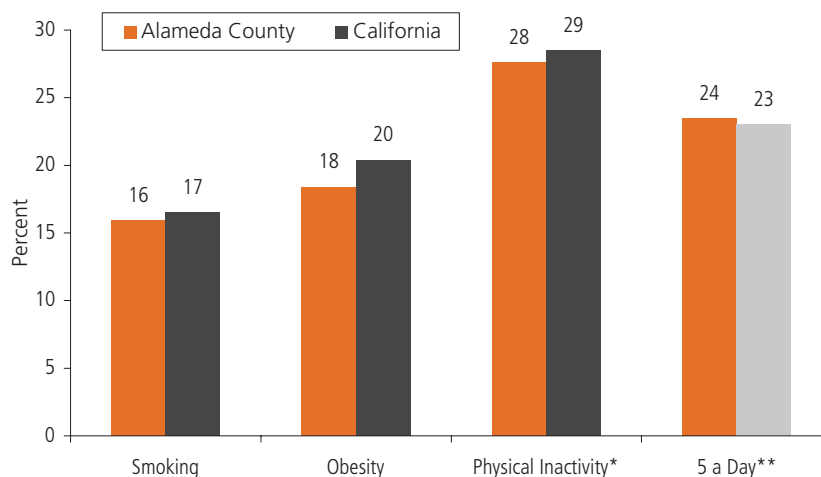
Chronic diseases, such as heart disease, cancer, and diabetes, are responsible for seven of every ten deaths in the United States. They are the leading cause of disability and death in the United States, claiming the lives of more than 1.7 million Americans per year and causing major limitations in activities of daily living for more than one in ten Americans. Chronic diseases account for 75% of the \$1 trillion spent on health care each year in the United States.^{5,6}

Although chronic diseases are among the most prevalent and costly health problems, they are also among the most preventable. Access to prevention and health care services affect chronic disease burden and outcome. To a large degree, the major chronic diseases—heart disease, cancer, stroke, chronic obstructive pulmonary disease, and diabetes—result from our lifestyles and our habits of daily living. Health-damaging behaviors include tobacco use, lack of physical activity, and poor eating habits.^{5,6}

Research has shown that there are major race/ethnic inequities in chronic disease burden and risk factors. Socioeconomic status is also an important determinant of chronic disease risk. People who are poor, have lower levels of education, or are isolated are more likely to engage in a wide array of risk-related behaviors. The social environment influences risk behaviors through the shaping of norms, patterns of social control, or environmental opportunities that determine individual behavior choices.^{3,5,7,8} Additionally, the social environment can impact people in ways that go beyond individual behavior choice. These can include factors which individuals may have little control over and can impact the health of entire communities, such as: exposure to environmental hazards, lack of access to quality education, and lack of clean and affordable housing (see Chapter 2).

What are the behavioral risk factors for chronic disease?

Figure 4.1: Select Chronic Disease Risk Factors Among Adults, Alameda County and California, 2003



Source: CAPE; California Health Interview Survey 2001 and 2003.
(*)=CHIS 2001 data (**)=California data not comparable; US shown in gray

Cigarette Smoking

It is estimated that in the United States, the health effects of smoking cause about 440,000 deaths each year, or roughly 20% of all deaths. Smoking increases the risk for a variety of cancers, heart disease, stroke, and lung disease.⁹

Cigarette smoking affects the health of nonsmokers as well. Nonsmoking adults exposed to second-hand smoke have an increased risk of lung cancer and coronary heart disease. Children are particularly vulnerable to the effects of environmental smoke because their lungs are not fully developed. Exposed children have a higher risk of sudden infant death syndrome, asthma, bronchitis, and pneumonia.¹⁰

In 2004, 21% of US adults were current smokers.¹¹ Men are more likely to smoke than women. American Indians, Hispanics, and Asian/Pacific Islanders (API) are less likely to smoke than other race/ethnic groups in the US. Cigarette smoking is about twice as common among the poor as among more affluent persons.⁸ The Healthy People 2010 objective (HP2010) is to reduce the percentage of current smokers to 12% or less among adults.¹²

In 2003, 17% of California adults were current smokers, about the same proportion as in Alameda County (16%).¹³ Twenty five percent of African Americans in the county reported being current smokers, a significantly higher proportion than Asians (11%) or Whites (15%), and slightly higher proportion than Latinos (19%). Smoking prevalence was highest among those with lower levels of education and lower income levels.

Obesity

Obesity is caused by a complex set of inter-related factors—nutritional, behavioral, and environmental. Genetic predisposition toward obesity plays a role as well.¹⁴ There is widespread agreement that obesity is associated with a higher risk of illness and death due to diabetes, hypertension, coronary heart disease, stroke, and some cancers.¹⁵ Being overweight in childhood is linked to several health problems that can last into adulthood. These include poor heart health (e.g. hypertension, high cholesterol), Type 2 diabetes, and impaired mental health (depression, low self-esteem).¹⁶

Today, 20% to 30% of adults in the United States are obese—double the estimates from ten years before. The prevalence of overweight among youth 6 to 17 years old has more than tripled since the 1960s to over 15% in 2000.¹⁷ The HP2010 objective is to reduce the proportion of adults who are obese to 15% or less.¹²

In 2003, 20% of California adults were obese, close to the prevalence in Alameda County (18%). African Americans had the highest obesity prevalence— 32% or three times that among Asian/Pacific Islanders (9%).¹³ Twenty-six percent of Latinos and 17% of Whites were obese in the county. The prevalence of obesity prevalence was higher among those with lower levels of education as well as among those at higher levels of poverty.

Physical Activity and Diet

Physical activity, along with a healthy diet plays an important role in the prevention of overweight and obesity.³ The combination of inactivity and unhealthy dietary pattern has an impact on obesity, and has been ranked as the second leading factor contributing to mortality in the US after tobacco use.¹⁸

Physical activity can take many forms and fitness can be achieved in different ways. Some people exercise regularly in their leisure time while others are employed to do manual labor and choose to relax during leisure time. Regular physical activity has been shown to protect against death from coronary heart disease, and reduce the risk of colon cancer, diabetes, and hypertension. It also helps to control weight, maintain healthy bones, joints, and muscle tone, reduce arthritis pain, and reduce anxiety and depression. Sedentary individuals can improve their health by increasing their physical activity. Research has shown that physical activity need not be strenuous to be beneficial.¹⁹ The HP2010 objective is to reduce the prevalence of physical inactivity among adults to 20% or lower.¹²

According to the 2003 National Health Interview Survey, 33% of US adults reported getting regular physical activity, and 38% reported being physically inactive.³ The proportion of adults reporting no leisure time physical activity is higher among women than men, among Hispanics than among Whites, among older than younger adults, and among the less affluent.⁸

In 2001, 29% of California adults and 28% of Alameda County adults reported no moderate or vigorous physical activity at all.²⁰ In the county, Latinos were twice as likely as Whites to be physically inactive (40% compared to 19%). Thirty five percent of Asians and 27% of African Americans were physically inactive. The percentage of people who reported being physically inactive was higher among those with lower income and education levels.

Research shows that good nutrition can help to lower people's risk for many chronic diseases, including heart disease, stroke, some cancers, diabetes, and osteoporosis.¹⁹ Numerous studies have shown

that diets rich in fruits and vegetables are associated with reduced risk of several chronic diseases.²¹ However, a large gap remains between recommended dietary patterns and what Americans actually eat. One measure of a healthy diet is number of servings of fruits and vegetables consumed in a day. Less than one-fourth of U.S. adults (23%) eat the recommended five or more servings of fruits and vegetables each day.¹⁹

As with adults nationally, about one-fourth of Alameda County adults reported eating the recommended five or more servings of fruits or vegetables a day.^{13,22} In 2003, 29% of Whites reported consuming five a day, a significantly higher percentage than Latinos or African Americans (17%), and a slightly higher percentage than Asians. Consumption of five a day was higher among those with higher education and income levels.

Coronary Heart Disease

What is it?

Coronary heart disease (CHD) develops when the arteries of the heart become narrowed or clogged and cannot supply enough blood to the heart. These coronary arteries carry oxygen-rich blood and nutrients to the heart muscle. Coronary heart disease usually results from the build up of fatty material and plaque (atherosclerosis) in the inner layer of the walls of the coronary arteries. If the blood supply to the heart muscle is inadequate, a person can experience chest pain or pressure called angina. A heart attack (myocardial infarction) occurs when the blood supply to parts of the heart muscle is cut off completely.^{1,2}

Why is it important?

Several risk factors for coronary heart disease can be modified through lifestyle changes. The risk of developing CHD can be reduced significantly through a healthy diet, regular exercise, reducing stress level, and not smoking, in addition to reducing or controlling high blood pressure, high blood cholesterol, and diabetes. Socioeconomic status, environment, and culture are also important risk factors in the development of the disease.³⁻⁵

Deaths from all types of heart disease have declined steadily over the past 50 years, mostly from better medical treatment and effective prevention efforts to reduce controllable risk factors such as hypertension, smoking, high blood cholesterol, and physical inactivity.³ Most deaths from heart disease are due to CHD. Other forms of heart disease include hypertensive heart disease and rheumatic heart disease.⁶

CHD is the most common cause of death in the United States, accounting for more than one of every five deaths. About 335,000 people per year die of CHD before ever being hospitalized. Most of these are sudden deaths caused by cardiac arrest.⁷

It is estimated that 13 million people in the United States, about 6.9% of the population 18 years and older, have CHD. In 2003, the age-adjusted death rate nationally was 162.6 per 100,000 population.⁸ In California it was 175.9 for the period 2001-2003.⁹ National rate met the HP2010 objective of 166 or fewer CHD deaths per 100,000, while the California rate still exceeded the HP2010 objective.³

From 1992 to 2002, the U.S. death rate from CHD declined 26.5%. More than 83% of people who died of CHD were 65 years and older. Approximately 11.5 years of life were lost on average due to heart attack.⁷ African American males had the highest CHD death rate (251 per 100,000), followed by White males (221), African American females (170), and White females (131).⁷

CHD occurs more often in men than in women. It is the leading cause of premature and permanent disability among U.S. workers, and accounts for 19% of social security's disability allowances.^{6,10,11} About two-thirds of heart attack patients do not make a complete recovery, but 88% of those less than 65 years are able to return to their usual work.⁶

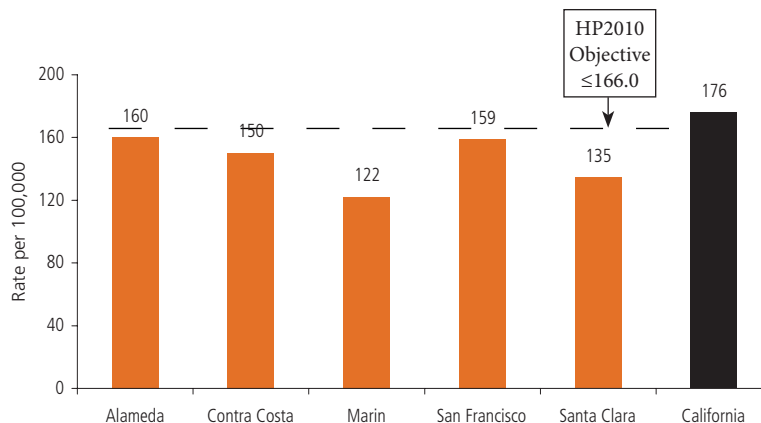
What is Alameda County's status?

Coronary Heart Disease Mortality

From 2001 to 2003, an average of 2,033 people per year died from CHD in Alameda County. The CHD mortality rate was 160 per 100,000 people.

Alameda County's death rate from CHD was higher than its four Bay Area neighbors for the three year period 2001 to 2003. However, the rate was significantly higher than only two counties, Marin and Santa Clara, and it was lower than the California rate. Alameda County, as well as its neighbors, have met the HP2010 national objective of 166 or fewer CHD deaths per 100,000 people.

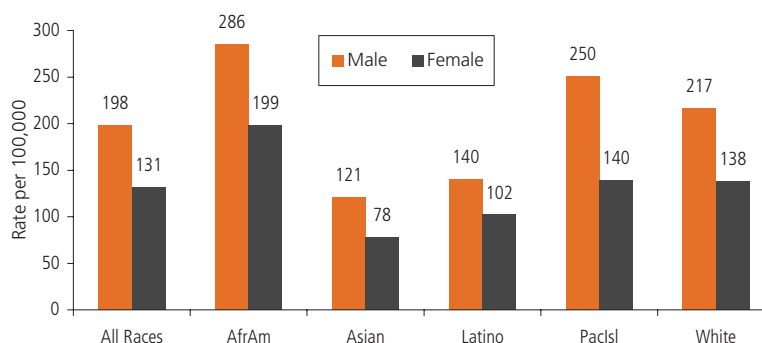
Figure 4.2: Coronary Heart Disease Mortality, Selected Counties and California, 2001-2003



Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

Both African American males and females experienced higher CHD mortality than any other race/ethnic group. Pacific Islander males were also noted for higher CHD mortality rate after African American males. Among African Americans, both male and female rates were more than twice the corresponding rates for Asians and Latinos. Males had 40-80% higher rates than females for every group. Among females, all groups except African Americans have met the HP2010 objective of no more than 166 deaths per 100,000 people. Among males, Asians and Latinos were the only groups to have met the HP2010 objective.

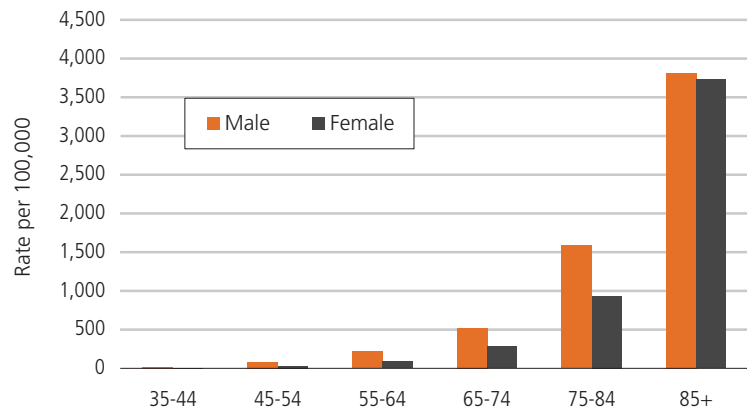
Figure 4.3: Coronary Heart Disease Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Very few deaths occurred in Alameda County under the age of 35. After age 35, CHD mortality increased with age. Between the ages of 35 and 64, the rate was two to three times higher for males than females. For the 85 and older age group, there was no gender difference.

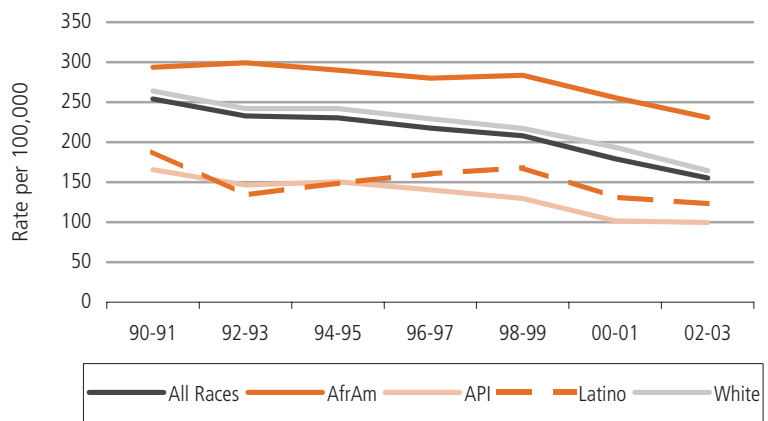
Figure 4.4: Coronary Heart Disease Mortality by Age and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Rates of death from CHD have declined significantly during the last decade for every race/ethnic group except Latinos. For the entire population, CHD mortality declined 7% per year from 1998 to 2003. Declines were greatest among Whites and APIs. For all groups, the most noteworthy declines have been in recent years.

Figure 4.5: Coronary Heart Disease Mortality by Race/Ethnicity, Alameda County, 1990-2003



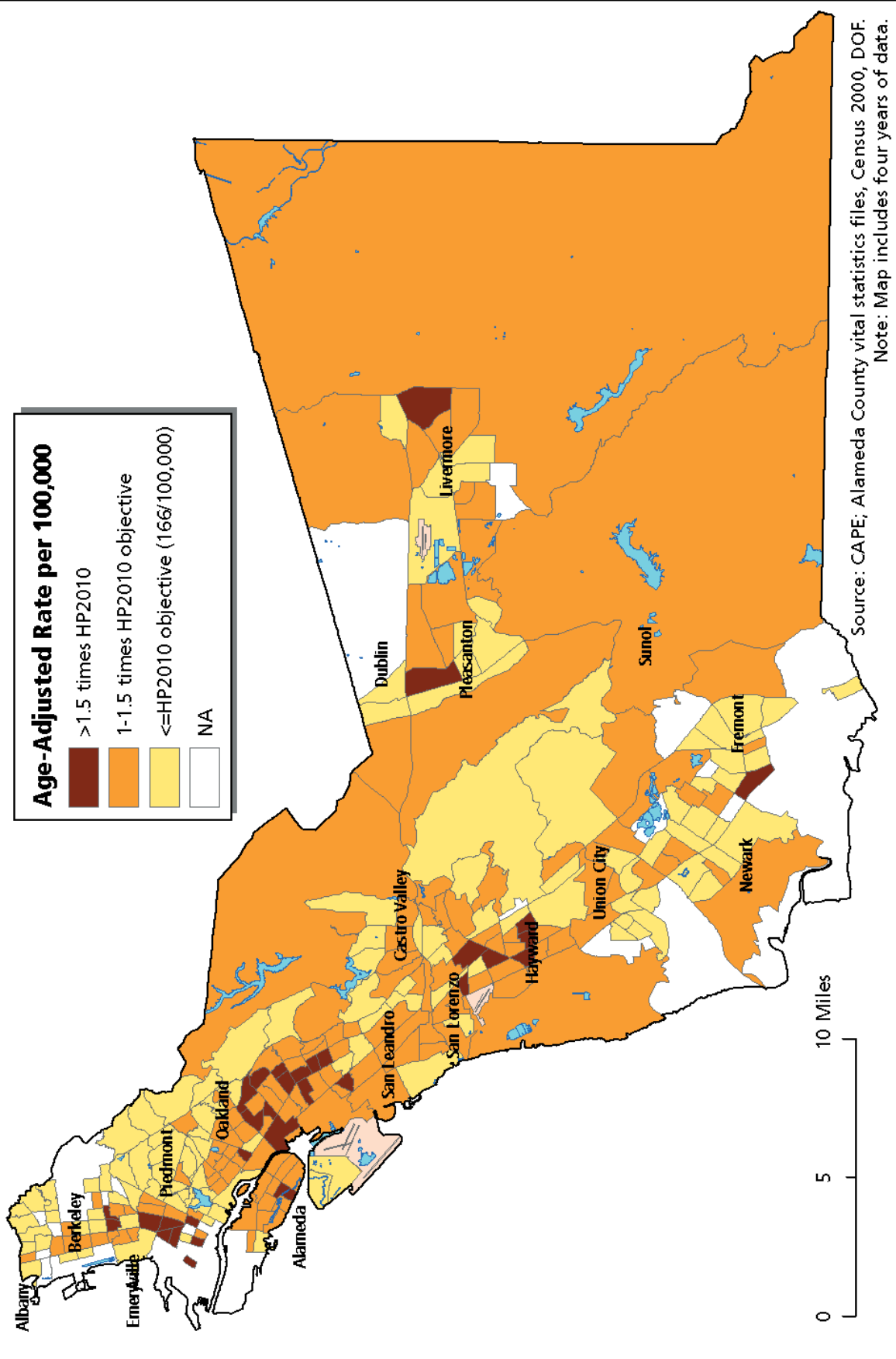
Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

African American CHD mortality has been consistently higher than any other group throughout the past decade. The disparities in rates between African Americans and other race/ethnic groups have increased over the decade. In 1990-91 the African American rate was 16% higher than the county rate; in 2002-03 it was 50% higher. The gap between African Americans and APIs increased even more.

