Ms. MAXINE WATERS of California. Mr. Speaker and Members, we have had another moment of silence, a moment of silence indicating that somehow we are concerned about what happened in Orlando, Florida. It is not good enough.

How many times have we done this? Whether we are talking about Sandy Hook, where those babies were killed, or we are talking about North Carolina or we are talking about San Bernardino or Aurora, Colorado, we keep getting up with a moment of silence because we don't want to deal with what is really going on.

This Republican leadership is pitiful. It is disgusting that they don't have the guts or the commitment to call it like it is and bring a bill to this floor to get rid of assault weapons. That weapon that killed those 50 people and harmed those other 53 is a weapon that is designed for war. Don't tell me about your hunting concerns. This AR–15 has nothing to do with hunting. This is about killing. And so this leadership is spineless, it is gutless, and it deserves not to have the ability to get up on this floor and talk about responsibility or innovation——

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Ms. MAXINE WATERS of California.—or any of this other stuff that they are talking about. I want to say over and over again, I don't care if my time is up, you stop me from talking if you will.

The fact of the matter is, we should all be on this. Business as usual? I don't think so. We should have stopped everything this evening, concentrated on how we can get a bill to the floor.

The SPEAKER pro tempore. The time of the gentlewoman has expired.

Ms. MAXINE WATERS of California. I know you don't want me to talk while you are waiting for your talking points from the leadership.

The SPEAKER pro tempore. The gentlewoman is no longer recognized.

Ms. MAXINE WATERS of California.

* * *

The SPEAKER pro tempore. The Chair is prepared to recognize the gentleman from California.

PROPERTY RIGHTS EXEMPTION FOR FARMS

(Mr. LAMALFA asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. LAMALFA. Mr. Speaker, last Friday a Federal court in California made an almost unbelievable ruling that the Army Corps of Engineers could regulate the plowing of fields despite clear exemptions for normal farming activities in the Clean Water Act.

Ruling against a family farm in my district, the court somehow found that the Corps was justified in attacking the farm for, believe it or not, planting wheat on land that had been used to grow wheat for decades. Wow. The nerve of this family, to grow crops on land historically used to grow crops.

Rarely have we seen an administration distort the legislative intent of Congress as it has in this instance. The Army Corps and EPA are ignoring language that exempts ''normal farming, silviculture, and ranching activities such as plowing, seeding, cultivating, minor drainage, harvesting . . . '' and so on—exactly the activity that occurred in this instance. In other words, Congress clearly and unambiguously exempted day-to-day activities, and yet the administration continues working to try to regulate them.

Mr. Speaker, we have enacted language I have sponsored to defund this type of lawless regulation, and yet the administration continues. We must rein in this executive overreach and develop reforms that end this abuse once and for all.

THE DEADLIEST SHOOTING IN AMERICAN HISTORY

(Mrs. LAWRENCE asked and was given permission to address the House for 1 minute.)

Mrs. LAWRENCE. Mr. Speaker, the June 12 mass shooting at a club in Orlando, Florida, was not only the deadliest shooting in American history, it was one of the most heinous hate crimes and acts of terrorism this country has ever seen. Too often hate crimes and acts of terrorism use guns. The epidemic overwhelmingly express the need to strengthen our gun laws.

A stronger background check system will help prevent hate crimes and acts of terrorism to protect Americans from terrorists who want to attack our way of life. We must give the FBI the authority to block sales to suspected terrorists, and we must require background checks for every gun sale in America.

Mr. Speaker, no more silence. Let's stand up as Americans, and in this Congress, and tell the American people, those who are mourning, and those across this country who have experienced this that we in Congress will do the work we were sent here to do, and that is to stand up and take action.

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BRIDGING THE DIVIDE: A CALL TO ACTION BY THE CONGRESSIONAL BLACK CAUCUS TO ELIMINATE RACIAL HEALTH DISPARITIES

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2015, the gentlewoman from Ohio (Mrs. BEATTY) is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Mrs. BEATTY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and add any extraneous materials relevant to the subject matter of this Special Order.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Ohio?

There was no objection.

Mrs. BEATTY. Mr. Speaker, I rise this evening, along with my colleague, Congressman HAKEEM JEFFRIES of the Eighth Congressional District of New York, for tonight's Congressional Black Caucus Special Order hour, Bridging the Divide: A Call to Action By the Congressional Black Caucus to Eliminate Racial Health Disparities.

Mr. Speaker, tonight, the Congressional Black Caucus comes to the House floor to discuss our overarching goal of promoting equality for African Americans across the healthcare spectrum.

Mr. Speaker, it is well known that poverty, socioeconomic status, and health disparities are closely linked and latched together. For example, individuals with low incomes tend to have more restricted access to medical care and face greater financial barriers to affordable health care, oftentimes contributing to health disparities.

Last week, Mr. Speaker, the House Republicans released their Conference's poverty plan called A Better Way. Unfortunately, but not unexpectedly, this Republican antipoverty proposal isn't a better way, Mr. Speaker. It isn't even a new way. Quite frankly, Mr. Speaker, it is the wrong way. It uses the same trickle-down, discredited policies that House Republicans have put forth in the past.

The House Republicans' poverty elimination proposal would repeal the Affordable Care Act and undermine affordable, quality health coverage that millions of Americans are now enjoying. It would also cut Medicaid, the Children's Health Insurance Program that we refer to as CHIP, and it would end the Medicare guarantee—programs with proven successes, Mr. Speaker, in reducing health disparities. So this is, in part, why we are here tonight.

We know that health coverage is the first step in securing better healthcare outcomes, and Medicaid and CHIP play a vital role in opening the doorway to the needed health care, especially for our children.

As we address the most pressing challenges in achieving health equity and equality for African Americans, I want hardworking American families to know that they have voices in Congress that aim to protect their safety, invest in their future, and provide affordable health care for all.

With the Affordable Care Act, which every member of the Congressional Black Caucus supported when it passed, we have improved access. We have improved affordability and quality of health care.

So tonight, Mr. Speaker, I want to thank President Obama for moving the needle forward in helping American families and African American families across this great country and Nation to have the financial and health security that comes with health care.

Mr. Speaker, we cannot repeal the ACA. We must continue to improve and strengthen it, and we will still have more work to do.

The Congressional Black Caucus, from its very inception, has long been the voice for bridging the divide on racial healthcare disparities. No, Mr. Speaker; we have been the voice for standing up for American people, and especially individuals who are African American, against all disparities. We will not only come to this floor tonight. We will continue our fight and we will continue to come to this floor.

Tonight, you are going to hear a lot of our members weave together our poverty plan. You are going to have members talk about gun violence. You are going to have members talk about all lives matter. If we don't end the gun violence, then we are not going to have a healthy nation.

Tonight, I want to applaud my good friend and colleague, Congresswoman ROBIN KELLY of the Second District of Illinois, chair of our Congressional Black Caucus Health Braintrust. I want to commend her for her report, the 2015 Kelly Report on Health Disparities in America, the official congressional analysis of the state of African Americans' health in the United States, and her work on the 40 Under 40 Leaders in Health Awards, leaders under 40 who are physicians and medical professionals. And lastly, let me just thank her for her courage and her leadership for recognizing that all lives matter.

We cannot come to this House floor and talk about poverty programs and health care and education and about finance if we do not bridge the gap with gun violence. I salute her for no longer standing up until we make a difference.

So tonight, we are coming, Mr. Speaker, with a strong call to action for us to keep this wonderful America healthy. You will hear from Congresswoman KELLY momentarily.

Mr. Speaker, I yield to the gentleman from North Carolina (Mr. BUTTERFIELD), chairman of the Congressional Black Caucus. He is a chairman who has been a longtime advocate and voice for not only the Congressional Black Caucus, but for his constituents in his congressional district in North Carolina. Tonight, he speaks for us. Tonight, he speaks for the call of action of us to bridge the gap.