Map 2: Coronary Heart Disease Mortality

While the county as a whole has met the HP2010 objective of 166 or fewer CHD deaths per 100,000 population, CHD mortality in many parts of Alameda County exceeds that target. The areas with CHD mortality below the objective are predominantly in the Oakland/Berkeley hills and scattered areas in south and east county. The areas with CHD mortality at least 50% above the objective are located in predominantly poorer census tracts in South Berkeley, North, West, and East Oakland, Alameda, San Lorenzo, Hayward, Fremont, Pleasanton, and Livermore.

Map 2: Coronary Heart Disease Mortality, Alameda County, 2000-2003



Coronary Heart Disease Hospitalization

From 2001 to 2003, an average of 16,653 hospitalizations per year for CHD-related illnesses occurred in Alameda County. The rate was 1,305 per 100,000 people. For all racial groups combined, the male CHD hospitalization rate was 65% higher than the female rate. The gender difference was largest for Whites, with the male rate 81% higher than the female rate, and lowest for American Indians (5%) and African Americans (16%).

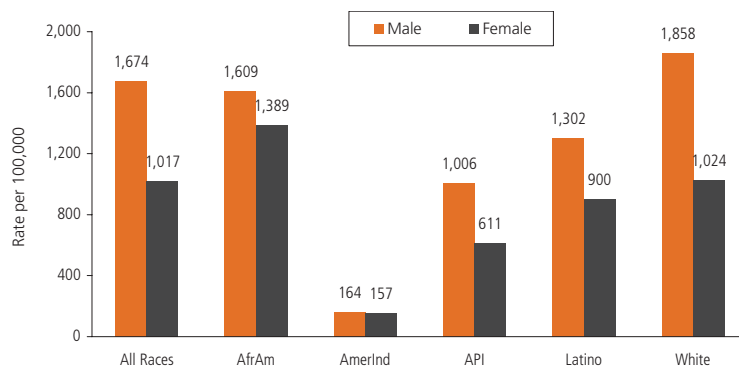
White males had the highest rate of CHD hospitalization, followed by African American males. African American female and Latino male rates were also high. The lowest rates were seen among American Indians.

The rate of CHD hospitalization increased with age. In Alameda County, rates were higher for men in every age group. Between the ages of 35 and 64, male rates were two times female rates. After 65 years of age, the gender differences were smaller.

Hospitalization due to CHD in Alameda County has declined in every race/ethnic group in recent years. For African Americans and APIs, significant increases throughout most of the 1990s were followed by significant declines. The only steady decline over the period was among American Indians. The Latino rate did not change significantly over the decade.

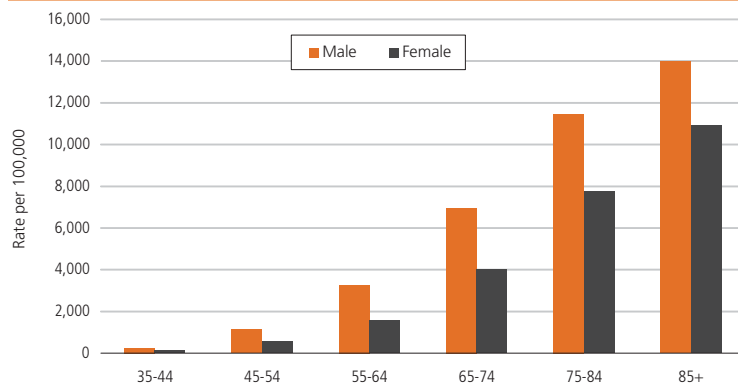
African Americans continue to have the highest rate of CHD hospitalization of any race/ethnic group. Their rate was 20% higher than the county rate in 1996-97, but that difference dropped to 12% in 2002-03.

Figure 4.6: Coronary Heart Disease-Related Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003



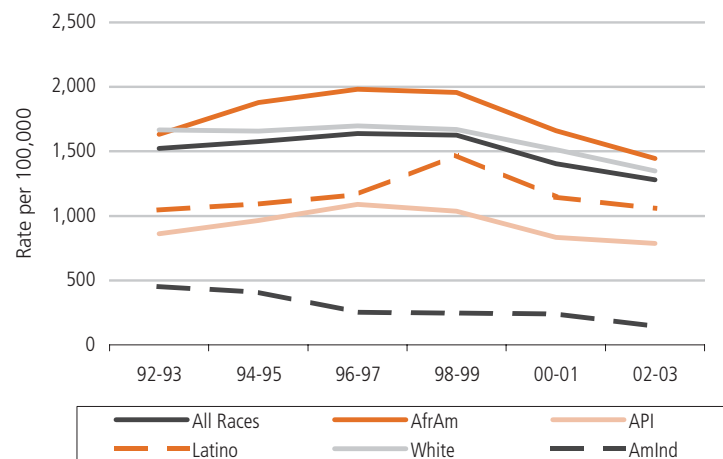
Source: CAPE; OSHPD, Census 2000, DOF.

Figure 4.7: Coronary Heart Disease-Related Hospitalization by Age and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Figure 4.8: Coronary Heart Disease-Related Hospitalization by Race/Ethnicity, Alameda County, 1992-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Stroke

What is it?

A stroke occurs when the blood supply to the brain is cut off or when a blood vessel bursts. Within a few minutes of being deprived of oxygen, brain cells begin to die. Death or permanent disability can result.

There are two main types of stroke: ischemic and hemorrhagic. Most strokes are of the ischemic type. Ischemic stroke is caused by blockage in an artery that supplies blood to the brain, resulting in a deficiency in blood flow. Ischemic stroke develops in major blood vessels on the brain's surface or in small blood vessels deep in the brain. During ischemic stroke, diminished blood flow initiates a series of events (called ischemic cascade) that may result in additional, delayed damage to brain cells. Early emergency medical intervention helps to lessen damage to the brain and subsequent disability.^{1,2}

Hemorrhagic stroke starts with the rupture of a blood vessel in the brain. Bleeding from the rupture compresses nearby blood vessels, depriving surrounding tissue of oxygen and causing stroke. Hemorrhagic stroke usually affects a large area of the brain, many times leading to death.^{1,2} Hypertension is the most common cause of hemorrhagic stroke. Strokes in young adults tend to be hemorrhagic.

Why is it important?

Stroke is the third leading cause of death in the United States. It also is a leading cause of serious, long-term disability. About 700,000 people experience a new or recurrent stroke each year. Death rates from stroke have declined steadily since the early part of the twentieth century.³⁻⁵ From 1992 to 2002 the U.S. death rate from stroke declined 13.8%.⁴

Nationally, the age-adjusted rate of death from stroke in 2003 was 53.6 per 100,000 population.⁶ The California rate was 53.3.⁷ These rates exceeded the HP2010 objective of no more than 48.0.⁵ Because women live longer than men, more women than men die of stroke each year. Women accounted for 61.5% of U.S. stroke deaths in 2002.⁸

In 2002, of all race/ethnic groups, African American males and females had the highest rates of death from stroke (81.7 and 71.8 per 100,000), followed by White males and females (54.2 and 53.4).⁸ The African American rate in California was 80.0, higher than the national rate of 76.3. Both were higher than their respective White rates, 55.4 in California and 54.2 nationally.^{4,7,8}

High blood pressure, diabetes, smoking, and having had a previous stroke or heart attack increase a person's chances of having a stroke. Maintaining healthy blood pressure through diet, exercise, and medication, if necessary, can decrease the risk for stroke.^{1,5}

What is Alameda County's status?

Stroke Mortality

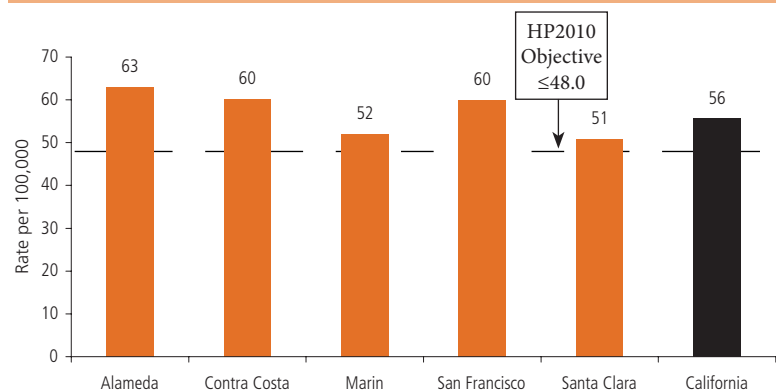
From 2001 to 2003, an average of 801 people per year died from stroke in Alameda County. The stroke mortality rate was 63 per 100,000 people.

Alameda County's death rate from stroke was higher than its four Bay Area neighbors for the three year period 2001 to 2003. However, the rate was significantly higher than only two counties, Marin and Santa Clara, as well as California. None of the five neighboring counties, nor the state, have met the HP2010 national objective of 48 or fewer stroke deaths per 100,000 people.

African American males experienced about 70-90% higher stroke mortality rate than any other race/ethnic group. No significant differences in stroke mortality were observed by gender for any race/ethnic group. None of the gender/racial groups has met the HP2010 objective, though rates for Asian and Latino females were close.

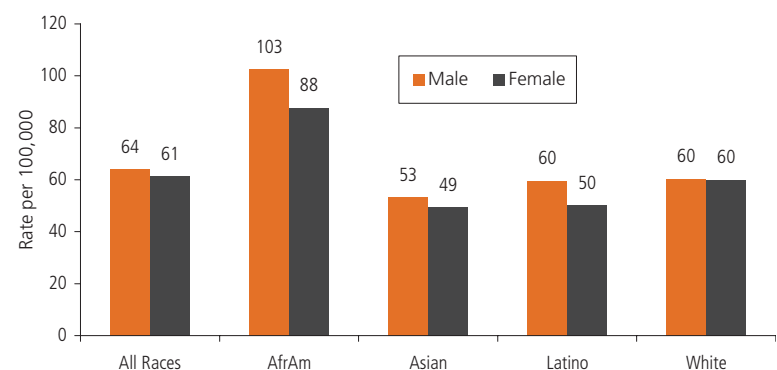
Stroke mortality increased with age starting at about 45 years. Rates were only slightly higher among males than females until age 85 when the female rate exceeded the male rate by 18%.

Figure 4.9: Stroke Mortality, Selected Counties and California, 2001-2003



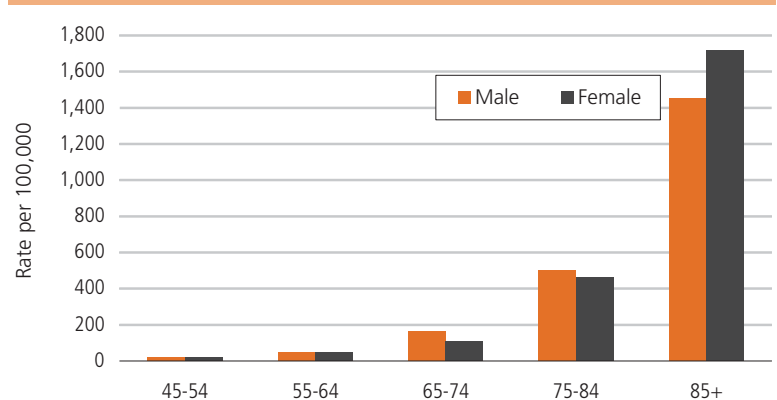
Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

Figure 4.10: Stroke Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Figure 4.11: Stroke Mortality by Age and Gender, Alameda County, 2001-2003

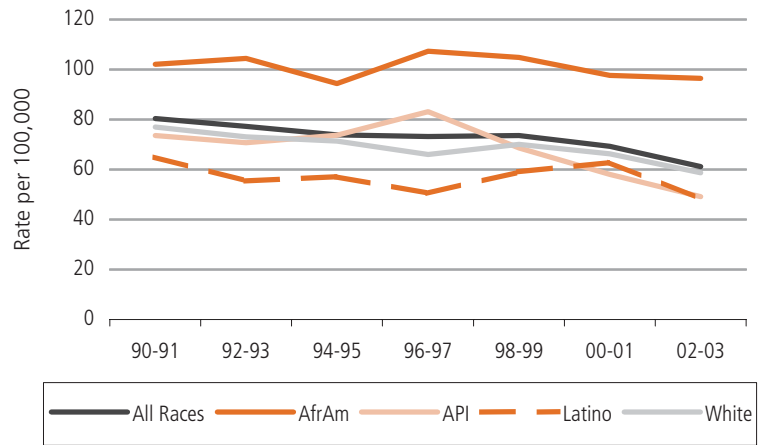


Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Stroke mortality for the county, as well as for Whites, has declined about 2% per year over the past decade. Rates among APIs dropped sharply after 1997 by about 8% per year. Both African American and Latino rates were variable, showing recent declines but no clear trend.

African American stroke mortality has been consistently higher than any other race/ethnic group throughout the decade. The disparities in rates between African Americans and the other race/ethnic groups have increased over the decade. In 1990-91 the African American rate was 27% higher than the county rate; in 2002-03 it was 58% higher. Relative to Latinos, the gap increased from 57% in 1990-91 to 100% in 2002-03.

Figure 4.12: Stroke Mortality by Race/Ethnicity, Alameda County, 1990-2003



Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

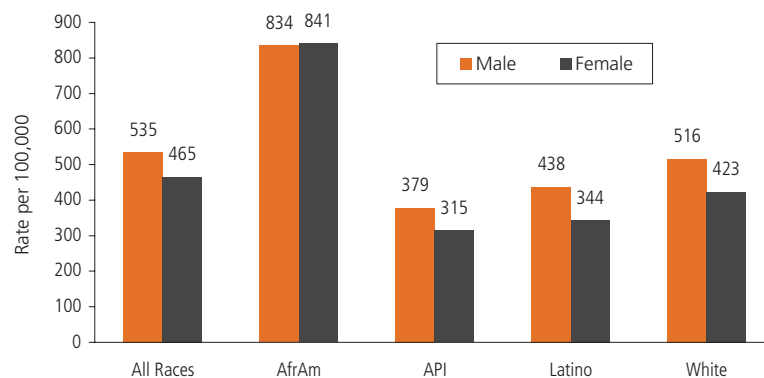
Stroke Hospitalization

From 2001 to 2003, an average of 6,333 hospitalizations per year for stroke-related illnesses occurred in Alameda County. The rate was 496 per 100,000.

African Americans had the highest rate of stroke hospitalization, and they are unique from other race/ethnic groups in that the female rate was essentially the same as the male rate. Among API, Latinos and Whites, male rates were significantly higher than female rates.

Compared to APIs, who had the lowest rate of stroke hospitalization, the rate for African Americans was 2.2 to 2.7 times higher.

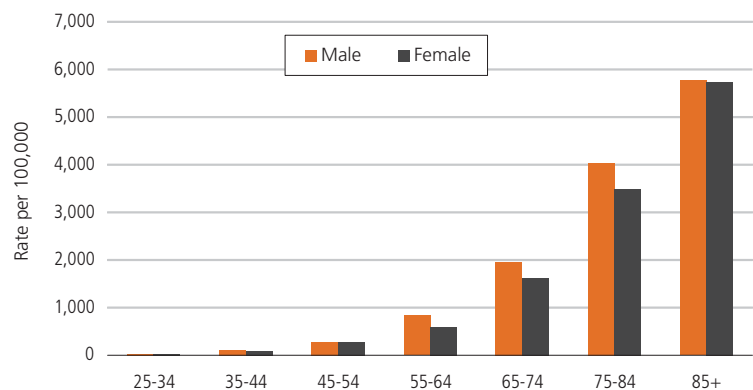
Figure 4.13: Stroke-Related Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Hospitalization for stroke is very uncommon prior to age 55. Rates increased substantially with age. In Alameda County, male rates were markedly higher than female rates between the ages of 55 and 84.

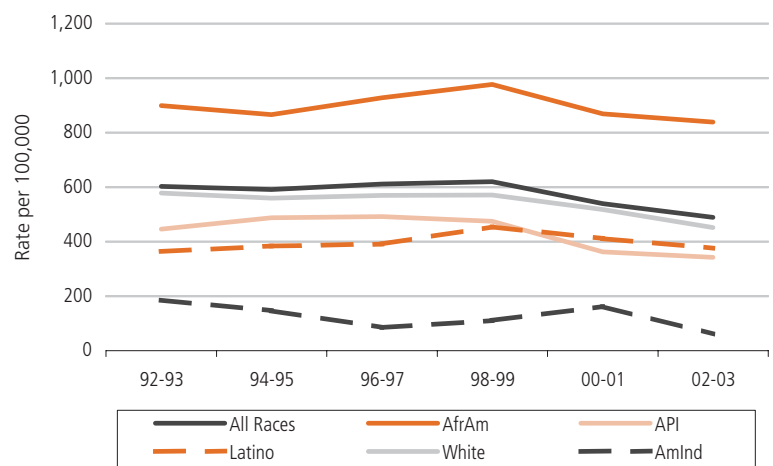
Figure 4.14: Stroke-Related Hospitalization by Age and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Rates of stroke hospitalization for the county were unchanged throughout the 1990s and then declined approximately 6% per year between 1998 and 2003. The pattern for Whites was similar. African Americans, APIs and American Indians also experienced declines, but these were not statistically significant. The Latino rate remained unchanged throughout the period.

Figure 4.15: Stroke-Related Hospitalization by Race/Ethnicity, Alameda County, 1992-2003



Source: CAPE; OSHPD, Census 1990 and 2000, DOF.

Despite a recent decline, African Americans continue to have the highest rate of stroke hospitalization compared to other race/ethnic groups. The gap between African Americans and the county grew over the decade, with the African American rate approximately 50% higher than the county in the early 1990s increasing to 72% higher by 2002-2003.

Diabetes

What is it?