Mr. BUTTERFIELD. I thank Congresswoman BEATTY for yielding to me this evening.

This is such a sad evening for all of us because of the events in Orlando. I thank her so very much for having the strength to come to the floor tonight to manage the important topic that we are all so concerned about.

I thank Congresswoman ROBIN KELLY for her incredible work chairing the CBC Health Braintrust and all the work she does related to health disparities in this country. I thank all of my colleagues for their tireless work.

Before I begin my remarks, let me just say that I sat on the floor a moment ago and listened to Congresswoman CORRINE BROWN. It was an incredible 1-minute speech she gave. I want to share in her sentiments this evening and align myself with the pain that she and her constituents are facing in Orlando. The mass shootings were absolutely horrific and unthinkable, under any definition. They are just unthinkable.

My prayers go out to the families in Orlando for their pain and for all that they are having to endure because of these mass shootings.

As someone said a few moments ago, a moment of silence is not enough. It is time for this Congress to act. It is time for this body, Mr. Speaker, to have a serious debate about gun violence and to pass legislation that will deprive people the right to own a high-capacity assault weapon and high-caliber bullets and use them to kill innocent people. Now is the time.

136 mass shootings have taken place during the first 164 days of this year. It is a sad statistic that we must address. The United States is 5 percent of the world's population, yet we are 31 percent of the mass shootings in the world. It is time to act.

Let me talk about the topic tonight, very briefly.

The Congressional Black Caucus has been committed to advancing access to affordable health care for all Americans so that we can eliminate racially based health disparities. That has been our mission for many years.

Eliminating health disparities means addressing inequities in environmental, social, and economic conditions in all of our communities. By all measurable statistics, from health outcomes to participation in health professions, African Americans lag so far behind.

For example, more than 40 percent of African Americans have high blood pressure—a rate that is one of the highest in the world. African Americans are more likely to develop hypertension at a younger age and are at higher risk of stroke, heart failure, end-stage renal disease, and death from heart disease.

Stroke, Mr. Speaker, is the third leading cause of death in the United States. African Americans are 50 percent more likely to experience a stroke than White Americans. That is a fact.

According to the Federal Centers for Disease Control and Prevention, African American children are twice as likely to have asthma as White children, and Black children are 10 times more likely than White children to die of complications from asthma.

African Americans were, on average, 6 years younger than Whites when they suffered sudden cardiac arrest. Cardiac arrest incidence among African American men was 175 per 100,000; whereas, the incidence for White males was just 84 per 100,000. Cardiac arrest in African American women was 90 per 100,000, as opposed to 40 per 100,000 for Caucasian women.

Another illness which disparately impacts the African American community is that of prostate cancer. In June of last year, I introduced the National Prostate Cancer Plan Act, a bipartisan bill which seeks to establish the National Prostate Cancer Council on Screening, Early Detection and Assessment and Monitoring of Prostate Cancer.

Prostate cancer impacts one in seven American men and is the second leading cause of cancer-related deaths among men in the U.S., with nearly 30,000 deaths anticipated just this year. African American men are particularly vulnerable, as they are twice as likely to be diagnosed with prostate cancer and 2.5 times more likely to die from the disease than their White counterparts.

Just last week, House Republicans released their A Better Way agenda to address poverty, but that proposal, like others they have released, will not lift Americans out of poverty. In some cases, these types of proposals can actually push low-income Americans even deeper into poverty, further limiting their access to health care and exacerbating health disparities.

So, Mr. Speaker, it is time for us to continue our efforts to address the health disparities and barriers. That is what the Congressional Black Caucus is advocating the evening. We are going to continue this work until every disparity is removed.

Mrs. BEATTY. I thank Congressman BUTTERFIELD for making us aware of 136 mass shootings in 164 days of this year. Certainly, that is relevant to tonight's topic, because whether it is death by guns or death by healthcare disparities, there are too many deaths.

I think you said it so well when you provided the data and the statistics of African American men and their mortality rates and what is happening to them. And yes, African Americans lag behind, and that is why we stand with you bridging the gap and for this call of action.

Mr. Speaker, I yield to the gentlewoman from Illinois (Ms. KELLY) from the Second Congressional District, my colleague, my confidant, and my friend. She is a champion of expanding health care. She is a champion, Mr. Speaker, of making sure that we understand that healthcare disparities must end.

She is the chair of the powerful and most prestigious Congressional Black Caucus Health Braintrust. She strives to increase healthcare opportunities for all: for our children, for our senior citizens, and for residents of the underserved communities. It is my honor to ask her to provide some information on today's topic.

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Ms. KELLY of Illinois. Mr. Speaker, I want to thank my colleagues and my classmates, the gentlewoman from Ohio (Mrs. BEATTY), my friend, and the distinguished gentleman from New

York (Mr. JEFFRIES), for leading this important conversation about bridging the divide to eliminate racial health disparities.

But I can't weigh in on that topic until I first address the horrific events of yesterday in Orlando, Florida. Our Nation is horrified and heartbroken by the tragedy in Orlando. We are disgusted by this brutal attack. We will not tolerate terrorism or hate in any form against any group of people because this is just not our way.

These ideas of hate will not endure because there is not strength to them. We will win the battle against terrorism and intolerance.

We will hold leaders accountable who put their NRA score ahead of the need to keep guns out of the hands of terrorists. We will stand with the LGBTQ community and value their lives, their health, and their security from the threat of violence and hate. And we will work to see that all Americans enjoy the very same freedoms and protections.

We have done a lot of moments of silence, but I believe in showing respect through action, not silence, and that is why we are here this evening to discuss what divides us as a country in a health sense.

For 45 years, the Congressional Black Caucus has been out front in Congress in fighting for these freedoms and protections. And when it comes to the matter of health equity, I have worked to champion the health policy concerns of vulnerable communities as my predecessors in the Congressional Black Caucus Health Braintrust, the Honorable Louis Stokes and Dr. Christensen, have done.

Some of my colleagues here know this, but I want to repeat it for anyone who doesn't. Before he was killed, Martin Luther King, Jr., was quoted as saying: ''Of all the forms of inequality, injustice in health care is the most shocking and inhumane.''

I couldn't agree more, and as the chair of the Health Braintrust, I have worked with many of the people in this room to focus on advancing this critical phase of the human rights and civil rights struggle: health equity.

When Benjamin Franklin created the Nation's first public hospital, The Pennsylvania Hospital, he did so in order to establish the promotion of public health as a core American value. He did so to care for our Nation's diseased and sick poor.

Nearly 300 years later, the Affordable Care Act cemented health care as a fundamental right for all Americans. Yet, today, we find ourselves at a crossroads in health care. Health disparities in communities of color continue to be intractable hurdles in the quest to achieve health equity in America.

African Americans are infected with HIV at a rate that is 8 times that of White Americans.

While White women are more likely to have breast cancer, African American women are 40 percent more likely to die from the disease.

African Americans, Latinos, Asians, and Pacific Islanders, as well as Native Americans, are diagnosed with lupus two to three times more frequently than Caucasians.

More than 13 percent of African Americans aged 20 or older have diagnosed diabetes. And people of color are two to four times more likely than Whites to reach end-stage renal disease.

This grim snapshot illustrates that, despite the gains we have made since the days of Ben Franklin and the ACA, there is still much ground to cover in closing the health equity gap.

Last year, I drafted a comprehensive report, The Kelly Report on Health Disparities, an official Congressional analysis of the state of minority health in the U.S. that offers a blueprint for reversing negative health trends in communities of color.

The Kelly Report brought Members of Congress together, medical professionals, and public health thought leaders to examine the root causes and impact of health disparities in America, and provide a comprehensive set of legislative and policy recommendations to address them.