Diabetes mellitus is a chronic disease in which the body does not produce or properly use insulin, which can lead to blood glucose (sugar) levels that are too high. This is generally due to the body's inability to produce insulin (the hormone produced by the pancreas to regulate blood sugar) or use it properly. There are two main types of diabetes, type 1 and type 2:

Type 1 diabetes was previously called insulin-dependent diabetes mellitus or juvenile-onset diabetes. It develops when the body's immune system destroys pancreatic beta cells, the only cells in the body that make the hormone insulin that regulates blood glucose. This form of diabetes usually strikes children and young adults, although disease onset can occur at any age. Type 1 diabetes may account for 5% to 10% of all diagnosed cases of diabetes. Risk factors for type 1 diabetes may include autoimmune, genetic, and environmental factors.

Type 2 diabetes was previously called non-insulin-dependent diabetes mellitus or adult-onset diabetes. Type 2 diabetes may account for about 90% to 95% of all diagnosed cases of diabetes. It usually begins as insulin resistance, a disorder in which the cells do not use insulin properly. As the need for insulin rises, the pancreas gradually loses its ability to produce insulin. Type 2 diabetes is associated with older age, obesity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity. African Americans, Latinos, American Indians, and some Asian Americans and Native Hawaiians or Other Pacific Islanders are at particularly high risk for type 2 diabetes. Type 2 diabetes is increasingly being diagnosed in children and adolescents.^{1,2}

Why is it important?

Diabetes requires rigorous management to reduce the risk of serious complications and premature death. It contributes to a variety of medical problems, including heart disease, stroke, high blood pressure, blindness, kidney disease, diseases of the nervous system, amputations, dental problems, and complications of pregnancy.¹

Diabetes was the sixth leading cause of death in the United States in 2002.³ The CDC estimates that in year 2005, nearly 21 million people of all ages, about 7.0% of the population, have diabetes. Most of these are adults aged 20 years and older. Approximately 6.2 million of these have yet to be diagnosed.^{1,2,4} The number of U.S. adults with diagnosed diabetes has increased 61% since 1991 and is projected to more than double by 2050.^{5,6}

In 2005, it is estimated that about 1.5 million adults 20 years and older were newly diagnosed with diabetes.^{1,5} While diabetes is most common among those 65 years and older, the rate of type 2 diabetes in children and adolescents has been increasing, especially among people of color.⁷

It is estimated that 15.1% of adult American Indians have diabetes, 13.3% of African Americans, 9.5% of Latinos, and 8.7% of Whites.¹ The prevalence of diabetes has increased steadily over the past 20 years among all race-sex groups. From 1980 to 2004, the age-adjusted prevalence rate of diagnosed diabetes was much higher among African Americans than Whites and highest among African American females. Recent increases have also occurred among Latinos.^{4,8}

In 2003, there were 73,965 deaths from diabetes in the United States. The age-adjusted death rate was 25.2 per 100,000.⁹ The diabetes death rate in California was 21.3 per 100,000 in 2001-2003.¹⁰ However, the statistics on deaths alone do not fully describe the problem. Over 200,000 people die each year of diabetes-related complications.² And, studies have shown that death certificates frequently do not

reflect diabetes as a cause of death or as an underlying cause of death.^{1,2}

According to the California Health Interview Survey (CHIS), about 1.5 million or 6.6% of Californians 19 years and older had been diagnosed with diabetes in 2001. Nearly 37% of cases were among seniors 65 years and older. Overall, about 9.2% of African American and 10.4% of American Indian adults have been diagnosed with diabetes in California. The race/ethnic disparity in diabetes was widest among older adults. Among adults 65 years and older, approximately one out of four African Americans and Latinos have been diagnosed with diabetes, at least two times the figure for Whites.¹¹

Adults living at or below the federal poverty level (FPL) had a higher diabetes prevalence than those with incomes above 300% FPL. In addition, the rate of diabetes was much higher among adults who never attended high school than among college graduates.¹¹

In 2003, 5.1% of Alameda County adults had been diagnosed with diabetes. The prevalence was higher among African Americans (8.2%) than Whites (5.0%).¹²

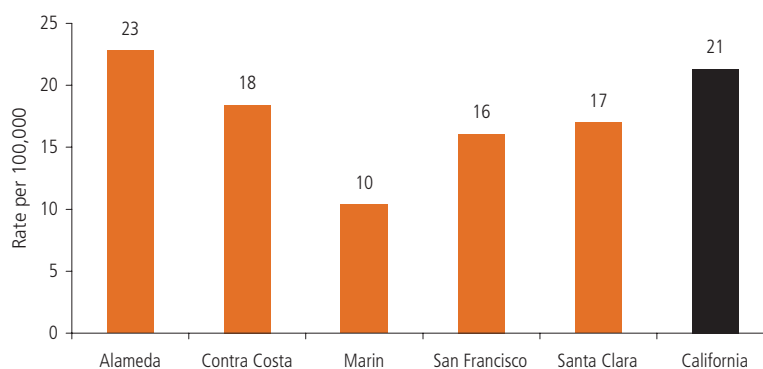
What is Alameda County's status?

Diabetes Mortality

From 2001 to 2003, an average of 289 people per year died from diabetes in Alameda County. The diabetes mortality rate was 23 per 100,000 people.

Alameda County's diabetes death rate was significantly higher than its Bay Area neighbors for the period 2001 to 2003. However, the rate was not significantly higher than that for Contra Costa County or California.

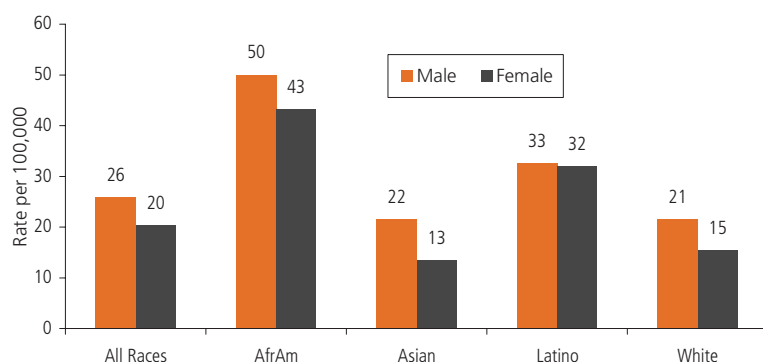
Figure 4.16: Diabetes Mortality, Selected Counties and California, 2001-2003



Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

For both males and females, the highest diabetes death rate was seen among African Americans, followed by Latinos. Asians and Whites had the lowest rates; however, they had the largest gender differences. The Asian male rate was 60% higher than the Asian female rate and the White male rate was 40% higher than the White female rate. No gender difference in diabetes mortality was found for Latinos.

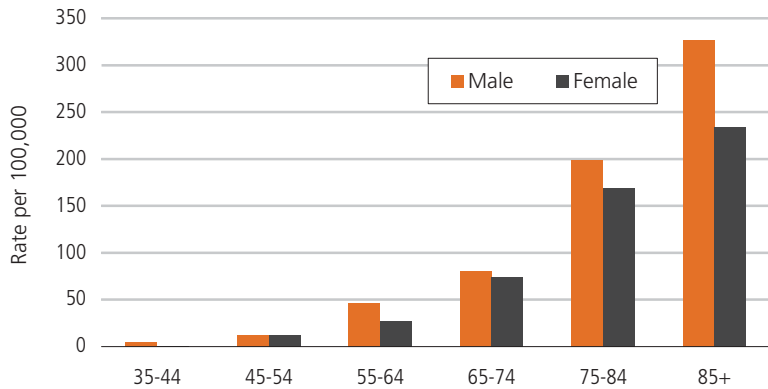
Figure 4.17: Diabetes Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Diabetes mortality was higher among males than females in almost every age group. There were very few deaths prior to the age of 35. However, after age 35 the death rate increased and was highest among males aged 85 and older.

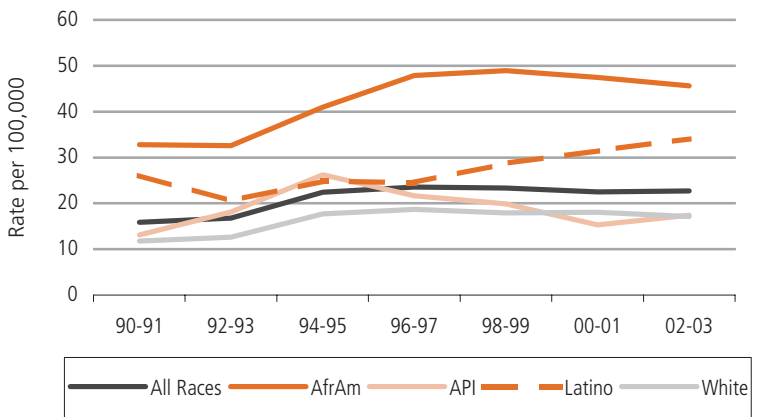
Figure 4.18: Diabetes Mortality by Age and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Diabetes mortality in Alameda County increased significantly until 1996 before leveling off. The same pattern was seen for Whites. Rates among Latinos increased significantly over the decade by about 3.6% per year and for African Americans about 3% per year. Rates among APIs were variable, showing no clear trend.

Figure 4.19: Diabetes Mortality by Race/Ethnicity, Alameda County, 1990-2003



Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

African American diabetes mortality has been consistently higher than any other race/ethnic group throughout the decade. The disparity in rates between African Americans and the county has remained steady, with the African American rate approximately twice the county rate across the period. Due to their increasing rates, Latinos are the only group to be closing the gap with African Americans. The African American rate has been about 2.6 times the White rate over the period.

Diabetes Hospitalization

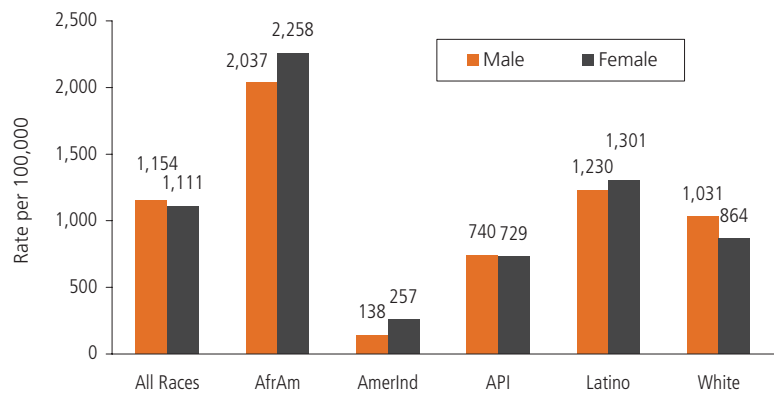
From 2001 to 2003, there was an average of 15,018 hospitalizations per year for diabetes-related illnesses in Alameda County. The rate was 1,129 per 100,000 people.

African American rates of diabetes hospitalization were significantly higher than any other race/ethnic group. Similarly, the Latino rate was higher than those among White, API and American Indian groups.

Among African Americans, the female rate was significantly higher than the male rate, while among Whites the male rate was significantly higher than the female rate.

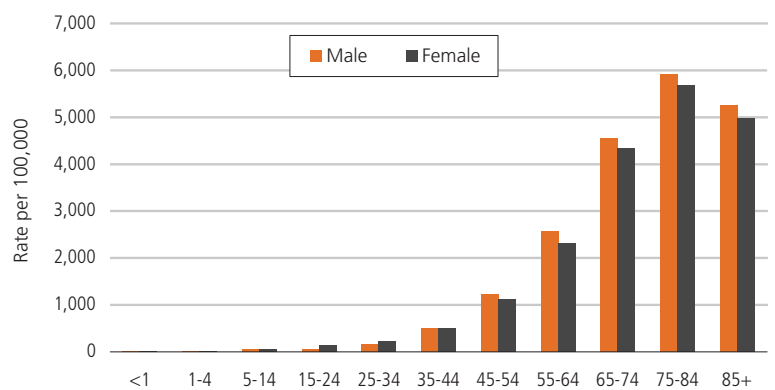
Rates of hospitalization for diabetes-related illnesses increased with age. In Alameda County, rates peaked in the age group 64 to 84. Male rates exceeded female rates by small margins after age 45.

Figure 4.20: Diabetes-Related Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Figure 4.21: Diabetes-Related Hospitalization by Age and Gender, Alameda County, 2001-2003

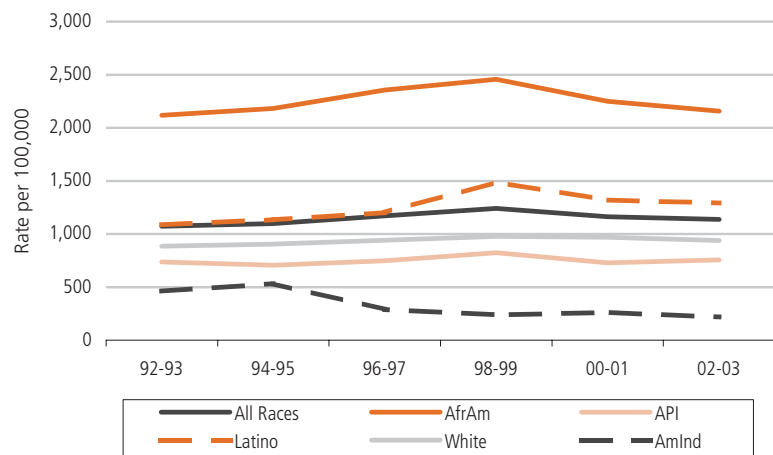


Source: CAPE; OSHPD, Census 2000, DOF.

In Alameda County, rates of hospitalization for diabetes-related illnesses increased significantly between 1991 and 1999, then declined slightly. A similar pattern was seen for African Americans, whose rates declined significantly from 1998 to 2003. While the American Indian rate declined steadily over the decade, those for Latinos and Whites increased significantly.

The African American diabetes hospitalization rate over the period was consistently two times the county rate. The gap narrowed slightly in the latest period with the African American rate 89% higher than the county rate. The Latino rate has also exceeded the county rate over the last 10 years, most recently by about 13%.

Figure 4.22: Diabetes-Related Hospitalization by Race/Ethnicity, Alameda County, 1992-2003

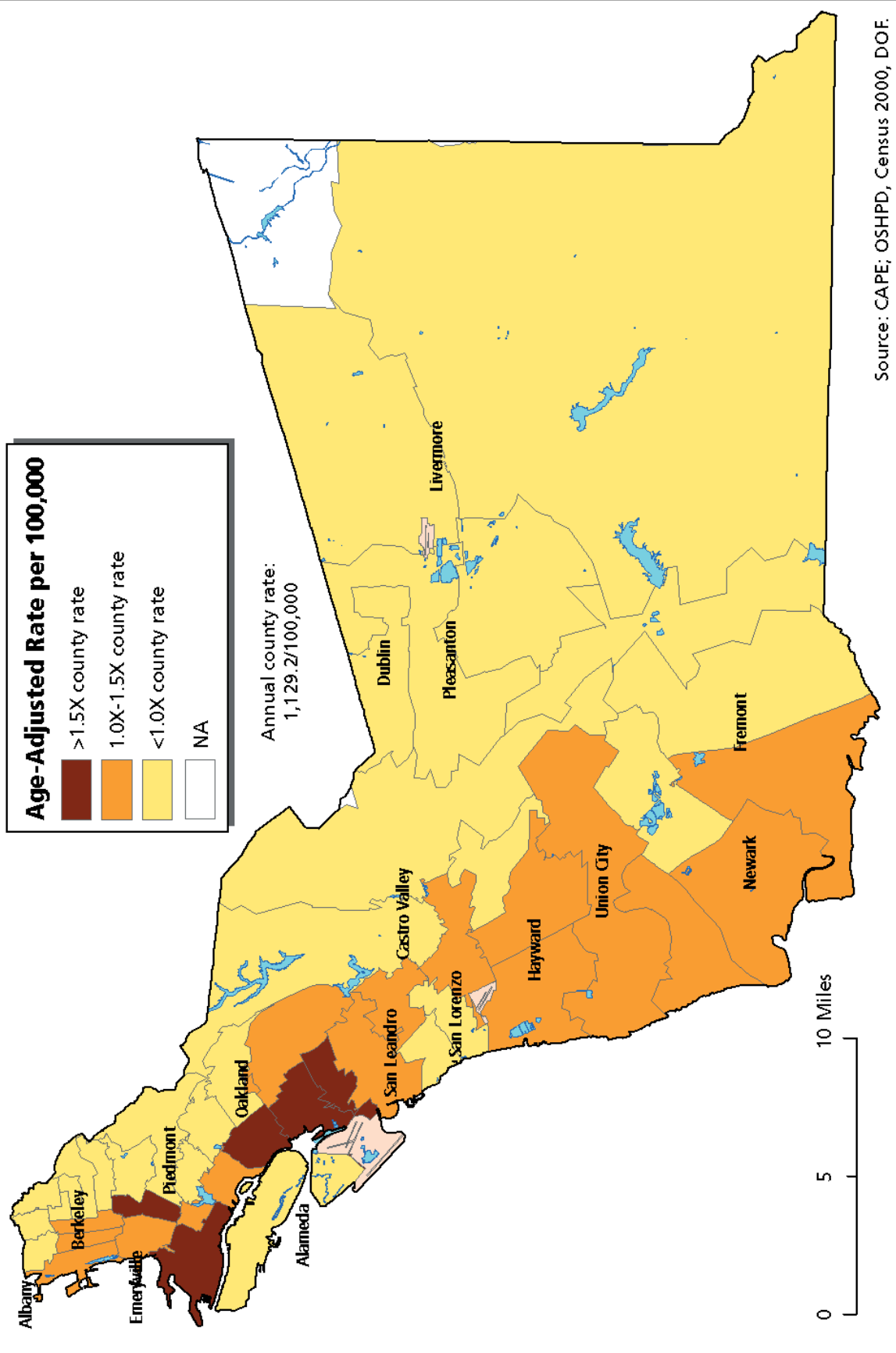


Source: CAPE; OSHPD, Census 1990 and 2000, DOF.

Map 3: Diabetes Hospitalization

Rates of hospitalization for diabetes-related illnesses are highest in parts of North, West, and East Oakland, and Fruitvale. Rates in these areas exceed the county rate of 1,129 per 100,000 by more than 50%. Alameda, the Oakland and Berkeley hills, San Lorenzo, and east county diabetes hospitalization rates are lower than the county average.

Map 3: Diabetes Hospitalization, Alameda County, 2001-2003



Asthma

What is it?

Asthma is a chronic lung condition that causes swelling, excess mucus, and narrowing of the airways. An asthma attack occurs when the airways become so swollen and clogged that the person has trouble getting enough breath. Symptoms include coughing, wheezing, shortness of breath, and a tight feeling in the chest. Asthma can be triggered by exposures and conditions such as respiratory infections, dust mites, animal dander, mold, pollen, tobacco smoke, wood smoke, indoor and outdoor air pollutants, and even exercise.¹ Although the exact cause of asthma is not known, the development of asthma is determined by the interaction between genetics and environmental exposures.

Why is it important?

There is no cure for asthma, so effective management of the condition is essential. Effective management of asthma involves: 1) controlling exposure to asthma triggers; 2) adequately managing asthma with medications; 3) monitoring lung function; and 4) educating asthma patients to work with medical providers as partners in their own care.¹

There are roughly 5,000 deaths nationally per year from asthma. The death rate for African Americans is 2.5 times that for Whites, and about 1.5 times higher among females than males. Asthma death rates increase with age.²

The prevalence of asthma has been increasing nationally since 1980.² The CDC estimates that over 19 million people in the United States have asthma and that 11 million have had an asthma attack in the past year.³ In general, asthma rates are higher among females and children five to 14 years. They are also higher among African Americans and low-income residents of inner cities.²

Data from the Behavioral Risk Factor Surveillance System show that 7.5% of U.S. adults and 6.4% of California adults currently have asthma.⁴ Estimates from the CHIS are higher: about 10% to 11% of children and adults in Alameda County have had asthma symptoms in the last year.⁵

Chronic conditions such as asthma can affect the physical, cognitive, social, and emotional development of young children. According to *The Health of Young Children in California*, asthma is the most common health condition among young children.⁶ Approximately 10.5% of California children ages one to five years have been diagnosed with asthma. The highest rates are for African American children. Many children diagnosed with asthma do not get the medication they need to control it, leaving them to suffer symptoms and physical limitations that could be controlled. In addition, about 22% of children diagnosed with asthma have an asthma-related ER visit each year. Asthma is the single largest contributor to preventable hospital admissions among children.⁶

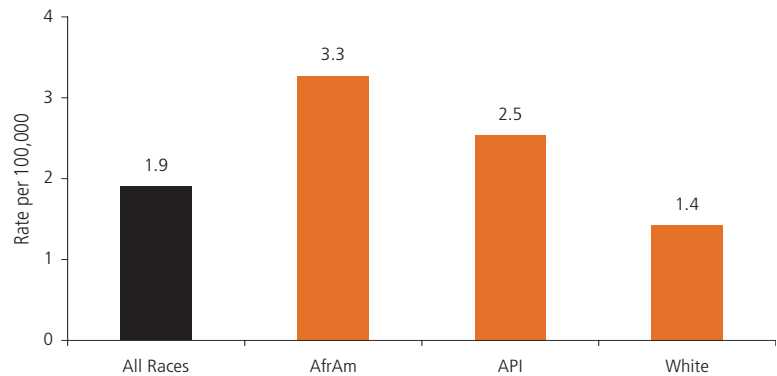
Nationally, there are approximately 484,000 asthma hospitalizations per year.³ Rates of asthma hospitalization are highest among children under five years, followed by children five to 14 years and adults 65 years and older. In California, asthma hospitalization rates are highest among African Americans even when income is taken into account. Statewide and nationally, rates among African Americans are at least three times those for Whites.⁷ Asthma hospitalization rates in Alameda County exceed California rates in every demographic group studied. Alameda County rates are the second highest among the state's 58 counties.⁸

What is Alameda County's status?

Asthma Mortality

During the three years, 2001 to 2003, 75 Alameda County residents died from asthma, an average of 25 per year. The county rate was 1.9 asthma deaths per 100,000 people. African Americans had the highest rate, 3.3 per 100,000, significantly higher than the White rate of 1.4.

Figure 4.23: Asthma Mortality by Race/Ethnicity, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

No asthma deaths occurred among people under age 25. Forty-four percent of those who died were 35-64 years of age, and 55% were age 65 or older. Alameda County appears to be well under the HP2010 target for the age groups <5, 5-14, and 15-34. However, due to small numbers of deaths in these age groups, the rates may vary substantially year to year.

Table 4.1: Asthma Mortality by Age, Alameda County, 2001-2003

Age Groups	3 year total number	Rate per million	HP2010 Target
<5	0	0.0	1
5-14	0	0.0	1
15-34	1	0.7	2
35-64	33	18.7	9
65+	41	92.0	60

Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Among 35-64 year-olds, the asthma death rate was 18.7 per million, two times higher than the HP2010 target of 9 per million. Among those over age 65, the rate was 92, 53% higher than the target rate of 60.

Asthma Hospitalization

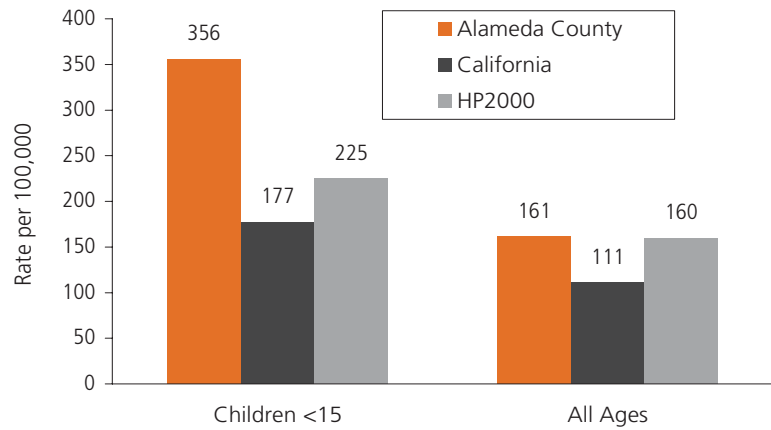
We continue to monitor asthma hospitalizations based on the *HP2000* objectives because the age group 0-14 years is of great interest. While the county is just meeting the objective for all ages combined, we have a great distance to go before reducing the rate among children under age 15 to 225 per 100,000.

From 2001 to 2003, an average of 1,084 asthma hospitalizations per year occurred among children in Alameda County. The rate was 356 per 100,000, two times the California rate and well above the HP2000 national objective of 225 asthma hospitalizations per 100,000 children ages 0-14.

During the same period, 2,290 asthma hospitalizations per year occurred among Alameda County residents of all ages, for a rate of 161 per 100,000. This rate is higher than the California rate but nearly equivalent to the HP2000 objective of 160 or less.

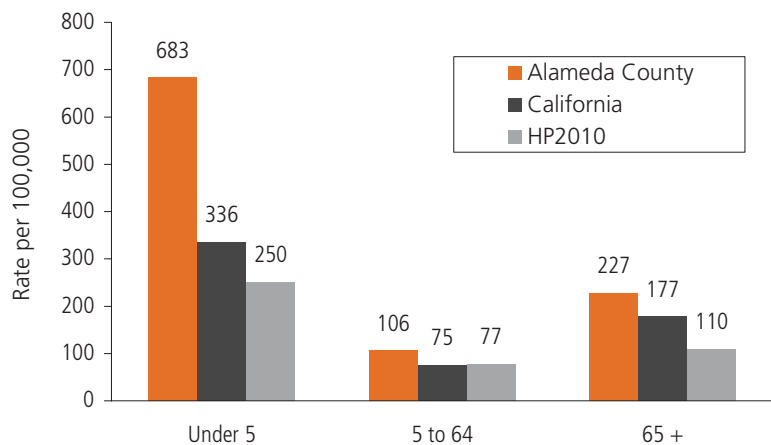
The newer HP2010 objectives for asthma hospitalization address three distinct age groups: 1) children under age five, 2) ages five to 64 years, and 3) ages 65 and older. Alameda County rates exceed California rates as well as the national objectives in all three age groups but most notably among children under five years of age. The rate for the under five age group is 2.7 times the HP2010 objective and the rate for those over age 65 is 2 times the HP2010 objective.

Figure 4.24: Asthma Hospitalization, Alameda County (2001-2003) and California (2003) with HP2000 National Objectives



Source: CAPE; OSHPD, Census 2000, DOF.

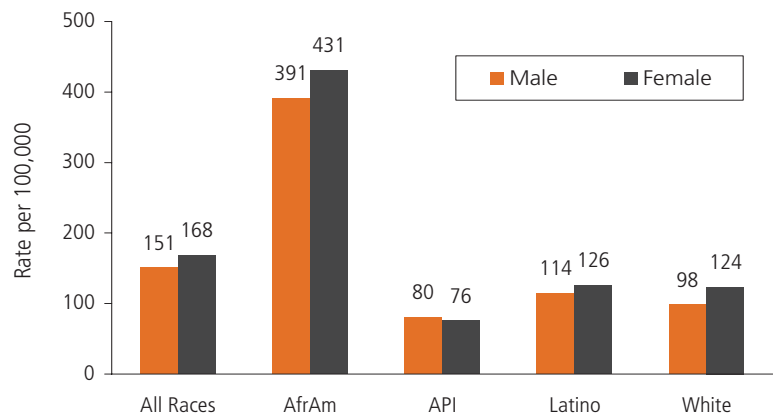
Figure 4.25: Asthma Hospitalization, Alameda County (2001-2003) and California (2003) with HP2010 National Objectives



Source: CAPE; OSHPD, Census 2000, DOF.

For all ages combined, there were only small gender differences in asthma hospitalization rates. African Americans were three to five times more likely than other race/ethnic groups to be hospitalized for asthma. Rates for APIs, Latinos and Whites were all well below the HP2000 objective of 160 while African American rates continue to be well over twice this target.

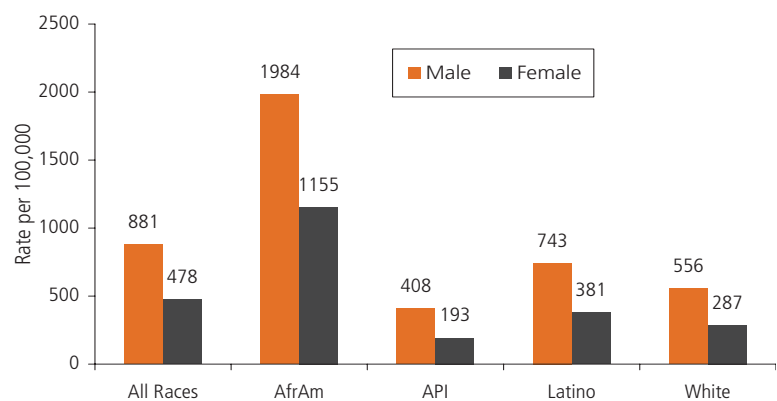
Figure 4.26: Asthma Hospitalization (All Ages) by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

For every race/ethnic group, asthma hospitalization rates for males under five years of age were about twice those for females.

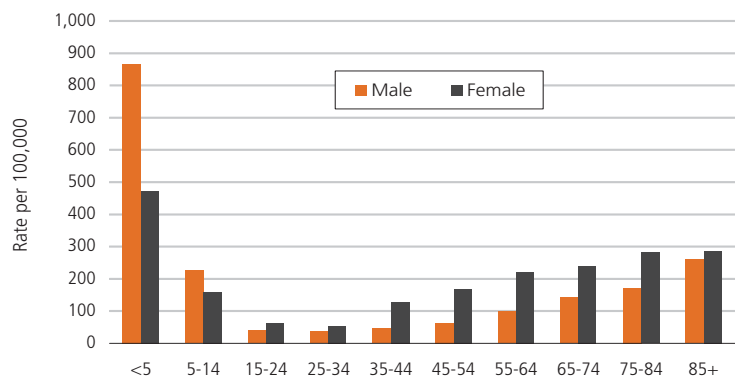
Figure 4.27: Asthma Hospitalization (<5 Years) by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Rates were very high among African American males, five times higher than for APIs and three to four times higher than for Whites and Latinos. A similar pattern was observed for females.

Figure 4.28: Asthma Hospitalization by Age and Gender, Alameda County, 2001-2003



Source: CAPE; OSHPD, Census 2000, DOF.

Only API females met the HP2010 objective of no more than 250 asthma hospitalizations per 100,000 children under five. African American male rates exceed the objective by eight times.

Boys under age 15 in Alameda County are hospitalized for asthma at higher rates than females. However, the pattern shifts during adolescence and young adulthood when females are hospitalized for asthma at higher rates than males.

These age-specific data show that children under five years of age are particularly vulnerable to asthma attacks serious enough to warrant hospitalization.

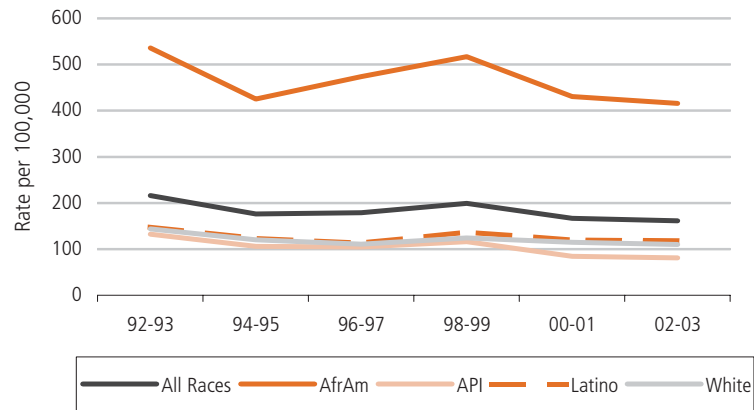
In Alameda County, rates of asthma hospitalization declined significantly over the past decade for every racial/ethnic group.

Despite this improvement, when the African American rate is compared to the county rate, the disparity persists, with African Americans 2.6 times more likely than others to be hospitalized for asthma across the decade.

Asthma hospitalization rates among children under age five declined significantly in the county between 1991 and 1996, by about 5% per year; they have increased slightly since then. A similar pattern was seen for Whites. The API rate declined significantly by 6% per year until recently. Latino and African American rates showed no clear trend.

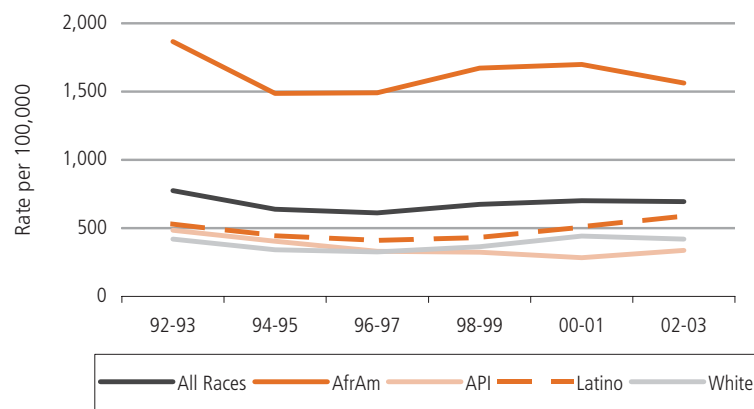
Over the decade, however, the African American rate has been consistently 2.2 to 2.5 times the county rate.

Figure 4.29: Asthma Hospitalization (All Ages) by Race/Ethnicity, Alameda County, 1992-2003



Source: CAPE; OSHPD, Census 1990 and 2000, DOF.

Figure 4.30: Asthma Hospitalization (<5 Years) by Race/Ethnicity, Alameda County, 1992-2003

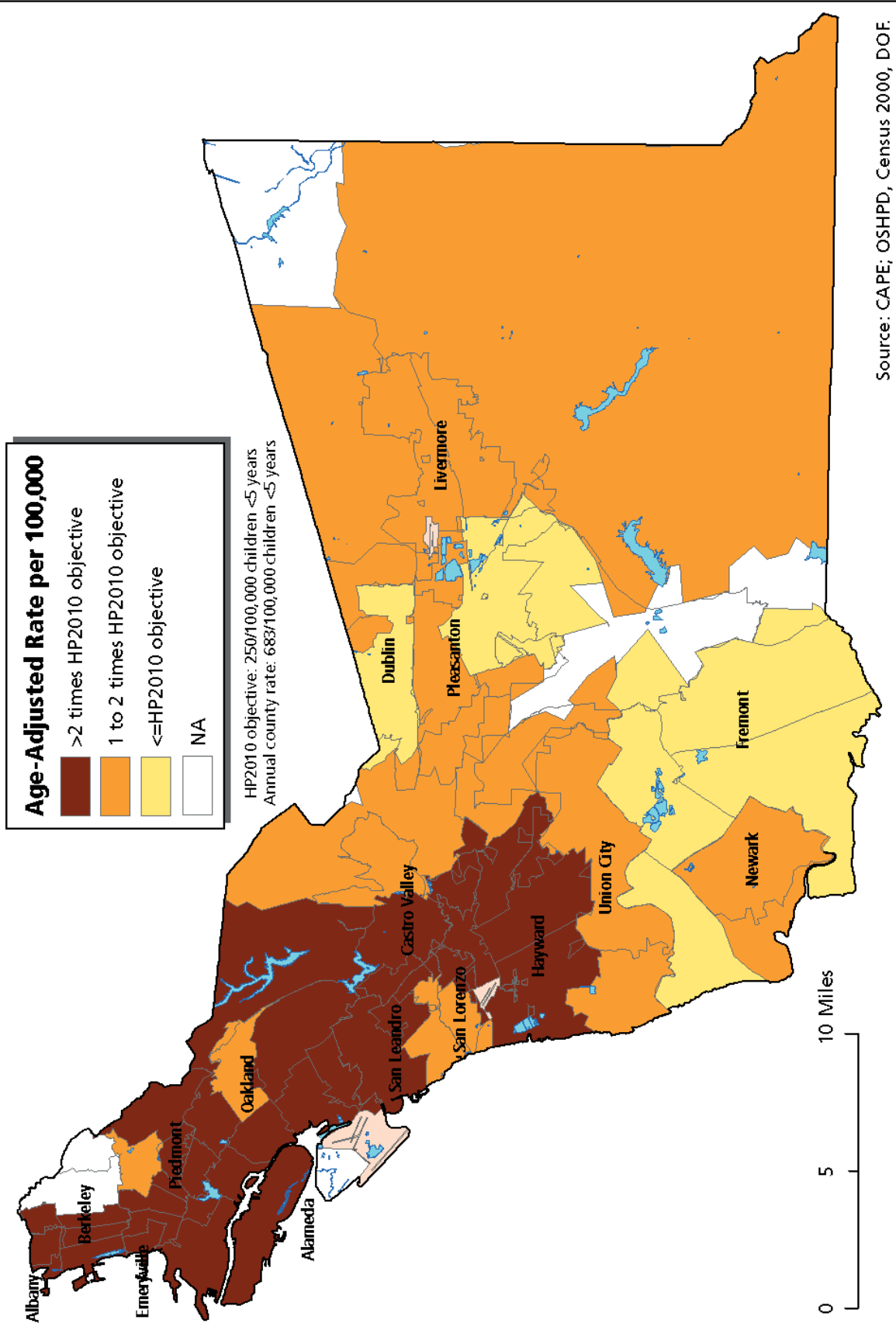


Source: CAPE; OSHPD, Census 1990 and 2000, DOF.

Map 4: Childhood Asthma Hospitalization

Rates of hospitalization for asthma among children under five years of age were highest in North, West, and East Oakland, exceeding the county average rate by two or more times. Other areas, including parts of Berkeley, Oakland, Alameda, and San Leandro also have childhood asthma hospitalization rates that are above the county average of 683 per 100,000 children.

Map 4: Childhood Asthma (<5 years) Hospitalization, Alameda County, 2001-2003



Cancer

What is it?