The whole can only ever be as healthy as its parts. For America to achieve true health equity, lawmakers, community leaders, and industry stakeholders must come together and aggressively work to reduce disparities nationwide. We all have a part to play in creating a healthier America.

We must take heed of Dr. King's words: ''Of all the forms of inequality, injustice in health care is the most shocking and inhumane.'' And we can and we must fix that.

Again, because of what happened in Orlando, and I want to say it is the mass shooting that we are talking about, and it is tragic, but the night before, one person was shot. And I often liken this to a 747 crash as we talk about that, but we don't talk about the two-seater. And that two-seater, the person that died alone in that club after she sung Friday night has a brother, a mother, a father, and their pain is just as harsh. So let's not forget that young lady that lost her life. And she did not lose her life to someone that was Muslim or someone that believed in ISIS. She lost her life to an American young man, a Caucasian.

Mrs. BEATTY. I thank the gentlewoman from Illinois, (Ms. KELLY). And how appropriate for tonight for the gentlewoman to remind us, as I ask her to constantly do, about why we must, to put it in her words, come together. We must do something.

Madam Speaker, tonight we say to you and to our Republican colleagues: Come together and do something.

I say to the gentlewoman, Congresswoman KELLY: Let today serve as a turning point in our Nation's ongoing struggle to stamp out hate of all forms. We must mourn those who lost their family members, but we must do more than mourn. We must have action. If we are going to have a hope for a better America, hate has no place in this great Nation.

So I thank the gentlewoman, and I will continue to remind others that we know firsthand what it does to our community.

But, Madam Speaker, we stand here tonight speaking to all communities. But here is what we know. The NAACP has shared with us that African American children and teens accounted for 45 percent of all child and teen gun deaths in 2008 and 2009, but were only 15 percent of the total child population.

The FBI says that approximately 47 percent of victims of the 165,000 homicides from 2000 to 2010, including over 111,000 gun-related homicides, were Black.

The Children's Defense Fund, Madam Speaker, says that in 2010, Black males between the ages of 15 and 19 were nearly 30 times more likely to die in a gun homicide than White males of the same age, and more than three times more likely to die in a gun homicide than Hispanic males of the same age.

So, Madam Speaker, tonight you will hear us repeatedly make a call for action. You will hear us repeatedly quote great leaders. And I think it is worth quoting again what Congresswoman KELLY said, in the words of Dr. Martin Luther King: ''Of all the forms of inequality, injustice in health care is the most shocking and inhumane'' of all inequalities, of all injustices.

As we speak of great leaders, it is, indeed, my honor and my privilege to ask my colleague, the gentleman from the 10th Congressional District of New Jersey (Mr. PAYNE), a man who has made a name for himself, a man who understands firsthand as a father of triplets, as a spouse, as a ranking member on Homeland Security's Subcommittee on Emergency Preparedness, Response, and Communications, a man who has been at the forefront in his community, a man who served before coming here as an elected official, but, more importantly, a person who understands health disparities and the call for action—it gives me great honor to yield to the gentleman from New Jersey (Mr. PAYNE) to share some wisdom with us tonight.

Mr. PAYNE. Madam Speaker, I first want to start by thanking Congresswoman BEATTY for that very kind and generous introduction. We, in our class, are very proud of our colleagues, and we support each other in times of need.

I just would like to also congratulate and acknowledge Congressman HAKEEM JEFFRIES, the gentleman from New York, who is also host of this Special Order. I appreciate the opportunity to discuss an issue that is very personal to me.

Before I begin, I just want to say that my heart goes out to the families and friends of the victims of the horrible

tragedy in Orlando, and I can only imagine what they are going through.

The other thing that is illuminating to me is that, as we came here and stood up for a moment of silence, after that moment of silence, I believe Members were given a 1-minute opportunity to speak on any topic that they would like to on the floor, as is customary, and not one person from the other side of the aisle mentioned what happened in Orlando.

So not only was it a moment of silence for the leadership in this House, but it appears that it is going to be a moment that remains silent or a topic that remains silent from the other side of the aisle.

Madam Speaker, eliminating racial-based health disparities depends on our ability to advance access to affordable health care for all. Even in the 21st century, health disparities are stark, especially in the African American communities, where life expectancies are lower and infant mortality rates are higher than among Whites.

Today, despite improvement in overall health in the United States, African Americans and other minority populations lag behind in numerous health areas, including access to quality care, timelines of care, and health outcomes.

For years, the Congressional Black Caucus has called on Republicans to join us and other House Democrats in developing a plan to eliminate racial health disparities, a plan that addresses the causes of health disparities, such as inequities in environmental, social, and economic conditions in our communities.

Instead, we get from them proposals like their so-called A Better Way poverty proposal, a stale, repackaging of failed policies presented under the guise of concern about Americans trapped in poverty.

Cutting job training programs, food assistance, and Head Start will push low-income Americans further into poverty, making it even more difficult for them to access the affordable and quality health care needed to secure their well-being and the well-being of their families. We need to, instead, use the government as a source of good.

Every American deserves to live in a safe and healthy environment. Yet, low-income and minority communities are much more exposed to high levels of pollution, resulting in serious health problems such as asthma, heart problems, and cancer.

This is a very real problem across America, a very real problem in my district. Thirteen million people, including 3.5 million children, are concentrated in the vicinity of transportation facilities and are exposed to unhealthy levels of air pollution.

□ 2015

My district is home to the Port Newark-Elizabeth Marine Terminal, part of the Port of New York and New Jersey, the third largest port in the country. According to the EPA, 25 percent of children in Newark suffer from asthma—three times the State average.

What we need are additional Federal actions to reduce harmful air pollution from ports and congested components of the national freight transportation system. The issue is critical to the low-income and minority community who suffer the disproportionately adverse health effects of these environmental hazards.

Now, since I am on the topic of environmental justice, I just want to remind everyone that the Republicans continue to block any action to help the thousands of children facing lifelong damage from drinking poisoned water in Flint, including a vote to block the Families of Flint Act emergency supplemental. Their radical refusal to address this health issue will have tragic consequences for American families, and, I think it is representative of their overall inadequate approach to health disparities in minority communities.

The way to eliminate racial health disparities is neither to downplay them nor to cut programs that will assist the most vulnerable. It is to address the environmental, social, and economic conditions that exacerbate those disparities. It is to expand access to quality health care that could eliminate or reduce the onset of many of these chronic illnesses and disproportionate health outcomes. It is to maintain and strengthen our investments in healthcare access and resources for disadvantaged populations.

In closing, Madam Speaker, I also want to stress that health education must also be a focus in any efforts to eliminate racial-based health disparities. African Americans and other communities are disproportionately affected by poor provider-patient communication and health literacy issues. Consequently, they often do not have access to information that enables them to make the appropriate health decisions.

We have a responsibility to work with our healthcare institutions and community health centers to make it easier for people to find, understand, and use the information and services.

As co-chair of the Congressional Men's Health Caucus, I have hosted and participated in a number of outreach events in my district to engage directly with constituents about the importance of making positive health decisions and staying proactive about their health and well-being. So I encourage everyone watching at home to get the information you need to make smart health decisions, to get the security you and your family deserve, and to get the health care that we all need.

Mrs. BEATTY. I thank Congressman PAYNE so much for giving us such compelling information and data and reminding us that the time is now for us to enact those programs that work, and the time is now for us to understand what is at risk. Also, let me thank the gentleman for his role on the Congressional Men's Health Caucus.

At this time, I yield to the gentlewoman from the State of Texas (Ms. JACKSON LEE). The gentlewoman from the 18th Congressional District of Texas is someone who I am always amazed when she comes to the mic, someone who is well researched, and someone who delivers an oratorical message that makes us take pause and pay attention.