Cancer is a large group of diseases in which abnormal cells divide uncontrollably. Cancer cells differ from normal cells in size and in function. They are characterized by uncontrolled growth and spread of abnormal cells throughout the body rapidly and independently from the primary site to other tissues in the body. They can spread, or metastasize, to other locations via the bloodstream, the lymphatic system, or by accidental transplantation from one site to another during surgery. Cancer is broadly classified according to histologic origin: carcinomas – those derived from cells found in the lining of various tissues, and sarcomas – those derived from the underlying supporting tissue.^{1,2}

Why is it important?

Nationally, there were 554,643 deaths from cancer in 2003. Cancer is the second leading cause of death in the United States, accounting for 23% of all deaths. The age-adjusted death rate in the US in 2003 was 189.3 per 100,000.³ In California it was 169.6 for the period 2001-2003.⁴ Both national and state rates exceeded the HP2010 objective of 159.9 or fewer cancer deaths per 100,000.⁵ Nationally, more than 1.37 million new cancer cases are expected to be diagnosed in 2005.⁶

In general, incidence and death rates for all cancers combined are lower among Asian/Pacific Islander, American Indian, and Latino populations than among White and African American populations. African Americans are more likely to die of cancer than any other race/ethnic group.⁷ An examination of national figures for four major cancer sites revealed disparities between White and African American populations (see Table 4.2 at end of chapter).⁷⁻¹⁰ African American males have a higher incidence of lung, prostate, and colorectal cancer than White males. They are also more likely to die from these diseases. The rate of new breast cancer cases among White females is higher than among African American females, yet African American females are more likely to die from breast cancer.

Latinos have higher rates of cervical, esophageal, gallbladder, and stomach cancers than non-Hispanic Whites. Rates of stomach and liver cancers are higher among Asian Americans than the rest of the population, and the death rate of lung cancer is the third highest among American Indian/Alaska Natives after African Americans and Whites.^{7,10}

Although the rates of cancer incidence and death have declined recently, the actual number of people diagnosed with cancer is expected to double in the next several decades, as the elderly population grows.¹¹ Adequate access to cancer screening and the availability of high quality treatment among poor and underserved populations are critical to reducing the burden of cancer.¹²

Many cancers can be cured if detected early and treated promptly. Cancers that can be detected by screening account for about half of all new cancer cases. The 5-year relative survival rate for all cancers diagnosed between 1995 and 2000 was 64%, up from 50% in 1974-1976.⁶ In addition, some cancers can be prevented by lifestyle changes. Maintaining a healthy weight, exercising regularly, and not smoking can reduce an individual's risk of cancer substantially.¹³

What is Alameda County's status?

Cancer Mortality

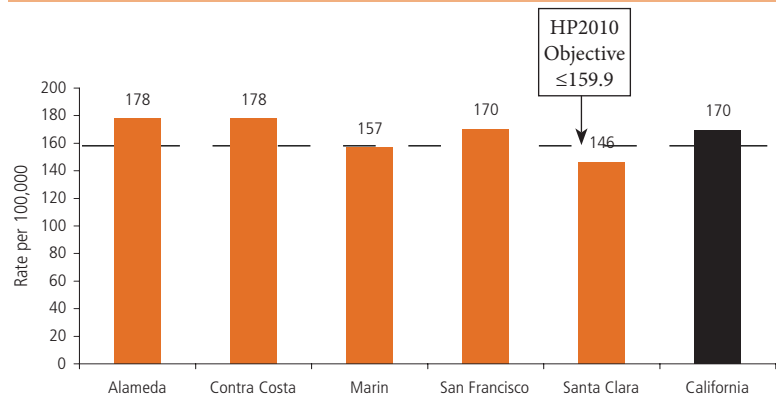
From 2001 to 2003, an average of 2,278 people per year died from cancer in Alameda County. The cancer mortality rate was 178 per 100,000 people.

Alameda County's death rate from all cancers was higher than its four Bay Area neighbors for the three year period from 2001 to 2003. However, the rate was significantly higher than only two counties, Marin and Santa Clara. It was nearly the same as in Contra Costa County and just slightly higher than in California. Alameda County has not yet met the HP2010 national objective of 159.9 or fewer cancer deaths per 100,000 people.

The highest rate of cancer mortality was seen among African American males, followed by White males. Male and female rates for African Americans were more than twice the corresponding rates for Asians and Latinos. With the exception of Pacific Islanders, males had 40-60% higher rates than females for every race/ethnic group. Asians of both genders, Latinas and Pacific Islander males were the only race/ethnic groups that met the HP2010 objective of no more than 159.9 cancer deaths per 100,000 people.

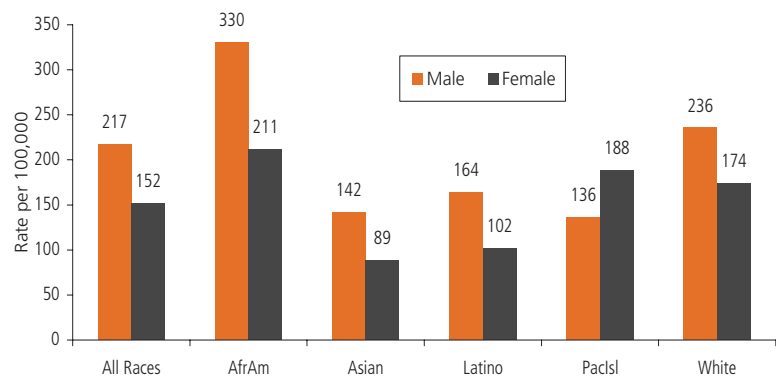
Cancer kills people of all ages, but it largely affects people over the age of 35. As age increases so do cancer mortality rates, significantly more for males than females. The male-to-female difference increased from 7% for the 45-54 age group to 56% for the age group 85 and older.

Figure 4.31: Cancer Mortality, Selected Counties and California, 2001-2003



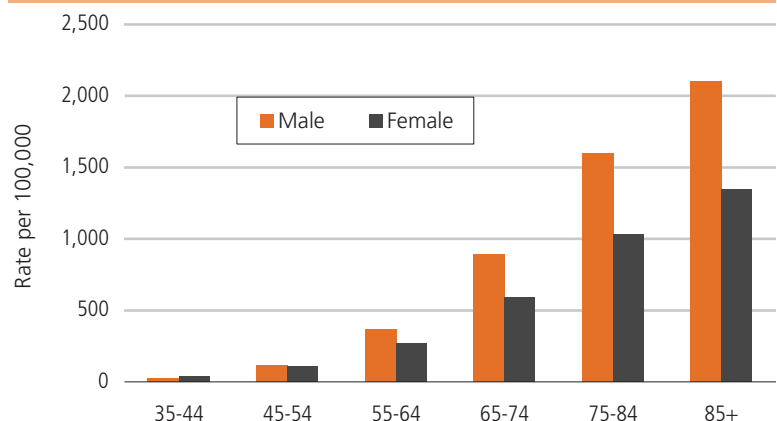
Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

Figure 4.32: Cancer Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Figure 4.33: Cancer Mortality by Age and Gender, Alameda County, 2001-2003

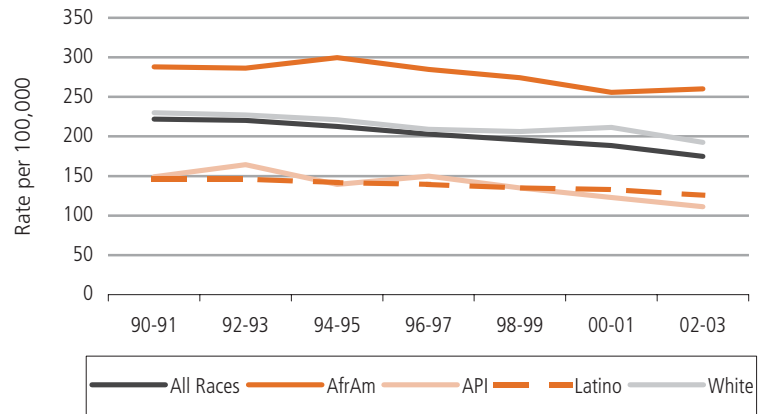


Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Mortality from all cancers has declined significantly during the last decade for every race/ethnic group. For the entire population, cancer mortality declined about 2% per year. The steepest decline was among APIs.

African American cancer mortality has been consistently higher than that of any other race/ethnic group throughout the decade. The disparity in rates between African Americans and the county widened during this time, from 30% higher in 1990-91 to 49% higher in 2002-03. Throughout the decade, the African American rate has been two times higher than those for APIs and Latinos.

Figure 4.34: Cancer Mortality by Race/Ethnicity, Alameda County, 1990-2003



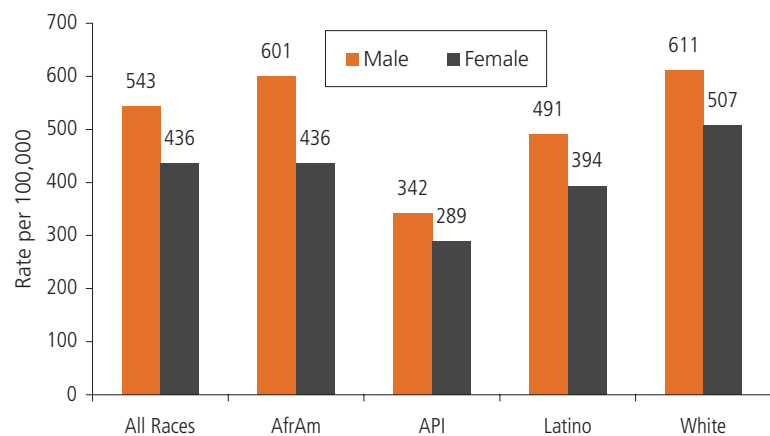
Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

Cancer Incidence

An average of 6,148 new cases of cancer per year were diagnosed in Alameda County between 2000 and 2002. The annual average incidence rate for all cancers combined was 478 per 100,000 people.

The highest rates were found among African American and White males. For all races combined, the incidence rate for males was 24% higher than for females. The gender difference was most pronounced among African Americans; the male rate was 38% higher than the female rate. APIs had the lowest rates and the smallest gender difference.

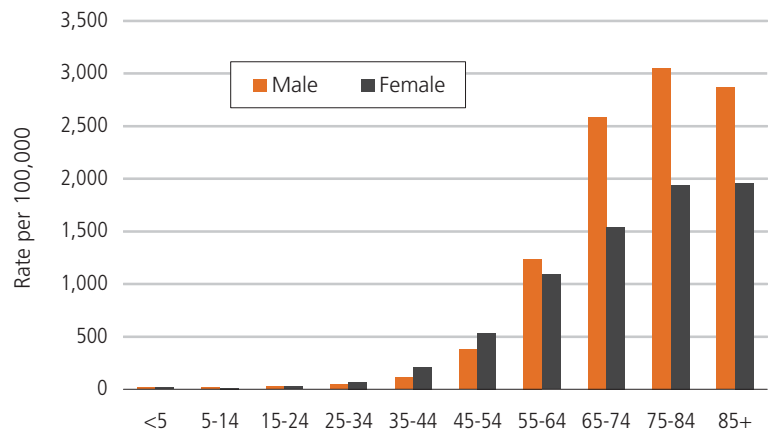
Figure 4.35: Cancer Incidence by Race/Ethnicity and Gender, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Cancer is uncommon before age 35. The incidence of all cancers combined goes up substantially among persons in their fifties. In Alameda County, male rates were higher than female rates in all age groups except between the ages of 25 and 54. Gender differences were most pronounced after 65 years of age, when male rates exceeded female rates by 46% to 68%.

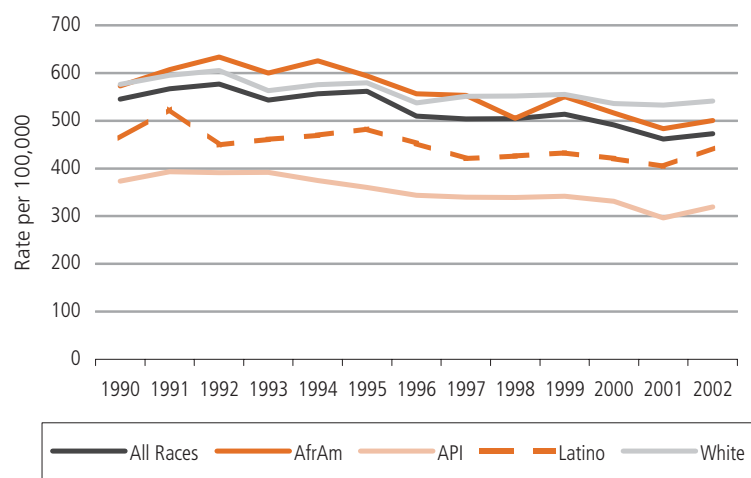
Figure 4.36: Cancer Incidence by Age and Gender, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

The incidence of all cancers combined declined significantly by about 1.6% per year in the county between 1990 and 2002. There were significant, steady declines among females and periodic declines among males (data not shown).

Figure 4.37: Cancer Incidence by Race/Ethnicity, Alameda County, 1990-2002



Source: CAPE; Northern California Cancer Center, Census 1990 and 2000, DOF.

Cancer incidence declined significantly for every race/ethnic group since 1990. The greatest declines were seen among APIs and African Americans, at about 2% per year. Rates declined about 1% per year for Latinos and Whites.

Over the period, African American rates were about 5% to 10% higher than the county rate, as were White rates. However, in 2001 and 2002, the White rate was about 15% higher than the county rate.

Lung Cancer

What is it?

Lung cancer is caused by an uncontrolled growth of abnormal cells in lung tissue. Primary lung cancer originates in the lungs, while metastatic lung cancer spreads to the lungs from another organ. Classification is based on the type of cell the cancer originates from and is broken down into two groups: small cell lung cancer and non-small cell lung cancer. The majority of lung cancer patients are non-small cell lung cancers. The most common form of lung cancer, squamous cell carcinoma, originates in the bronchi and is slow to spread to other parts of the body. About 20%-25% of lung cancer cases are caused by small cell carcinomas. Small cell lung cancer is more likely to spread to other parts of the body than non-small cell lung cancer.^{1,2}

Why is it important?

Lung cancer is the leading cause of death from cancer in the United States for both men and women, accounting for 28% of all cancer deaths. More than 157,500 people in the United States died of lung cancer in 2003.³ The American Cancer Society estimates that more than 172,500 new cases of lung cancer will be diagnosed in the United States in 2005.⁶ Although there has been some progress in treatment of lung cancer, the chances of full recovery are very low because a large proportion of cases are diagnosed at an advanced stage. Only about 15% of those treated for lung cancer survive five or more years.⁶

Nationally, the age-adjusted lung cancer death rate in 2003 was 53.9 deaths per 100,000 population.³ In California, it was 43.8 for the period 2001-2003.⁴ The national rate exceeds the Healthy People 2010 objective of 44.9 or fewer lung cancer deaths per 100,000 while the California rate meets the objective.⁵

While the lung cancer death rate has declined since 1990 among males, it has continued to increase among females. Since 1987, more females have died from lung cancer than from breast cancer.⁵ Age-adjusted lung cancer death rates are more than 30 percent higher among African American males than White males (see Table 4.2 at end of chapter).^{7,10} Part of this racial difference is believed to be due to factors associated with poverty.¹⁴

During the last 50 years patterns of lung cancer mortality among males changed dramatically. Early on, lung cancer mortality was higher among men in wealthier areas. However, by the early 1970s, the pattern reversed and men from poor areas had the higher rates.¹⁵

These racial and socioeconomic inequities will likely widen in the future if current racial and socioeconomic differences in smoking, dietary patterns, cancer screening, and cancer survival continue to persist or increase.^{15, 16}

According to the American Cancer Society, a single behavior – cigarette smoking – is thought to be responsible for eight out of ten cases of lung cancer. In addition, non-smokers who breathe the smoke of others also have an increased risk of developing lung cancer.^{17, 18} Although per-capita cigarette consumption is currently lower than at any point since World War II, an estimated 25% of men and 20% of women still smoke cigarettes, and approximately 82% of these people still smoking daily.¹⁹ Thus, preventing and reducing cigarette smoking is key to reducing illness and death from lung cancer.

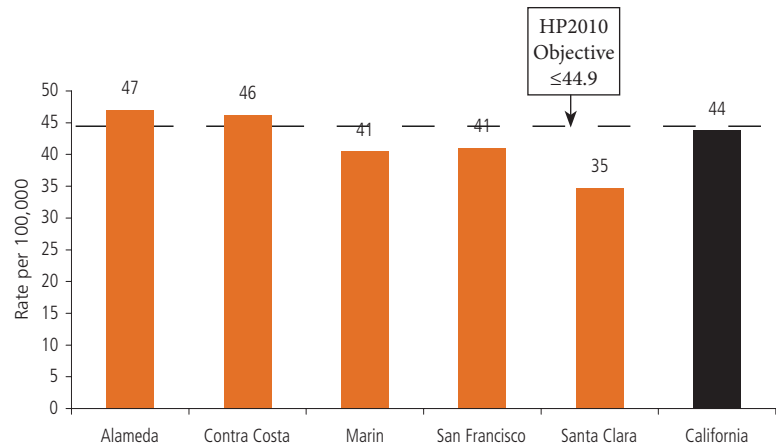
What is Alameda County's status?

Lung Cancer Mortality

From 2001 to 2003, an average of 595 people per year died from lung cancer in Alameda County. The lung cancer mortality rate was 47.4 per 100,000 people.

Alameda County's death rate from lung cancer was higher than its four Bay Area neighbors in the three year period 2001 to 2003. However, the rate was only significantly higher than Santa Clara County. The Alameda County rate was higher than the California rate as well as the HP2010 national objective of 44.9 or fewer lung cancer deaths per 100,000 people.

Figure 4.38: Lung Cancer Mortality, Selected Counties and California, 2001-2003

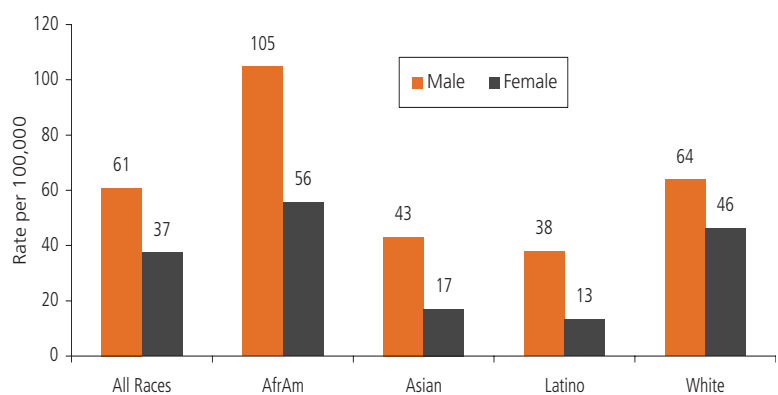


Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

The rate of lung cancer mortality was significantly higher among African American men than any other group. The lowest rates were seen among Asian and Latino women. African American male and female rates were two to four times higher than those of Asians and Latinos.