Tonight, I would like to say that Congresswoman SHEILA JACKSON LEE is a movement. Earlier, I heard her use that word in talk about how we, Madam Speaker, must be the movement against violence, that we must be leading that movement against these disparities in health care.

Ms. JACKSON LEE. Madam Speaker, there is no doubt how much I appreciate the Congressional Black Caucus and Congresswoman BEATTY and Congressman JEFFRIES for always being timely in allowing us to give a message to our colleagues. We hope maybe the American people will hear us, but we accept that this body is the body to which and to whom we speak. So I am thankful for that.

I want to pay tribute, overall, to the Congressional Black Caucus because we are actually here speaking of health disparities, because it was the caucus that triggered this debate through the years that we have been trying to get universal access to health care and was the moving force in the 2009, 2008, and 2010 passage, ultimately, of the Affordable Care Act, where the work that we did, joining Congresswoman Donna Christian-Christiansen, at that time, and FRANK PALLONE on the Congressional Health Caucus, but on the CBC we had the health disparities task to ensure that the language in the Affordable Care Act addressed the issue of health disparities.

There was a large section on that that built on some of the work that some of us had already done creating the Office of Minority Health that I had worked on in years past. So it was the lightning bolt of the caucus, and then working with the Congressional Asian Pacific American Caucus and then the Congressional Hispanic Caucus that we raised the issue that no one was talking about.

I remember debating on the floor of the House on the issues of dealing with senior citizen African American men and how they access health care, how do women access health care, and how do women impacted by diabetes access health care. These are some of the diseases that have a proclivity to the African American population.

We were finding out that we even had an issue where medical professionals didn't know how to ask the questions. How do you address someone who needs to be diagnosed for prostate cancer or may be diagnosed for prostate cancer and is an African American male, a senior citizen? My father ultimately died from cancer that metastasized from the prostate to the lungs and the brain, so we knew we had a serious issue.

So today, I want to mention four points, but I am going to focus on the last one, obesity—a question of access to health care and physical fitness.

Many times we live in areas where there is no access to a pool or a tennis court. Mental health—if you lived your life in a segregated America, if you were called ''Boy'' and ''Girl,'' it is a different mental health situation than maybe others may have faced. If you live in a situation of poverty, of a single household, maybe—this is not across the board—these issues will be impacted. If you lived around gun violence, if you saw your 15-year-old friend being shot dead in the street, there is a question of mental health that we need access to that care for us to be able to reach out or maybe counselors to be able to provide for children.

HIV/AIDS is something that we have lived through. I remember going to funerals of friends in the 1980s and into the 1990s, particularly with HIV/AIDS. So we have worked in the Congressional Black Caucus to massively talk about testing.

Let me get to this point that I want to dwell just for a moment on, and that is gun violence. I was here on the floor earlier with my head held down and my heart heavy as my district, today, had a memorial. They had one yesterday. We will have one tomorrow and have one on Wednesday. I mourn with Congresswoman CORINNE BROWN of Florida.

We are offering legislation dealing with the assault weapons and to complement legislation already passed or already in place. But it is important to note that this is a health issue, because the Centers for Disease Control can assess and study every health issue that faces America today, but they are legislatively, by law, prohibited by my friends on other side of the aisle, by Republicans, disallowed every year to give them permission to study gun violence.

Gun violence is killing our children and killing our families. In Orlando, it killed Latinos who happened to be the attendees at the Pulse Club. The LGBTQ community was the dominant community, and a hateful terroristic act using AR–15s and Glock guns killed them.

The incident was the deadliest mass shooting. The next deadliest incidents in recent history were April 16, 2007, Virginia Tech, 32 killed, 17 injured; December 14, 2012, Sandy Hook, 26 killed, 1 injured; October 16, 1991, Killeen, Texas, 23 killed, 27 injured. According to Everytown index of mass shootings where four or more people are shot and killed, the incident was the ninth mass shooting in the United States in 2016, and the 150th mass shooting in United States since January 1, 2009.

The mass shooting with guns impacts both the mental health, the sanctity, and the minority community. It is shameful that we are not allowed to engage in the kind of research that a Harvard professor talked about, and that is the assessing of violence and the assessing of violence with guns.

The materials I have before me make it very clear that most of these violent acts are done with guns—done with guns. San Bernardino, Chattanooga, Charleston, Garland, Oak Creek, and Fort Hood were all done with guns.

So I stand here today to challenge this issue of health disparities to say that the heavy brunt of killings, singular killings, are impacted by poverty, lack of access to health care, the proliferation of guns in our inner city communities, and the failure of the United States Congress to put real gun safety legislation, closing the loophole, the Jim Clyburn rule that says that, if you don't get the review and approval by ATF, you do not get the gun. You have to wait until you get the approval from ATF, which may be trying to determine whether this person with multiple problems, mental health or background issues, doesn't need to get a gun and then ultimately go kill their spouse, their children, their neighbors, their family members or strangers.

So it is my belief today that this health disparities debate is crucial, and we should come away from here recognizing that obesity, the issues of mental health and HIV/AIDS can be, with great investment, researched for cures, or cancer that proliferates in our community, triple negative breast cancer, legislation that I have put forward and have gotten passed about that impact. But it is the gun violence that we are doing absolutely nothing about. The disparities and the impact on minority communities is atrocious.

I want to close simply by saying the word or the acronym LGBTQ community. I want to say it over and over again, because I think it is shameful that, in our debate, in our recognition of the tragedy of Orlando, that we don't acknowledge the horrific hate crime and the hatefulness against that community. As I stand here, that community is diverse, and there are African Americans who are LGBTQ.

So I would ask that, as we move forward this week, we will be reminded of this hatefulness and we will have a cure. We will be reminded of this violence, and we will have a cure. That cure, first of all, will be to restrain the use of assault weapons and these weapons of war-type bullets that men and women in the United States military say have no business on the streets of America.

I believe, Congresswoman, that health disparities are an important wall and division to overcome. I thank the gentlewoman for having this Special Order to ensure that we will confront these issues and try to save lives.

Racial disparities refer to the variation in rates of disease occurrence and disabilities between socioeconomic and/or geographically defined population groups.

I want to focus on four areas of racial disparities in health that impact African Americans that we can do something about: 1. Obesity; 2. Mental Health; 3. HIV/AIDS; and 4. Gun Violence.

African Americans, based on 2015 Census data, comprise 13.2 percent of the U.S. population, or about 42 million people.

Socioeconomic status, in turn, is linked to mental health: People who are impoverished, homeless, incarcerated or have substance abuse problems are at higher risk for poor mental health.

As the founder and chair of the Congressional Children's Caucus, I am especially concerned about the childhood obesity epidemic among African-American youth.

More than 40 percent of African American teenagers are overweight, and nearly 25 percent are obese.

The percentage of children aged 6–11 years in the United States who were obese increased from 7 percent in 1980 to nearly 18 percent in 2012.

African American youth are consuming less nutritious foods such as fruits and vegetables and are not getting enough physical exercise.

This combination has led to an epidemic of obesity, which directly contributes to numerous deadly or life-threatening diseases or conditions, including the following: Hypertension; Dyslipidemia (High Cholesterol or High Triglyceride Levels); Type 2 Diabetes; Coronary Heart Disease; Stroke; Gallbladder Disease; Osteoarthritis; Asthma, bronchitis, sleep apnea, and other respiratory problems; Cancer (Breast, Colon, and Endometrial).

When ethnicity and income are considered, the picture is even more troubling.

African American youngsters from low-income families have a higher risk for obesity than those from higher-income families.

Efforts such as the Let's Move! Campaign by the First Lady are pivotal to ensuring that communities are able to provide healthy snacks and food and encourage healthier decisions.

Since the mid-1970s, the prevalence of overweight and obesity has increased sharply for both adults and children.