Males were more likely than females of every race/ethnic group to die of lung cancer. Gender differences were most pronounced among African Americans, Asians and Latinos, with male rates two to three times higher than female rates. In comparison, White male rates were only 40% higher than White female rates. Asians and Latinos of both genders were the only race/ethnic groups that met the HP2010 objective.

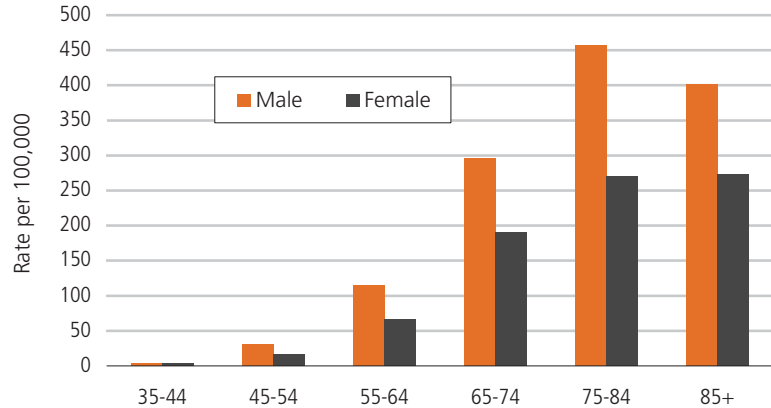
Figure 4.39: Lung Cancer Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

There were no lung cancer deaths below the age of 35 in Alameda County from 2001 to 2003. Lung cancer mortality was 50% to 90% higher among males than females. The highest rates were found among males over 75 years of age.

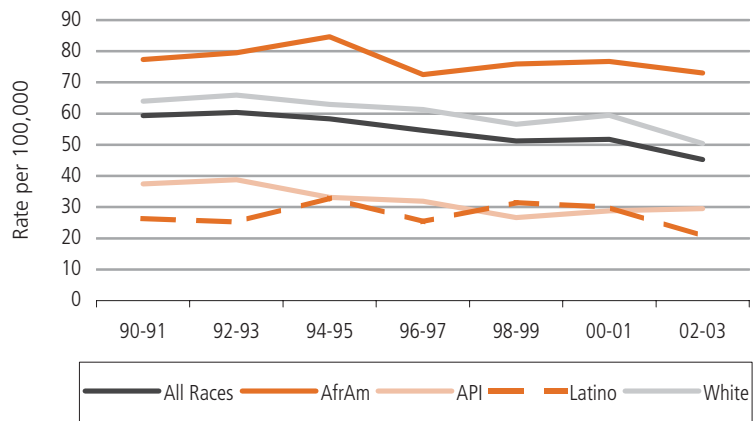
Figure 4.40: Lung Cancer Mortality by Age and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Lung cancer mortality in the county has declined significantly over the last decade by about 2% per year. A significant decline was also observed for Whites. African American, API, and Latino rates were variable and showed no clear trends.

Figure 4.41: Lung Cancer Mortality by Race/Ethnicity, Alameda County, 1990-2003



Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

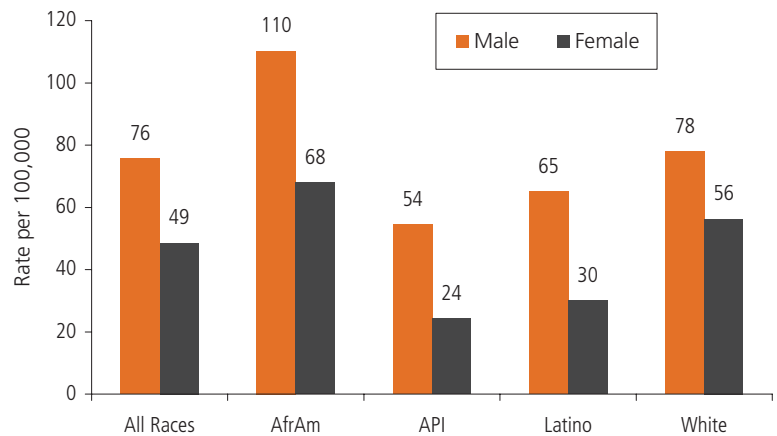
African American lung cancer mortality has been consistently higher than any other race/ethnic group throughout the past decade. The disparity in rates between African Americans and the county as a whole has increased over the decade. In 1990-91 the African American rate was 30% higher than the countywide rate and in 2002-03 it was 61% higher. The gap between African Americans and Whites has also grown. Throughout the decade, the African American rate has varied from 2 to 3.5 times higher than those for APIs and Latinos.

Lung Cancer Incidence

An average of 740 new cases of lung cancer per year were diagnosed in Alameda County from 2000 to 2002. The incidence rate was 60 per 100,000 people. Three-fourths of new cases were diagnosed at a late stage of the disease.

The rate among African American males was significantly higher than any other group. Rates for African American females were at least twice those for APIs and Latinas. For all races combined, male incidence rates exceeded female rates by 56%. The gender difference was most pronounced among Latinos and APIs, for whom male rates were 2.2 times female rates. The African American male rate was 62% higher than that for females.

Figure 4.42: Lung Cancer Incidence by Race/Ethnicity and Gender, Alameda County, 2000-2002

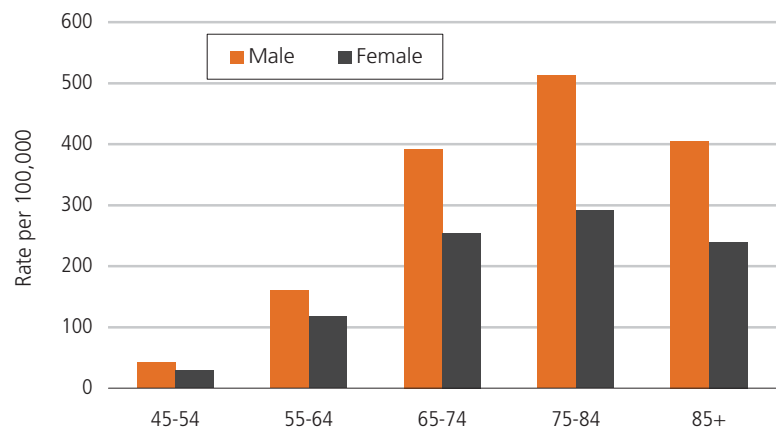


Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Lung cancer is uncommon before age 45. In Alameda County, the incidence increased notably with age and was highest among the elderly in the 75 to 84 age group.

Males had a higher incidence of lung cancer than females in all age groups. This gender difference was most pronounced in the 75-84 age group, where male rates exceeded female rates by 76%.

Figure 4.43: Lung Cancer Incidence by Age and Gender, Alameda County, 2000-2002



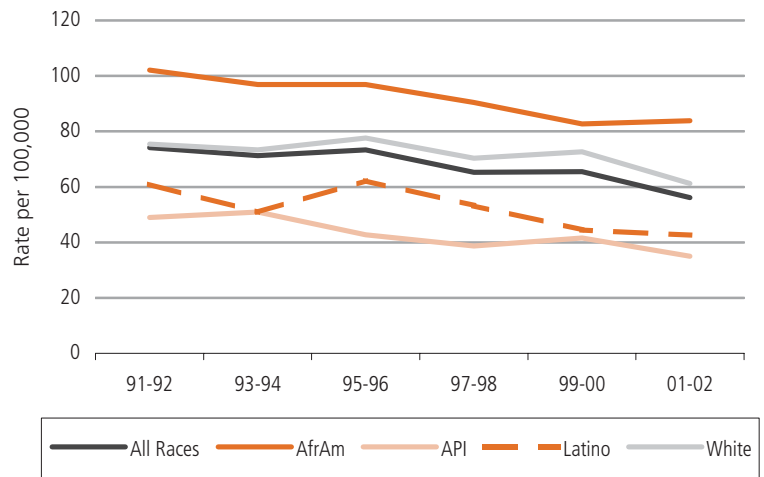
Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

The incidence of lung cancer in the county declined significantly by about 2.3% per year between 1990 and 2002. Declining rates were observed for every race/ethnic group over the decade. The steepest declines were seen among APIs (2.8% per year) and Latinos (2.6%). The White rate dropped 2% per year. The African American rate declined as well; however the trend was not statistically significant.

The declining trend in lung cancer incidence was significant among both males and females (data not shown).

Disparities in rates of lung cancer have been variable over the past decade. African Americans had a rate of lung cancer incidence that was 30% to 50% higher than the county rate during this period.

Figure 4.44: Lung Cancer Incidence by Race/Ethnicity, Alameda County, 1991-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Colorectal Cancer

What is it?

Colorectal cancer is caused by abnormal tissue growth in the colon or rectum that is malignant. Symptoms for colorectal cancer may include rectal bleeding, abdominal discomfort, pain, bloating, a change in bowel habits, iron deficiency anemia, and unexplained weight loss.^{1,2} Most colorectal cancers develop over many years from benign polyps. Precancerous polyps can be detected and removed during certain screening procedures, thereby preventing colorectal cancer. If colorectal cancer is found early and treated appropriately, the chance of survival is greatly enhanced.^{18, 20-23} However, only 39% of cases are diagnosed at this early stage.⁶

Why is it important?

Colorectal cancer is the second leading cause of cancer-related death in the United States and it is the third most common cancer in men and women.^{18, 20, 21} It is estimated that approximately 145,290 new colorectal cancer cases will be diagnosed in 2005 and that 56,290 Americans will die of colorectal cancer in 2005.⁶

Nationally, there were 55,616 deaths from colorectal cancer in 2003 and the age-adjusted death rate was 18.9 deaths per 100,000.³ In California, the rate was 18.1 per 100,000 during the period 1997-2001.²⁴ Both the national and state rates exceed the HP2010 objective of 13.9 or fewer deaths per 100,000.⁵

For males, incidence rates of colorectal cancer have declined over the past ten years for every race/ethnic group except Latinos. For females, incidence rates have stabilized in every race/ethnic group. However, mortality rates have steadily declined for both males and females.²¹

The risk of developing colorectal cancer increases with advancing age. Most cases are diagnosed in those 50 years and older. The risk is also higher among people with inflammatory bowel disease (ulcerative colitis or Crohn's disease), a family history of colorectal cancer or colorectal polyps, and certain hereditary syndromes. Lack of regular physical activity, low fruit and vegetable intake, a low-fiber and high-fat diet, obesity, alcohol consumption, and tobacco use are associated with colon cancer.^{1, 6, 20, 21}

All adults 50 years and older should be screened routinely for colorectal cancer. Studies have found that at least 75% of colorectal cancers occur among people with no family or personal history of colorectal cancer and no risk factors that would place them at high risk for developing colorectal cancer.²⁰⁻²³ Despite of the proven effectiveness of colorectal cancer screening and the availability of various screening tests, colorectal cancer screening is not widely used.^{21, 22, 25}

Both incidence and mortality rates of colorectal cancer are highest among African American males and females (see Table 4.2 at end of chapter).⁷ Studies show that African Americans were more likely to be diagnosed after the disease had spread beyond the colon and were less likely to receive recommended treatment and therapy.^{21, 26, 27}

What is Alameda County's status?

Colorectal Cancer Mortality

Colorectal cancer mortality among females in Alameda County for the five-year period, 1998-2002, was similar to female rates in neighboring counties and the Greater Bay Area. Only Santa Clara's rate was significantly lower.

Male rates were similar across counties and the Greater Bay Area. Marin County's rate was the lowest, but not significantly different from Alameda County's rate.

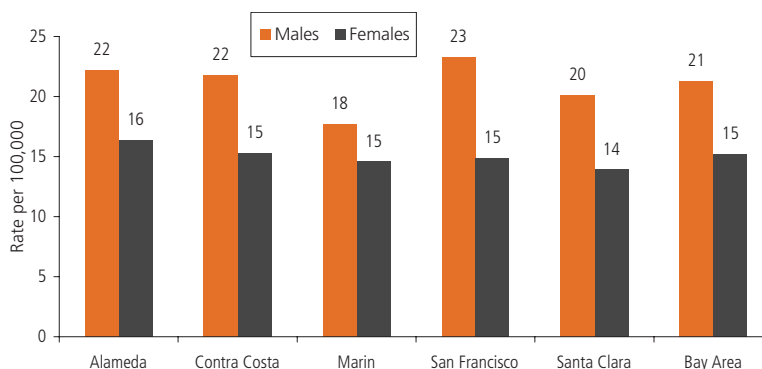
Neither males nor females in Alameda County have met the HP2010 objective of 13.9 or fewer colorectal cancer deaths per 100,000.

From 2001 to 2003, an average of 228 people per year died from colorectal cancer in Alameda County. The colorectal cancer mortality rate was 17.9 per 100,000 people.

Males of every race/ethnic group except Latinos had 20%-30% higher rates than females. Among Latinos, the male rate was 70% higher.

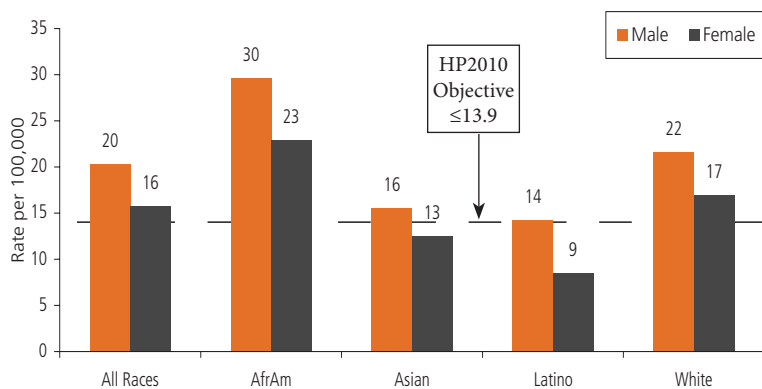
Colorectal cancer death rates among African Americans, both males and females, were higher than any other race/ethnic group. African American males were twice as likely to die from the disease as Asian and Latino males. African American females were 2.7 times more likely to die than Latinas. Asian females and Latinas were the only groups that met the HP2010 objective of no more than 13.9 colorectal cancer deaths per 100,000.

Figure 4.45: Colorectal Cancer Mortality by Gender, Selected Counties and the Bay Area, 1998-2002



Source: CAPE; Northern California Cancer Center; Census 2000, DOF.

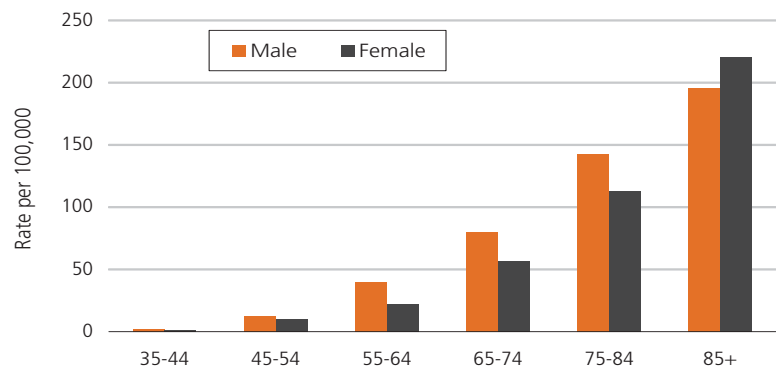
Figure 4.46: Colorectal Cancer Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

There were no colorectal cancer deaths below the age of 25 in Alameda County from 2001 to 2003. Colorectal cancer mortality increased steadily with age and was higher among males than females in every age group except the oldest, those aged 85 and older.

Figure 4.47: Colorectal Cancer Mortality by Age and Gender, Alameda County, 2001-2003

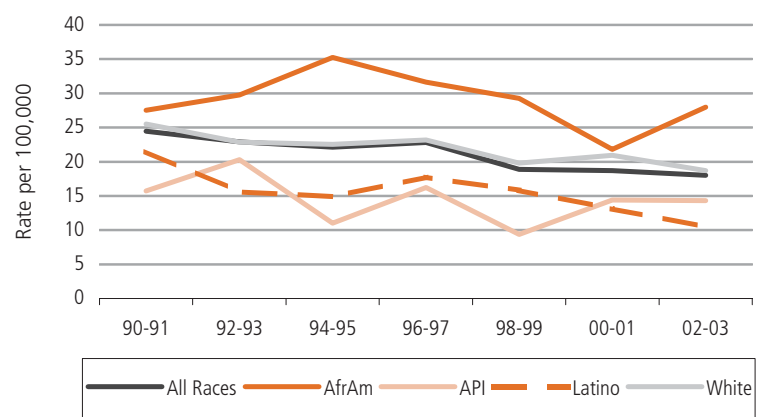


Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Colorectal cancer mortality declined significantly over the decade in every race/ethnic group except APIs. The county rate dropped about 3% per year. The decline in the Latino rate was the most pronounced, about 4.5% per year.

African American colorectal cancer mortality has been consistently higher than any other race/ethnic group throughout the past decade. In the 2000-01 period, however, it dropped close to the White rate. The variability in the African American rate makes it difficult to assess change in health disparities. Additional years of data are necessary to determine if the overall downward trend for African Americans continues, especially relative to change in other groups.

Figure 4.48: Colorectal Cancer Mortality by Race/Ethnicity, Alameda County, 1990-2003



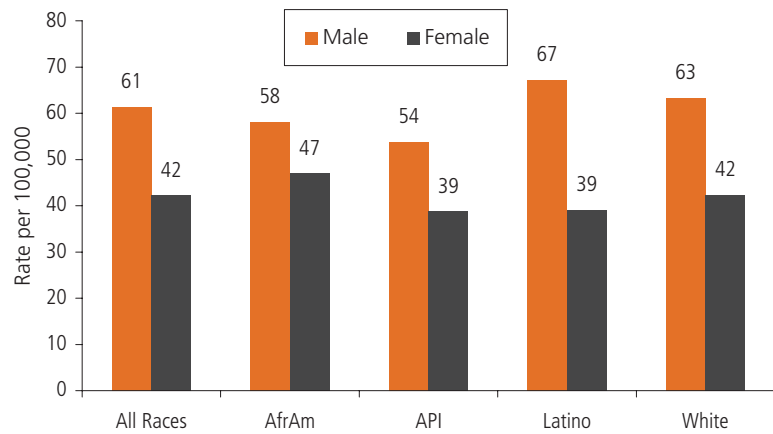
Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

Colorectal Cancer Incidence

An average of 637 new cases of colorectal cancer per year were diagnosed in Alameda County between 2000 and 2002. The incidence rate was 51 per 100,000 people. Sixty percent of new cases of colorectal cancer were diagnosed at a late stage of disease.

For all races combined, male incidence rates exceeded female rates by 45%. The gender difference was most pronounced among Latinos for whom male rates were 72% higher than female rates. The smallest gender difference, and the highest female rate was seen among African Americans.

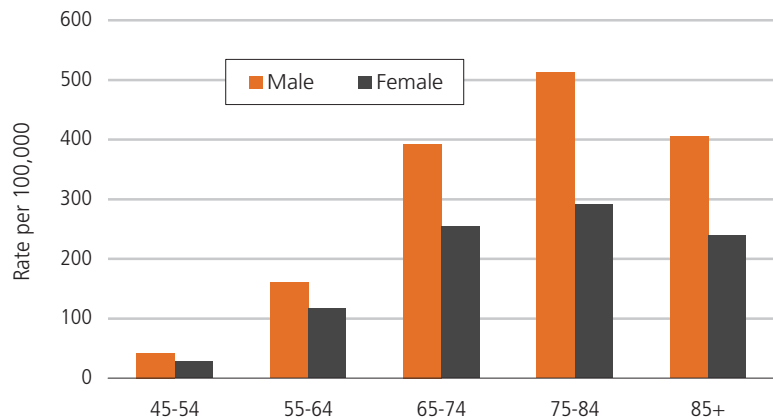
Figure 4.49: Colorectal Cancer Incidence by Race/Ethnicity and Gender, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Colorectal cancer screening is recommended at age 50 or older. In Alameda County, the incidence of colorectal cancer increased with age and was greater among males than females in all age groups. The most pronounced gender difference was in the 45 to 54 age group, where the male rate exceeded the female rate by 70%.

Figure 4.50: Colorectal Cancer Incidence by Age and Gender, Alameda County, 2000-2002



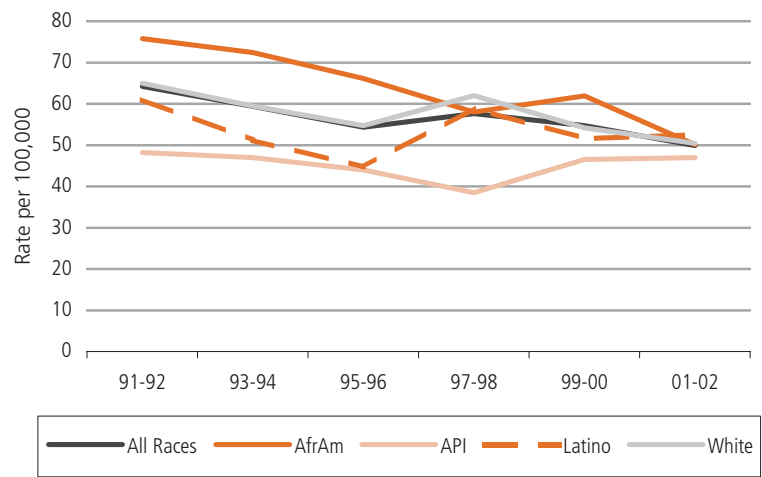
Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

The incidence of colorectal cancer in the county declined significantly by about 2.1% per year between 1990 and 2002. African Americans had the steepest decline in incidence (3.4% per year), followed by Whites (2%). No clear trend was observed for APIs or Latinos.

Rates for both males and females declined significantly during the period (data not shown).

Racial/ethnic disparities in the incidence of new colorectal cancer cases grew smaller over the decade, especially after 2000. The African American incidence rate was 20% higher than the county rate in 1990 and was the same as the county rate in 2002. Disparities in incidence were most pronounced among African Americans and APIs throughout the decade.

Figure 4.51: Colorectal Cancer Incidence by Race/Ethnicity, Alameda County, 1991-2002



Source: CAPE; Northern California Cancer Center, Census 1990 and 2000, DOF.

Female Breast Cancer

What is it?

Female breast cancer is a disease in which cancer cells are found in the tissues of the breast. In its early stages, the cancer cells stay in the breast as a tiny nodule or lump. In later stages, some cells from the lump spread to other parts of the body and cause tumors to grow in these new sites. While breast cancer can occur in men, women comprise the vast majority of breast cancer cases. The earlier breast cancer is discovered, the greater the chance for survival.^{1,2}

Why is it important?

Breast cancer is the second leading cause of cancer death among women and the most commonly diagnosed cancer among women in the United States.⁶ Women at high risk of developing breast cancer include those who: have a family history of breast cancer, have never been pregnant, were first pregnant after age 31, have had endometrial, ovarian, or unilateral breast cancer, or were exposed to low level ionizing radiation. Estrogen therapy and diet are also associated with breast cancer.^{1,2,12}

Seventy percent of all diagnosed cases of breast cancer are among women 50 years or older. The American Cancer Society estimates that more than 211,200 American women will be diagnosed with breast cancer in 2005 and over 40,400 women will die from the disease.⁶

In 2002, breast cancer killed 41,514 women in the United States.¹⁰ The age-adjusted death rate from breast cancer among U.S. women was 25.6 per 100,000. At the national level, breast cancer death rates are more than 30% higher among African American women than among White women (see Table 4.2 at end of chapter).^{7,10} In California, the breast cancer death rate is 23.4 per 100,000 women for the period 2001-2003.⁴ Both the national and state rates exceed the HP2010 objective of no more than 22.3 per 100,000 women.⁵

Breast cancer can be detected early through a combination of regular self-breast examination, clinical breast examination, and mammography. It is estimated that timely mammography screening among women older than age 40 could prevent 15% to 30% of all deaths from breast cancer.¹²

According to the National Health Interview Survey, there was a significant increase in the percentage of women aged 40 and older who reported having had a mammogram within the past 2 years during the last decade.²⁸

Since 1990, the breast cancer death rate has decreased for White females. There are no clear trends for other race/ethnic groups. Deaths due to breast cancer for African Americans continued to increase until 1995 and then showed a gradually decreasing trend. However, for other race/ethnic groups the death rates leveled off since the mid-1990s.^{8,9} This difference may be due to the fact that breast cancer tends to be diagnosed at later stages in African Americans and Hispanics compared to non-Hispanic White females.^{5,14,29} Also, African American and Hispanic women may be less likely to be screened for breast cancer, and they may be more likely to delay seeking treatment once symptoms are present.^{14,30} Other studies also suggest that the racial differences in breast cancer survival decrease when socioeconomic factors are taken into account.^{31,32}

What is Alameda County's status?

Female Breast Cancer Mortality

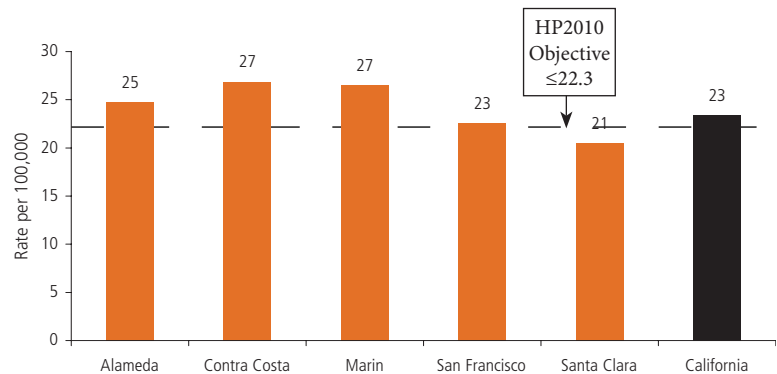
The female breast cancer death rate in Alameda County for the period 2001 to 2003 was higher than those in San Francisco and Santa Clara Counties and lower than in Contra Costa and Marin Counties, but none of these differences were statistically significant. Alameda County has yet to meet the national HP2010 objective of 22.3 or fewer breast cancer deaths per 100,000 women.

From 2001 to 2003, an average of 183 women per year died from breast cancer in Alameda County. The breast cancer mortality rate was 24.5 per 100,000 women.

African Americans had the highest breast cancer death rate, followed by Whites. Asians had the lowest rate. The African American rate was about three times that of Asians and two times that of Latinas. Asians and Latinas were the only race/ethnic groups that met the HP2010 objective of no more than 22.3 breast cancer deaths per 100,000 women.

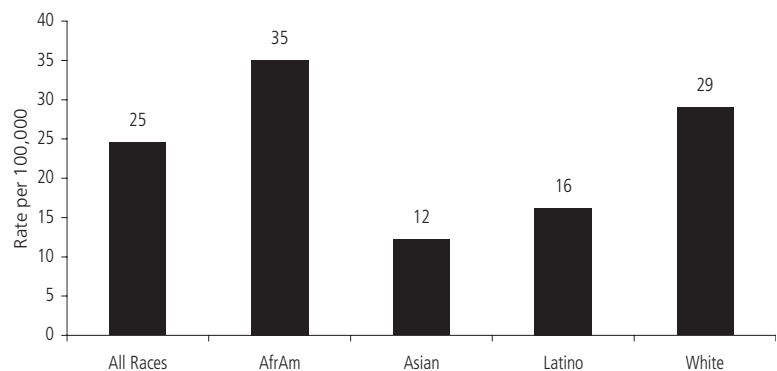
There were no breast cancer deaths below the age of 25 in Alameda County from 2001 to 2003. Breast cancer mortality increased steadily with age.

Figure 4.52: Female Breast Cancer Mortality, Selected Counties and California, 2001-2003



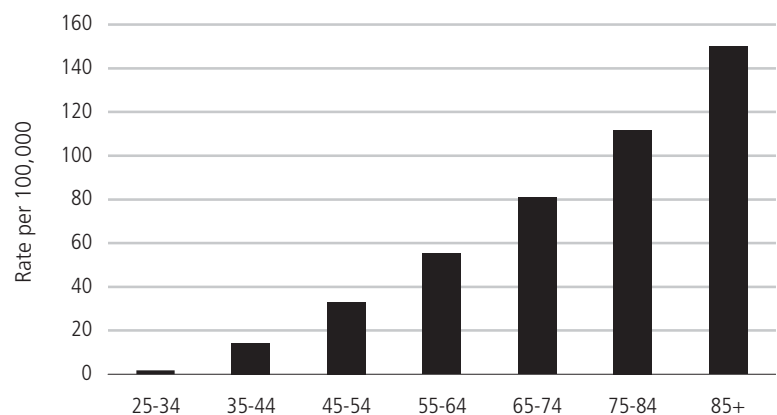
Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

Figure 4.53: Female Breast Cancer Mortality by Race/Ethnicity, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Figure 4.54: Female Breast Cancer Mortality by Age, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Breast cancer mortality among Alameda County women has declined significantly over the last decade by about 2.5% per year. Significant declines were also observed for Whites and APIs. Rates for African Americans and Latinas were variable and showed no clear trends.

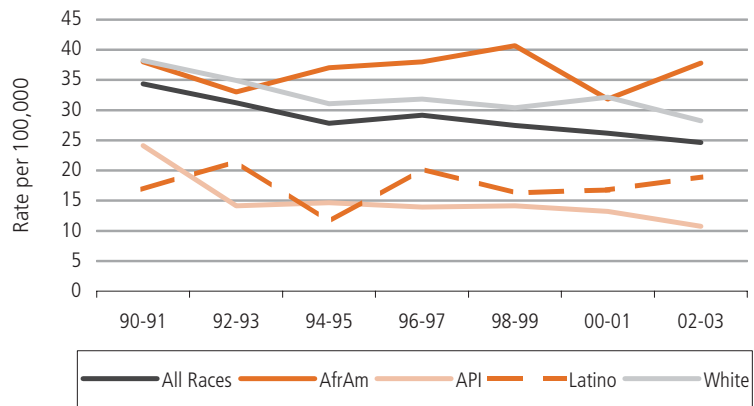
For most of the past decade, African American breast cancer mortality rates have exceeded those of other race/ethnic groups, tracking closely at times with Whites. In the 2002-03 period, the African American rate was 53% higher than the county rate, compared to 11% in 1990-91. While the variability in African American rates prevents us from drawing conclusions about trends, it is clear that the gap between the African American and the county rate is wider now than it was in 1990-91.

Female Breast Cancer Incidence

An average of 1,167 new cases of breast cancer per year were diagnosed in Alameda County between 2000 and 2002. The incidence rate was 161 per 100,000 women.

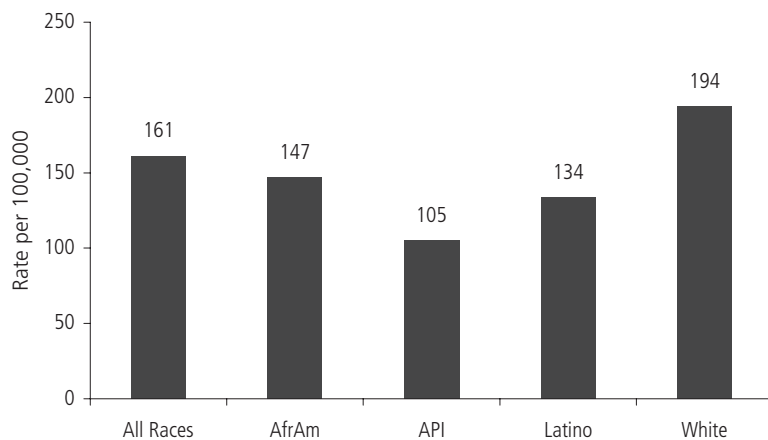
The breast cancer incidence rate for White females was significantly higher than any other race/ethnic group, and the API rate was significantly lower than any other group. The White rate exceeded the API rate by 85%, the Latino rate by 45%, and the African American rate by 32%.

Figure 4.55: Female Breast Cancer Mortality by Race/Ethnicity, Alameda County, 1990-2003



Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

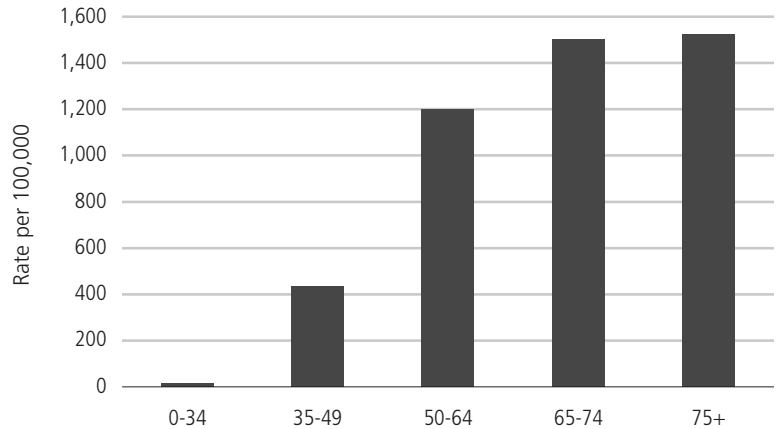
Figure 4.56: Female Breast Cancer Incidence by Race/Ethnicity, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Breast cancer diagnosis among women is very rare before 35 years of age. In Alameda County, the incidence of breast cancer increased with age and was highest among post-menopausal women.

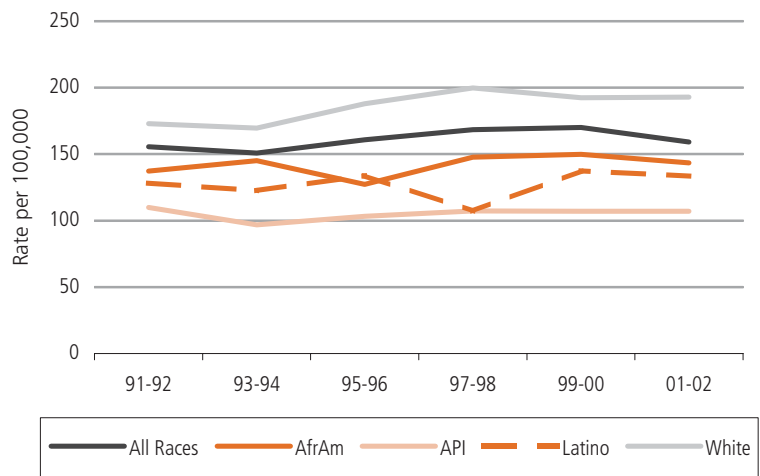
Figure 4.57: Female Breast Cancer Incidence by Age, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

The rate of new breast cancer cases in Alameda County changed very little between 1990 and 2002. However, the rate among White women increased significantly by about 1% per year. Rates for all other race/ethnic groups did not change significantly during this time period.

Figure 4.58: Female Breast Cancer Incidence by Race/Ethnicity, Alameda County, 1991-2002



Source: CAPE; Northern California Cancer Center, Census 1990 and 2000, DOF.

The disparity in breast cancer incidence between White women and the county increased over the decade, from 11% in 1991-92 to 21% in 2001-02.

It is noteworthy that the percentage of new breast cancer cases in Alameda County diagnosed at an early stage increased over the last decade, from 66% in 1990 to 71% in 2002.

Prostate Cancer

What is it?

Prostate cancer is caused by malignant, abnormal tissue growth in the prostate gland, the walnut-sized gland deep in the pelvis, between the bladder and the penis. The prostate, which wraps around the urethra, produces the fluid part of semen, which carries sperm. Most prostate cancer develops in the posterior part of the prostate gland, and the rest near the urethra. Prostate cancer is a slow-growing cancer that rarely produces symptoms until it is well advanced.^{1,2}

Why is it important?

Prostate cancer is the second leading cause of cancer-related death among men in the United States, as well as the most commonly diagnosed cancer among men. The American Cancer Society estimates that in 2005, there were 232,090 new cases of prostate cancer and approximately 30,350 deaths from the disease.⁶

Nationally, the age-adjusted prostate cancer death rate in 2002 was 27.9 deaths per 100,000 men; 30,446 men died from the disease.¹⁰ About 70% of prostate cancer cases are diagnosed among elderly men who are 65 years or older.³³ In California, the age-adjusted prostate cancer death rate was 28.0 per 100,000 during the period 1997-2001.²⁴ Both national and state rates are slightly lower than the Healthy People 2010 objective of no more than 28.8 per 100,000 men.⁵

Since 1990 there has been a gradual decline in the prostate cancer death rate among all race/ethnic groups monitored. This trend is more notable among Whites than among African Americans.^{8,29,33} The death rates for African American men continue to be two times higher than those for White men (see Table 4.2 at end of chapter).^{7,10}

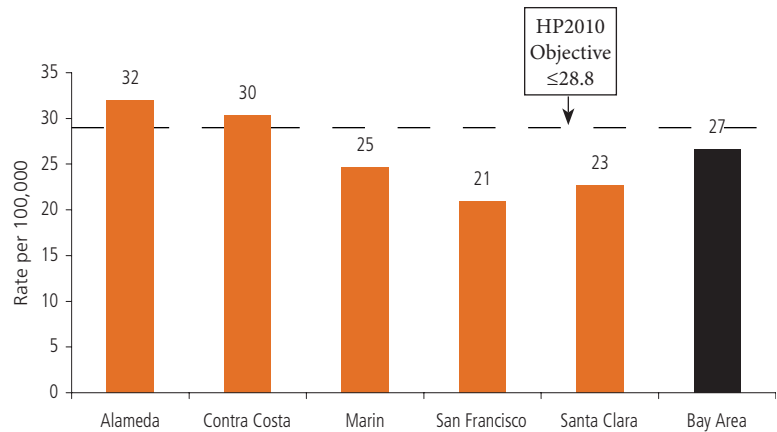
The declining trend might be explained by technological advances in medicine and early screening for prostate cancer known as prostate-specific antigen (PSA) testing.^{29,33} From a public health perspective, the effectiveness of PSA screening in reducing mortality has not yet been clearly demonstrated because the test produces a large number of false positives.³³

What is Alameda County's status?