Non-Hispanic blacks have the highest age-adjusted rates of obesity at 47.8 percent.

According to the CDC, 37.6 percent of men and 56.9 percent of women twenty years and over are obese.

Every year, more than 40 million Americans struggle with mental illness.

African American men are as likely as anyone else to have mental illness, but they are less likely to get help.

Racism continues to have an impact on the mental health of African Americans.

Negative stereotypes and attitudes of rejection have decreased, but continue to occur with measurable, adverse consequences.

Historical and contemporary instances of negative treatment have led to a mistrust of authorities, many of whom are not seen as having the best interests of African Americans in mind.

According to the Department of Health and Human Services Office of Minority Health:

Adult blacks are 20 percent more likely to report serious psychological distress than adult whites.

Adult blacks living below poverty are two to three times more likely to report serious psychological distress than those living above poverty.

Adult blacks are more likely to have feelings of sadness, hopelessness, and worthlessness than are adult whites.

How African Americans view mental health over generations is a major barrier to accessing mental health services and treatment.

In 1996, MHA commissioned a national survey on clinical depression.

The survey explored the barriers preventing Americans seeking treatment and gauged overall knowledge of and attitudes toward depression.

This survey revealed that:

63 percent of African Americans believe that depression is a personal weakness.

This is significantly higher than the overall survey average of 54 percent.

Only 31 percent of African Americans believed that depression was a ''health problem.''

African Americans were more likely to believe that depression was ''normal'' than the overall survey average.

56 percent believed that depression was a normal part of aging.

45 percent believed it was normal for a mother to feel depressed for at least two weeks after giving birth.

40 percent believed it was normal for a husband or wife to feel depressed for more than a year after the death of a spouse.

Many of these problems persist to this day. As Doctor William Lawson of Howard University (and MHA's District of Columbia affiliate) pointed out in an NPR interview in 2012, ''Many African-Americans have a lot of negative feelings about, or not even aware of mental health services.

The ''Mental Health: Culture, Race and Ethnicity Supplement'' to the 1999 U.S. Surgeon General's Report on Mental Health, states the following:

African-American physicians are five times more likely than white physicians to treat African-American patients.

African-American patients who see African-American physicians rate their physicians' styles of interaction as more participatory.

African Americans seeking help for a mental health problem would have trouble finding African American mental health professionals: In 1998, only 2 percent of psychiatrists, 2 percent of psychologists and 4 percent of social workers said they were African Americans.

The public mental health safety net of hospitals, community health centers, and local health departments are vital to many African Americans, especially to those in high-need populations.

African Americans of all ages are underrepresented in outpatient treatment but over-represented in inpatient treatment.

Few African-American children receive treatment in privately funded psychiatric hospitals, but many receive treatment in publicly funded residential treatment centers for emotionally disturbed youth.

In 2012, there were an estimated 356,268 inmates with severe mental illnesses in U.S. prisons and jails.

There were only 35,000 mentally ill individuals in state psychiatric hospitals.

The report, ''The Treatment of Persons With Mental Illness in Prisons and Jails,'' jails ''in 44 of the 50 states and the District of Columbia, a prison or jail in that state holds more individuals with serious mental illness than the largest remaining state psychiatric hospital.'' the report said.

African Americans today are overrepresented in our jails and prisons.

People of color account for 60 percent of the prison population.

The Stanford Law School Three Strikes Project's report stated that, ''over the past 15 years, the number of mentally ill people in prison in California has almost doubled.''

In California, 45 percent of state prison inmates have been treated for severe mental illness within the past year.

African Americans also account for 14 percent of regular drug users, but for 37 percent of drug arrests.

Illicit drug use is frequently associated with self-medication among people with mental illnesses.

In January 2014, the Texas Observer reported that, of the 9,000 inmates in Harris County Jail more than 25 percent take medication for mental illness, which means that the jail treats more psychiatric patients than all 10 of Texas' state-run public mental hospitals combined.

The passage of the Affordable Care Act created access to health care for those who purchase health insurance and for the poor living in states that are participating in the Medicaid component of the ACA.

Disparities can occur, if physicians do not refer patients with signs of mental illness for proper treatment or if referred patients do not seek out treatment.

Disparities in access to care and treatment for mental illnesses have also persisted over time.

As noted by the Office of Minority Health:

Only 8.7 percent of adult blacks, versus 16 percent of adult whites, received treatment for mental health concerns in 2007–2008.

Only 6.2 percent of adult blacks, versus 13.9 percent of adult whites, received medications for mental health concerns during 2008.

While 68.7 percent of adult whites with a major depressive episode in 2009 received treatment, only 53.2 percent of adult blacks did.

The Affordable Care Act will have an impact on this gap by 2016.

Depression and other mental illness can be deadly if left untreated.

Suicide is the third leading cause of death among African Americans 15 to 24 years old.

Untreated mental illness can also make African American men more vulnerable to substance abuse, homelessness, incarceration, and homicide.

African Americas are the racial/ethnic group most affected by HIV in the United States.

According to the CDC, 44 percent (19,540) of estimated new HIV Diagnoses in the United States were among African Americans, who comprise 12 percent of the US population.

HIV/AIDs are now the leading cause of death among African Americans ages 25 to 44—ahead of heart disease, accidents, cancer, and homicide.

At the end of 2012, an estimated 496,500 African Americans were living with HIV, representing 41 percent of all Americans living with the Virus.

Of African Americans living with HIV, around 14 percent do not know they are infected.

African Americans accounted for an estimated 44 percent of all new HIV infections among adults and adolescents (aged 13 years or older) in 2010, despite representing only 12 percent of the U.S. population.

HIV is a sexually transmitted disease or STD; it is also spread through intravenous drug use.

HIV infections spread through sharing of needles has declined with needle programs, while the STD rates of infection among African Americans has increased at rate higher than any other ethnic group.

Have their HIV status checked—not once but annually.

Know the HIV status of sexual partner.

If HIV positive: Know how to get on antiviral medication, 2 small pills taken each day, and stay on them.

Where to go for information if you or your partner is HIV positive.

In 2010, men accounted for 70 percent (14,700) of the estimated 20,900 new HIV infections among all adult and adolescent African Americans.

The estimated rate of new HIV infections for African American men (103.6/100,000 population) was 7 times that of white men, twice that of Latino men, and nearly 3 times that of African American women.

In 2010, African American gay, bisexual, and other men who have sex with men represented an estimated 72 percent (10,600) of new infections among all African American men and 36 percent of an estimated 29,800 new HIV infections among all gay and bisexual men.

Of those gay and bisexual men, 39 percent (4,321) were young men aged 13 to 24.

According to the CDC, the numbers of new HIV diagnoses among African American women fell 42 percent between 2005 to 2014, but it is still high compared to women of other races/ethnicities.

Most new HIV infections among African American women (87 percent; 5,300) are attributed to heterosexual contact.

In 2012, there were 72,010 Texans living with HIV/AIDS.

Texas has the 10th highest number of HIV diagnoses in 2013 and ranks 18th for deaths from HIV.

Currently 14 percent of the people living with HIV are undiagnosed and only 30 percent of the people with HIV are virally suppressed, which means that 70 percent of the people who are ill are not on medication that can help limit their ability to infect others.

HIV is an unnecessarily disproportionate burden on the African American and Latino community.

There is a wall of misinformation about the illness and an uncomfortable silence regarding the need to speak about the illness not only to the young, but also the older persons.

When treatments were first developed in the 1990s they had lots of side effects that made patients very ill.

Few talk about the advances in HIV treatment that now involve taking 2 small pills a day with the result leaving patients feeling healthy and able to engage in life's normal activities.

The virus count for those who take their medication is so low that it often does not register in tests.

This does not mean that people are cured, but it does mean that there is no reason not to get tested so that you know if you are in need of treatment.

Anyone can become infected—so it is up to all of us to educate our families, neighbors, co-workers and friends about getting tested.

There are some insurance company practices that have a detrimental impact on the ability of people with HIV to enroll in qualified health insurance plans.

In states like Texas that are not fully participating in the Affordable Care Act's Medicaid

expansion this is especially problematic for HIV patients who are poor.

Some states allow insurance carriers to post misleading or intentionally vague formularies on market place websites or excluding essential HIV medications from drug formularies and impressing high cost sharing.

Out of pocket medication cost each month should be capped.

Mrs. BEATTY. Madam Speaker, I thank Congresswoman SHEILA JACKSON LEE for reminding us that we should be done with guns like the assault weapons. I thank the gentlewoman for reminding us of the impact that health disparities have on our communities in this Nation.

□ 2030

Madam Speaker, I have two documents that will be entered into the RECORD.

The first document is from Congresswoman EDDIE BERNICE JOHNSON. I would like to state for the RECORD that she was the first nurse to serve in this United States Congress. And the second is a portion of the Special Feature on Racial and Ethnic Health Disparities: 30 Years After the Heckler Report.

SPECIAL FEATURE ON RACIAL AND ETHNIC HEALTH DISPARITIES: 30 YEARS AFTER THE HECKLER REPORT

INTRODUCTION

The 1985 Report of the Secretary's Task Force on Black and Minority Health, released by then Secretary of Health and Human Services Margaret Heckler, documented significant disparities in the burden of illness and mortality experienced by blacks and other minority groups in the U.S. population compared with whites (41). The report laid out an ambitious agenda, including improving minority access to high-quality health care, expanding health promotion and health education outreach activities, increasing the number of minority health care providers, and enhancing federal and state data collection activities to better report on minority health issues. In the 30 years since the Heckler Report, national efforts to improve minority health through outreach, programming, and monitoring have included the formation of the Department of Health and Human Services (HHS) Office of Minority Health in 1986 (42); the annual National Healthcare Quality and Disparities Reports first issued in 2003 (43); the adoption of disparities elimination as an overarching goal of Healthy People 2010 (44); and most recently, an HHS Action Plan to Reduce Racial and Ethnic Health Disparities—a comprehensive federal commitment to reduce and eventually eliminate disparities in health and health care (45).

Race is a social construct influenced by a complex set of factors (46,47). Because of the complexity and difficulty in conceptualizing and defining race, as well as the increasing representation of racial and ethnic subgroups in the United States, racial classification and data collection systems continue to evolve and expand. In 1977, the Office of Management and Budget (OMB) required that all federal data collection efforts collect data on a minimum of four race groups (American Indian or Alaskan Native, black, Asian or Pacific Islander, and white) and did not allow the reporting of more than one race (48). In 1997, in response to growing interest in more detailed reporting on race and ethnicity, OMB mandated data collection for a minimum of five race groups, splitting Asian or Pacific Islander into two categories (Asian, and Native Hawaiian or Other Pacific Islander) (49). In addition, the 1997 standards allowed respondents to report more than one race. A minimum of two categories for data collection on ethnicity, ''Hispanic or Latino'' and ''Not Hispanic or Latino,'' were also required under the 1997 OMB standards. Consequently, whereas the Heckler Report primarily documented black-white differences in health and mortality due to data limitations, this Special Feature is able to report on more detailed racial and ethnic groups. For example, Figures 19–21 display trends in infant mortality and low-risk cesarean section deliveries, and the current data on preterm births for five Hispanic-origin groups.

At the time of the Heckler Report, 22.3% of the population were considered racial or ethnic minorities (Table 1). Current Census (2014) estimates identify 37.9% of the population as racial or ethnic minorities (50). In 2014, Hispanic persons, who may be of any race, comprised 17.4% of the U.S. population. Non-Hispanic multiple race persons were 2.0% of the population. For the single race groups, non-Hispanic American Indian or Alaska Native persons were 0.7%, non-Hispanic Asian persons were 5.3%, non-Hispanic black persons were 12.4%, non-Hispanic Native Hawaiian or Other Pacific Islander persons were 0.2%, and non-Hispanic white persons were 62.1% of the U.S. population in 2014 (50).

Understanding the demographic and socioeconomic composition of U.S. racial and ethnic groups is important because these characteristics are associated with health risk factors, disease prevalence, and access to care, which in turn drive health care utilization and expenditures. Non-Hispanic white persons are, on average, older than those in other racial and ethnic groups, with a median age of 43.1 years, and Hispanic individuals are the youngest, with a median age of 28.5 years in 2014 (50). About one-quarter of black only persons (26.2%) and Hispanic persons (23.6%) lived in poverty compared with 10.1% of non-Hispanic white only persons and 12.0% of Asian only persons in 2014 (51). Non-Hispanic black only children and Hispanic children were particularly likely to live in poverty (37.3% and 31.9%, respectively, in 2014) (52). However, Hispanic individuals are often found to have quite favorable health and mortality patterns in comparison with non-Hispanic white persons and particularly with non-Hispanic black persons, despite having a disadvantaged socioeconomic profile—a pattern termed the epidemiologic paradox (53).

HHS defines a racial or ethnic health disparity as ''a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group'' (54). There are many different ways to measure racial and ethnic differences in health and mortality, which can lead to different conclusions (55–58). This Special Feature on Racial and Ethnic Health Disparities (Special Feature) uses the maximal rate difference, one of three overall measures used in Healthy People 2020 to measure differences among groups of people (see Technical Notes). The maximal rate difference is an overall measure of health disparities calculated as the absolute difference between the highest and lowest group rates in the population for a given characteristic (59). The identification of groups that experience the highest and lowest rates in this Special Feature was based on observed rates and was not tested for a statistically significant difference against other rates. Ties in highest or lowest rates were resolved by examining decimal places. With respect to changes in health disparities over time, tracking the maximal rate difference over time enables one to determine whether the absolute difference between the highest and lowest group rates is increasing, decreasing, or stable.

The Special Feature charts that follow provide detailed comparisons of key measures of mortality, natality, health conditions, health behaviors, and health care access and utilization, by race, race and ethnicity, or by detailed Hispanic origin, depending on data availability. A majority of the 10 graphs in this year's Special Feature present trends in health from 1999–2014. Results indicate that trends in health were generally positive for the overall population and several graphs illustrate success in narrowing gaps in health by racial and ethnic group. Differences in life expectancy, infant mortality, cigarette smoking among women, influenza vaccinations among those aged 65 and over, and health insurance coverage narrowed among the racial and ethnic groups. For example, the absolute difference in infant mortality rates between infants born to non-Hispanic black mothers (highest rate) and infants born to non-Hispanic Asian or Pacific Islander mothers (lowest rate) narrowed between 1999–2014. Differences by racial and ethnic group in the prevalence of high blood pressure and smoking among adult men remained stable throughout the study period, with non-Hispanic black adults more likely to have high blood pressure than adults in other racial and ethnic groups throughout the period, and non-Hispanic black and non-Hispanic white males more likely to be current smokers than Hispanic and non-Hispanic Asian men. For low-risk cesarean sections, influenza vaccinations among adults aged 18–64, and unmet dental care needs, the gap widened among the racial and ethnic groups between 1999–2014.

Despite improvements over time in many of the health measures presented in this Special Feature, disparities by race and ethnicity were found in the most recent year for all 10 measures, indicating that although progress has been made in the 30 years since the Heckler Report, elimination of disparities in health and access to health care has yet to be achieved.

LIFE EXPECTANCY AT BIRTH

In 2014, life expectancy was longer for Hispanic men and women than for non-Hispanic white or non-Hispanic black men and women.