Prostate Cancer Mortality

Alameda County's prostate cancer death rate for the five-year period, 1998-2002, was significantly higher than rates in Marin, San Francisco and Santa Clara Counties, as well as the Greater Bay Area. Alameda County has not yet met the national HP2010 objective of 28.8 or fewer prostate cancer deaths per 100,000 men.

Figure 4.59: Prostate Cancer Mortality, Selected Counties and the Bay Area, 1998-2002

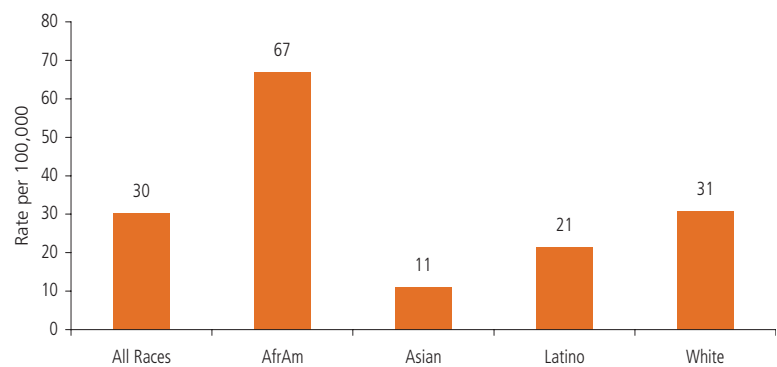


Source: CAPE; Northern California Cancer Center; Census 2000; DOF.

For the three-year period, 2001 to 2003, an average of 144 men per year died from prostate cancer in Alameda County. The prostate cancer mortality rate was 30 per 100,000 men.

Mortality from prostate cancer was significantly higher among African Americans than any other race/ethnic group. Asians had the lowest rate. The African American rate was six times that of Asians, three times that of Latinos and two times that of Whites. Asians and Latinos were the only race/ethnic groups that met the HP2010 objective of no more than 28.8 prostate cancer deaths per 100,000 men.

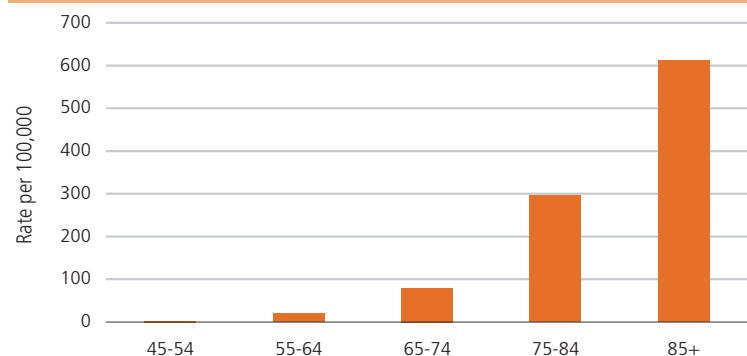
Figure 4.60: Prostate Cancer Mortality by Race/Ethnicity, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

There were no prostate cancer deaths below the age of 35 in Alameda County from 2001 to 2003. Prostate cancer mortality increases steeply with age.

Figure 4.61: Prostate Cancer Mortality by Age, Alameda County, 2001-2003

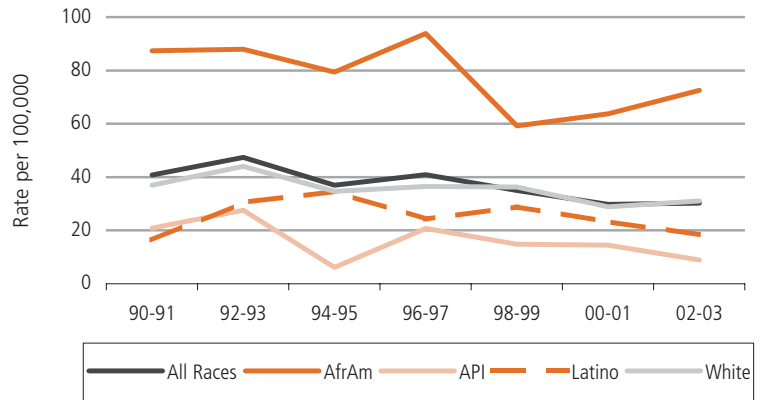


Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Prostate cancer mortality among Alameda County men declined significantly over the last decade by about 3% per year. Significant declines were also observed for Whites and APIs. Death rates for African Americans declined overall, but due to variability in the rate, the decline was not statistically significant. The rates for Latinos rates changed very little over the decade.

African American prostate cancer mortality has been consistently higher than any other group throughout the past decade. The African American rate remains about two times higher than both the county rate and the White rate.

Figure 4.62: Prostate Cancer Mortality by Race/Ethnicity, Alameda County, 1990-2003



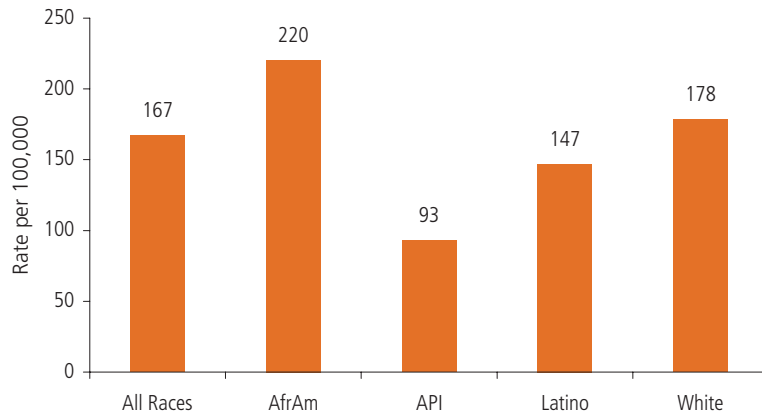
Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

Prostate Cancer Incidence

An average of 901 new cases of prostate cancer per year were diagnosed in Alameda County between 2000 and 2002. The incidence rate was 167 per 100,000 men.

The prostate cancer incidence rate for African American men was significantly higher than that for any other race/ethnic group, while the API rate was significantly lower. The African American rate was 2.4 times the API rate. It exceeded Latino rates by 50% and White rates by 24%.

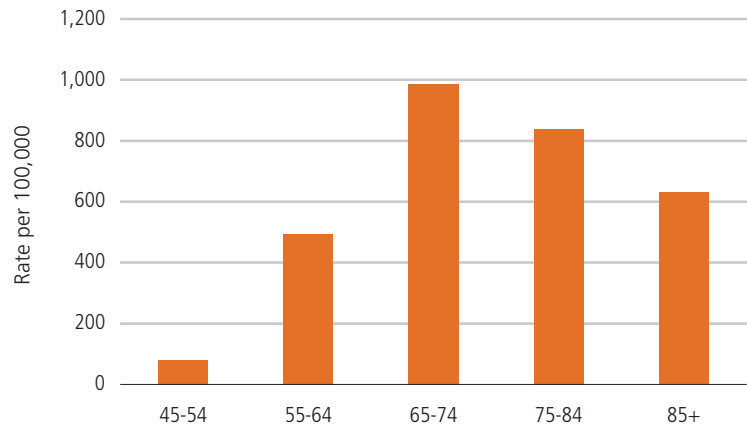
Figure 4.63: Prostate Cancer Incidence by Race/Ethnicity, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Prostate cancer screening is recommended among men age 50 or older. Survival from prostate cancer has improved dramatically since the mid-1990s when screening practices became increasingly widespread. In Alameda County, incidence of prostate cancer increased with age, peaking in the age group 65-74 years and then declining.

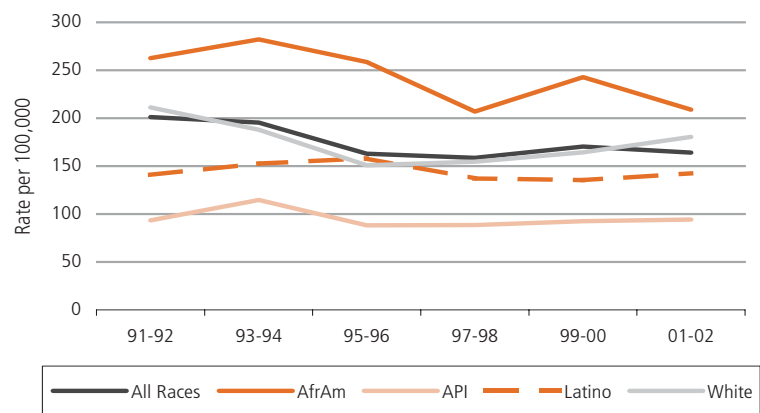
Figure 4.64: Prostate Cancer Incidence by Age, Alameda County, 2000-2002



Source: CAPE; Northern California Cancer Center, Census 2000, DOF.

Prostate cancer incidence in the county has been relatively stable over the past decade except for a period of decline between 1992 and 1996 of about 7% per year. Among African Americans, it decreased steadily by about 2% per year between 1990 and 2002. Among Whites the rate declined 10% per year between 1992 and 1996, then increased after 1996 about 4% per year. Trends in prostate cancer incidence among APIs and Latinos were stable.

Figure 4.65: Prostate Cancer Incidence by Race/Ethnicity, Alameda County, 1991-2002



Source: CAPE; Northern California Cancer Center, Census 1990 and 2000, DOF.

The incidence rate for African Americans has been 30% to 40% higher than the county rate throughout most of the past decade. The gap was widest at 60% in 1995-96, and narrowest at 27% in the most recent period, 2001-2002. Throughout the decade, the African American rate was two to three times that for APIs.

Prostate cancer cases in Alameda County diagnosed at an early stage increased from 56% in 1990 to 79% in 2002.

Table 4.2: Average Annual Age-adjusted Incidence and Death Rates (per 100,000) for Cancers by Race in United States, 1998-2002

All Cancers

		White	African American	Asian/Pacific Islander	Latino	American Indian
Incidence rate	Total	479.7	512.3	335.6	352.4	233.6
	Male	556.4	682.6	383.5	420.7	255.4
	Female	429.3	398.5	303.6	310.9	220.5
Death rate	Total	195.3	248.1	119.9	135.2	132.4
	Male	242.5	339.4	148.0	171.4	159.7
	Female	164.5	194.3	99.4	111.0	113.8

Lung Cancer

		White	African American	Asian/Pacific Islander	Latino	American Indian
Incidence rate	Male	76.7	113.9	59.4	44.6	42.6
	Female	51.1	55.2	28.3	23.3	23.6
Death rate	Male	75.2	101.3	39.4	38.7	47.0
	Female	41.8	39.9	18.8	14.8	27.1

Colorectal Cancer

		White	African American	Asian/Pacific Islander	Latino	American Indian
Incidence rate	Male	61.7	72.5	56.0	48.3	36.7
	Female	45.3	56.0	39.7	32.3	32.2
Death rate	Male	24.3	34.0	15.8	17.7	16.2
	Female	16.8	24.1	10.6	11.6	11.8

Female Breast Cancer

		White	African American	Asian/Pacific Islander	Latino	American Indian
Incidence rate		141.1	119.4	96.6	89.9	54.8
Death rate		25.9	34.7	12.7	16.7	13.8

Prostate Cancer

		White	African American	Asian/Pacific Islander	Latino	American Indian
Incidence rate		169.0	272.0	101.4	141.9	50.3
Death rate		27.7	68.1	12.1	23.0	18.3

Source: National Cancer Institute; National Center for Health Statistics.

What are we doing?

The Nutrition Services Program in the Community Health Services Division, Alameda County Public Health Department (ACPHD), promotes healthy eating habits and increased physical activity in the community to improve health and reduce morbidity and mortality due to chronic diseases. Through partnerships with both public and private organizations, the Nutritional Services Program:

- Works with several Alameda County school districts to promote healthy food practices, increase physical activity opportunities, and develop effective nutrition policies that 1) support the sale of nutritious foods, 2) ban the sale of unhealthy foods/sodas on campus, and 3) require regular physical activity in the curriculum.
- Partners with community organizations to provide nutrition education and training to increase capacity to promote healthy habits and environmental changes. Conducts community leadership forums and bi-annual workshops and maintains a “Nutrition Warmline” to answer nutrition questions. Works with communities to promote initiatives to increase physical activity and improve nutrition through mini-grants, assessments, and other strategies.
- Conducts community-based nutrition education with parents, food service workers, teachers, principals, senior citizens, children in schools, and after-school programs, including the Oakland Parks and Recreation Department. ACPHD staff works in neighborhoods to identify and promote local farmer’s markets and community gardens.
- Convenes community Healthy Living Councils in selected senior centers and Oakland Unified School District schools to ensure that conditions exist for community members to eat better and be more active. Provides nutrition education programs to these councils and supports members in making both individual and environmental changes.
- Actively identifies and supports legislation to address key nutrition and physical activity issues in schools and regulate food advertising to children.
- Develops a community education campaign that includes public service messages and health education materials on important health topics such as the benefits of physical activity and good nutrition in preventing chronic diseases.
- Promotes employee health within the department by organizing and promoting inter-departmental walking challenges such as “Tour de Earth”. In collaboration with the Employee Wellness Coordinator, staff have provided several “Lunch and Learn” sessions on improving nutrition and physical activity levels. The Nutrition Services Program also maintains an educational Nutrition and Physical Activity lobby display board for all staff viewing. The Program is currently developing a policy on vending machine sales and recommendations on workplace food and nutrition practices.

The Diabetes Program in the Community Health Services Division, ACPHD, provides diabetes self-management education to Alameda County residents living with type 2 diabetes. The Program offers information to medical professionals on guidelines for the care of people with diabetes, and it provides case management to people living with type 2 diabetes. In addition, the Program is developing a peer educators network to assist in educating the community on diabetes prevention and management. The Program is extending its efforts to assist the Oakland Unified School District in the man-

agement of students with diabetes and is in the process of developing a pediatric coalition of diabetes care providers to plan coordinated service delivery.

The Asthma Start Program in the Community Health Services Division, ACPHD, provides case management services to children with asthma living in Alameda County. Services include health education, environmental home assessments for asthma triggers, asthma trigger reduction counseling (including smoking cessation and reducing exposure to second hand smoke), provision of asthma trigger reduction supplies (such as mattress encasings or vacuum cleaners) as appropriate, and advocacy mentoring for negotiating the health care system. The Asthma Start Program also participates in, and actively supports, partnerships and coalitions to provide services in a seamless manner, share referrals, raise awareness of best practices towards managing asthma, and coordinate service delivery.

The Tobacco Control Program of the ACPHD works with various community groups, organizations, educators, and policy makers to counter pro-tobacco influences in the community through a variety of strategies, including: 1) providing education on tobacco-related disease prevention, 2) reducing exposure to environmental tobacco smoke, 3) increasing the number of smoke-free public spaces, worksites, schools, and communities; and 4) reducing the availability of tobacco products to youth.

To reduce exposure to environmental tobacco smoke, the Tobacco Control Program encourages community-based agencies, grass-roots organizations, businesses, and schools to incorporate new health promotion strategies, policies, and ordinances aimed at preventing smoking and reducing exposure to second hand smoke. It also provides training and support to local police departments in enforcement of smoke-free public spaces and restrictions on sales of tobacco to minors.

In 2005, Office of Urban Male Health was established in the Office of the Director of the Alameda County Public Health Department. The new office was established with the aim of improving health and reducing premature deaths among men and boys in Alameda County. The new office will address health problems and associated risk factors that disproportionately affect males in urban environments. To accomplish this, the office is coordinating outreach and awareness efforts on a regional level, promoting preventive health behaviors, and providing central resources for providers of men's health services. The goals of the program are three-fold: 1) To develop strategies, policy recommendations, and programs that are designed to increase healthcare access and advance a continuum of care for underserved men and boys; 2) To improve health outcomes for men in specific disease areas, including but not limited to prostate and testicular cancers, cardiovascular diseases (such as high blood pressure, stroke, and heart attacks), depression, suicide, and diabetes; and 3) To study local health problems which predominately affect men, and make appropriate recommendations.

As one of its first activities, the Office of Urban Male Health has launched a pilot project aimed at increasing healthcare access for underserved men and fathers in urban Alameda County. The pilot will inform efforts to start up a five year demonstration project called the Passports System. The goals of the Passport system are aligned with those of the Office itself. The program will offer comprehensive health care services and case management and other services that address social determinants of health such as housing and employment. Additionally, the program aims to help families develop positive relationships with fathers and enable fathers to care for their families by promoting paternal health. The program's target population is uninsured and underinsured men, with special focus on low income men, teenage males, men of color, elderly men, and formerly incarcerated men.

What else do we need to do?

Nutrition

- Expand funding sources for health promotion/chronic disease prevention to include a diversified funding base.
- Integrate built community approaches into chronic disease prevention interventions including pedestrian and transit planning and economic development.
- Expand the development of Healthy Living Councils in additional school districts, including Livermore and Fremont.
- Enhance worksite wellness with ACPHD to include the development of a vending machine policy and recommendations for worksite food and nutrition practices.
- Work with County Risk Management to explore discounted memberships to health clubs for County employees.
- Develop and disseminate healthy living tips and guidelines for ACPHD employees.
- Work to establish a countywide policy for the following: (1) Allow the use of county facilities for employee physical activity; (2) Ensure that all vending machines used by county employees in county owned or leased spaces meet specific criteria for healthy food options; and (3) Ensure that healthy food is provided when county funds are used to purchase food for county business.

Diabetes

- Develop a diabetes education program for women that have had gestational diabetes and people with pre-diabetes.

Asthma

- Develop healthy eating classes for parents of children with asthma.
- Produce a newsletter for parents of children with asthma.
- Develop an asthma support group for parents.

Tobacco

- Utilize the recent California Air Resources Board ruling that second-hand smoke is a toxic air contaminant to more effectively protect the residents of Alameda County.
- Provide additional resources to assist smokers in quitting smoking.
- Expand sustainable resources for monitoring sales of tobacco to minors by working with local cities to pass an annual tobacco retailer license. This means that any retailer selling tobacco products would need to pay an annual fee (the amount would be decided by the jurisdiction); the proceeds from these fees would support local enforcement of laws prohibiting sales of tobacco to minors.
- Work to establish Reasonable Distance ordinances in Alameda County cities where ordinances currently do not exist.

- Ensure that all cities in Alameda County that have Reasonable Distance ordinances have included language that specifies footage requirements.

Men's Health

- The Office of Men's Health will seek sources of funding in order to launch the Passports five-year demonstration project and to sustain this effort over the long term.
- The Office will create public and private partnerships through coordination with contracted health care providers, build relationships with community-based organizations targeting the same groups, and build inter-county alliances with other agencies dealing with the same mobile population.
- The Office will also develop education and outreach campaigns directed at both the target population and at increasing awareness among providers. Strategies will include brochures, health fairs, media partnerships, peer-to-peer health events, workplace health programs, and working at San Quentin and in target neighborhoods.
- Additional development goals include supporting men in their ability to pay child support; providing domestic violence interventions; promoting men's emotional wellness through promotion of positive fatherhood programs; and changing policy to require paternal inclusion in mandated maternal programs at state and local levels.

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