Life expectancy is a measure often used to gauge the overall health of a population. Life expectancy at birth represents the average number of years that a group of infants would live if the group were to experience the age-specific death rates present in the year of birth. Differences in life expectancy among various demographic subpopulations, including racial and ethnic groups, may reflect subpopulation differences in a range of factors such as socioeconomic status, access to medical care, and the prevalence of specific risk factors in a particular subpopulation (60,61).

During 1980–2014, life expectancy at birth in the United States increased from 70.0 to 76.4 years for males and from 77.4 to 81.2 years for females (Table 15, and data table for Figure 18). During this period, life expectancy at birth for males and females was longest for white persons and shortest for black persons. For both males and females, racial differences in life expectancy at birth narrowed, but persisted during 1980–2014. Life expectancy at birth was 6.9 years longer for white males than for black males in 1980, and this difference narrowed to 4.2 years in 2014.

In 1980, life expectancy at birth was 5.6 years longer for white females than for black females, and this difference narrowed to 3.0 years in 2014.

In 2014, Hispanic males and females had the longest life expectancy at birth, and non-Hispanic black males and females had the shortest. In 2014, life expectancy at birth was 7.2 years longer for Hispanic males than for non-Hispanic black males and 5.9 years longer for Hispanic females than for non-Hispanic black females.

INFANT MORTALITY

During 1999–2013, infant mortality rates were highest among infants born to non-Hispanic black women (11.11 infant deaths per 1,000 live births in 2013).

Infant mortality, the death of a baby before his or her first birthday, is an important indicator of the health and wellbeing of a country. It not only measures the risk of infant death but it is used as an indicator of maternal health, community health status, and availability of quality health services and medical technology (62,63).

The infant mortality rate in the United States decreased from 7.04 infant deaths per 1,000 live births in 1999 to 6.75 in 2007, and then decreased at a faster rate to 5.96 in 2013. Trends in infant mortality rates during 1999–2013 varied among the five racial and ethnic groups. During 1999–2013, infants born to non-Hispanic black mothers experienced the highest rates of infant mortality (11.11 in 2013) and infants born to non-Hispanic Asian or Pacific Islander mothers experienced the lowest rates (3.90 in 2013). The difference between the highest and lowest infant mortality rates among the five racial and ethnic groups was stable from 1999 to 2006 and then narrowed from 2006 to 2013. The difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian or Pacific Islander) infant mortality rates was 9.41 deaths per 1,000 live births in 1999, compared with 7.21 in 2013.

For infants born to Hispanic mothers, the infant mortality rate remained stable during 1999–2008 (5.71 infant deaths per 1,000 live births in 1999) and then decreased to 5.00 in 2013. During 1999–2013, the infant mortality rate for Hispanic infants varied by the mother's Hispanic-origin group. Throughout this period, infants born to Puerto Rican mothers experienced the highest mortality rates. In all years except 2009, infants born to Cuban mothers and those born to Central and South American mothers experienced the lowest mortality rates at alternate times throughout 1999–2013. The difference between the highest (Puerto Rican) and lowest (Cuban) infant mortality rates among Hispanic-origin groups narrowed from 3.71 deaths per 1,000 live births in 1999 to 2.88 in 2013. During 1999–2013, the difference in infant mortality rates was narrower for mothers in the Hispanic-origin groups than for mothers in the five racial and ethnic groups.

PRETERM BIRTHS

In 2014, non-Hispanic black mothers had the highest percentage of preterm births of the five racial and ethnic groups, and Puerto Rican mothers had the highest percentage of preterm births of the five Hispanic-origin groups.

An infant's gestational age is an important predictor of his or her survival and subsequent health (64–70). Preterm birth prior to 37 weeks gestation affects infant mortality rates and racial and ethnic disparities in infant mortality (Figure 19) (71). The degree of prematurity matters—infants born prior to 32 weeks gestation are at greatest risk of death during infancy, with the risk of infant death decreasing as gestational age increases (72).

In 2014, 7.7% of singleton births occurred before 37 weeks of gestation; 5.7% at 34–36 weeks; 0.8% at 32–33 weeks gestation; and 1.2% before 32 weeks (data table for Figure 20). In 2014, among the five racial and ethnic groups, non-Hispanic black women had the highest percentage of singleton births before 37 weeks (11.1%) and non-Hispanic Asian or Pacific Islander women had the lowest percentage (6.8%). Non-Hispanic black women also had the highest percentage of singleton preterm births at each preterm gestational age. The difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian or Pacific Islander) percentages of singleton preterm births among the five racial and ethnic groups was 4.3 percentage points (before 37 weeks), 2.0 percentage points (34–36 weeks), 0.6 percentage points (32–33 weeks), and 1.7 percentage points (before 32 weeks).

Among Hispanic-origin groups in 2014, Puerto Rican mothers had the highest percentage of singleton births before 37 weeks (9.1%) and Cuban mothers had the lowest percentage (7.2%). The difference between the highest (Puerto Rican) and lowest (Cuban) percentages of singleton preterm births among the Hispanic-origin groups was 1.9 percentage points (before 37 weeks) and 1.3 percentage points (34–36 weeks). Central and South American mothers had the lowest percentage of singleton births before 34 weeks. For preterm births before 34 weeks, the difference between the highest (Puerto Rican) and lowest (Central and South American) percentages was 0.2 percentage points (32–33 weeks) and 0.6 percentage points (before 32 weeks).

LOW-RISK BIRTHS DELIVERED BY CESAREAN SECTION

During 1999–2014 non-Hispanic black mothers experienced the highest percentage of low-risk cesarean deliveries among the five racial and ethnic groups (29.9% in 2014); Cuban mothers experienced the highest percentage of low-risk cesarean deliveries among the five Hispanic-origin groups (41.49–6 in 2014).

Cesarean deliveries comprise approximately one-third of all births in the United States (32.2% in 2014) and can place mothers and infants at increased risk for poor health outcomes (74). Over the past decade, professional medical groups have attempted to reduce low-risk cesarean deliveries defined as cesarean deliveries among full term (37 or more completed weeks of gestation), singleton, vertex (head first) births to women giving birth for the first time (75,76).

The percentage of low-risk births that were delivered by cesarean section increased from 19.5% to 26.6% during 1999–2005, stabilized during 2005–2009, and then decreased to 26.0% in 2014 (data table for Figure 21). Throughout the period 1999–2014, non-Hispanic black mothers experienced the highest percentage of low-risk cesarean deliveries (29.9% in 2014) among the five racial and ethnic groups, while non-Hispanic American Indian or Alaska Native mothers experienced the lowest percentage (21.5% in 2014). The difference between the highest (non-Hispanic black) and lowest (non-Hispanic American Indian or Alaska Native) percentages widened from 4.8 percentage points in 1999 to 8.4 percentage points in 2014.

Among Hispanic mothers, the percentage of low-risk births that were delivered by cesarean section increased from 18.7% to 24.6% during 1999–2004, increased at a slower rate from 2004–2009, and then remained stable during 2009–2014 (data table for Figure 21). Throughout the period 1999–2014 Cuban mothers experienced the highest percentage of low-risk cesarean deliveries (41.4% in 2014), while Mexican mothers experienced the lowest percentage (24.1% in 2014). Among Hispanic-origin groups, the difference between the highest and lowest percentages of low-risk cesarean deliveries was stable during 1999–2002, widened sharply during 2002–2006, and then narrowed during 2006–2014. The difference between the highest (Cuban) and lowest (Mexican) percentages was 11.7 percentage points in 1999, 21.5 percentage points in 2006, and 17.3 percentage points in 2014.

CHILDREN AND ADOLESCENTS WITH OBESITY

In 2011–2014 for children and adolescents aged 2–19 years, Hispanic children and adolescents had the highest prevalence of obesity and non-Hispanic Asian children had the lowest prevalence.

Childhood obesity is a serious public health challenge in the United States and many other industrialized nations in the world (Figure 8) (19,77,78). Excess body weight in children is associated with excess morbidity in childhood and excess body weight in adulthood (13,14). Obesity among children and adolescents is defined as a body mass index at or above the sex- and age-specific 95th percentile of the CDC growth charts (15). Between 1999–2000 and 2013–2014, the percentage of children and adolescents aged 2–19 with obesity increased from 13.9% to 17.2% (79). However, among youth aged 2–19, the prevalence of obesity did not change from 2003–2004 through 2013–2014 (79).

In 2011–2014 for children and adolescents aged 2–19, the percentage with obesity was highest for Hispanic children and adolescents and lowest for non-Hispanic Asian children and adolescents. For those aged 2–19, the difference between the highest (Hispanic) and lowest (non-Hispanic Asian) percentages was 13.3 percentage points.

For children aged 2–5, the percentage with obesity was highest for Hispanic children and lowest for non-Hispanic white children. (The estimate for non-Hispanic Asian children aged 2–5 was not stable and is not shown.) The difference between the highest (Hispanic) and lowest (non-Hispanic white) percentages was 10.4 percentage points for children aged 2–5. For children aged 6–11, the percentage with obesity was highest for Hispanic children and lowest for non-Hispanic Asian children. For children aged 6–11, the difference between the highest (Hispanic) and lowest (non-Hispanic Asian) percentages was 15.2 percentage points.

In 2011–2014 for adolescents aged 12–19, the percentage with obesity was highest for Hispanic adolescents and lowest for non-Hispanic Asian adolescents. The difference between the highest (Hispanic) and lowest (non-Hispanic Asian) percentages was 13.4 percentage points for adolescents aged 12–19 years.

HYPERTENSION

In 2011–2014, non-Hispanic black men and women were the most likely to have hypertension compared with adults in the other racial and ethnic groups.

Hypertension is an important risk factor for cardiovascular disease, stroke, kidney failure, and other health conditions (80,81). In 2011–2014, 84.1% of adults with hypertension were aware of their status, and 76.1% were taking medication to lower their blood pressure (82). Despite improvement in increasing the awareness, treatment, and control of hypertension, diagnosis and treatment of hypertension among minority groups remains a challenge (83).

Hypertension is defined as reporting taking antihypertensive medication and/or having a measured systolic blood pressure of at least 140 mm Hg or a measured diastolic blood pressure of at least 90 mm Hg. The age-adjusted percentage of adults aged 20 and over with hypertension was stable during 1999–2014 (30.8% in 2013–2014) (data table for Figure 23). During 1999–2014, non-Hispanic black adults had the highest percentage with

hypertension among the three racial and ethnic groups (42.7%, age-adjusted in 2013–2014), while with the exception of 1999–2000, adults of Mexican origin had the lowest percentage with hypertension (28.8%, age-adjusted in 2013–2014). The difference between the highest and lowest age-adjusted percentages of adults with hypertension among the three racial and ethnic groups was stable during 1999–2014; in 2013–2014, the difference between the highest (non-Hispanic black) and lowest (Mexican-origin) percentages was 13.9 percentage points.

In 2011–2014, the age-adjusted percentage of adult men and women with hypertension was similar (31.0% and 29.7%, respectively, data table for Figure 23). The difference between the highest (non-Hispanic black) and lowest (Hispanic) age-adjusted percentages of men with hypertension among the four racial and ethnic groups was 14.7 percentage points; for women, the difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian) was 19.0 percentage points in 2011–2014.

CURRENT CIGARETTE SMOKING

During 1999–2014, differences in cigarette smoking between racial and ethnic groups were larger for women than for men.

Smoking causes more than 480,000 deaths each year, accounting for about one in five deaths in the United States (84). Smokers are more likely to develop heart disease, stroke, and cancer. Smoking also increases the risk for diabetes, cataracts, rheumatoid arthritis, and stillbirth (85).

During 1999–2014, the age-adjusted percentage of adults aged 18 and over who were current cigarette smokers decreased from 25.2% to 19.0% for men and from 21.6% to 15.1% for women (data table for Figure 24). Within each of the four racial and ethnic groups, men were more likely to be current cigarette smokers than women.

In 2014 for men, the age-adjusted percentage of current cigarette smokers was highest for non-Hispanic black men (22.0%) and lowest for Hispanic men (13.8%). The difference between the highest and lowest age-adjusted percentages of current cigarette smokers among the four racial and ethnic groups remained stable during 1999–2014 because levels for men in all racial and ethnic groups declined similarly during this period. The difference between the highest (non-Hispanic black) and lowest (Hispanic) percentages for men was 8.2 percentage points in 2014.

For women, non-Hispanic white women consistently had the highest age-adjusted percentage of current cigarette smokers among the four racial and ethnic groups throughout 1999–2014 (18.3% in 2014), while non-Hispanic Asian women had the lowest age-adjusted percentage (5.1% in 2014). For women, the difference between the highest (non-Hispanic white) and lowest (non-Hispanic Asian) percentages narrowed from 17.5 percentage points in 1999 to 13.2 in 2014. During 1999–2014, racial and ethnic differences in cigarette smoking prevalence were larger for women than for men.

INFLUENZA VACCINATION

During 1999–2014, influenza vaccination was highest for those aged 65 and over and lowest for those aged 18–64, for all racial and ethnic groups.

Influenza is a serious illness that can lead to hospitalization and sometimes death. Influenza vaccination is especially important for people who are at risk of getting seriously ill from influenza, including those with chronic conditions, older adults, and young children.

The percentage of adults aged 18–64 who received an influenza vaccination in the past 12 months remained stable during 1999–2006 and then increased to 35.8% in 2014 (data table for Figure 25). This pattern was present for all racial and ethnic groups. Decreases in influenza vaccination coverage in 2005 were related to a vaccine shortage (86). For those aged 18–64, no racial and ethnic group was consistently the most likely to receive influenza vaccination during 1999–2014. In 2014, non-Hispanic Asian adults had the highest percentage for influenza vaccination receipt (41.3%) and Hispanic adults had the lowest percentage (27.9%). For adults aged 18–64, the difference between the highest and lowest percentages of adults receiving an influenza vaccination among the four racial and ethnic groups widened from 6.9 percentage points in 1999 (non-Hispanic white compared with Hispanic) to 13.4 in 2014 (non-Hispanic Asian compared with Hispanic).

For adults aged 65 and over, the percentage who received an influenza vaccination in the past 12 months increased from 65.7% to 70.1% during 1999–2014. During this period, trends in influenza vaccination coverage varied by racial and ethnic group, and no racial and ethnic group was consistently the most or least likely to receive influenza vaccination. In 2014, non-Hispanic Asian adults had the highest percentage for receipt of influenza vaccination (72.7%) and non-Hispanic black adults had the lowest (57.4%). For adults age 65 and over, the difference between the highest (non-Hispanic Asian) and lowest (non-Hispanic black) percentages of older adults receiving an influenza vaccination among the four racial and ethnic groups was stable during 1999–2003 and then narrowed to 15.3 percentage points in 2014.

HEALTH INSURANCE COVERAGE

During 1999 through the first 6 months of 2015 among adults aged 18–64, lack of health insurance coverage was highest among Hispanic adults.

Health insurance is a major determinant of access to health care. Children are less likely to be uninsured than adults aged 18–64 because they are more likely to qualify for public coverage, primarily Medicaid and the Children's Health Insurance Program (CHIP) (see data table for Figure 26 for estimates for children) (26,87). Passage of the Affordable Care Act (ACA) in 2010 (38) authorized states to expand Medicaid eligibility (88) and to establish the health insurance marketplace in 2014.

For adults aged 18–64, the percentage without coverage increased from 17.9% to 20.5% during 1999–2013, and then decreased to 12.7% in the first 6 months of 2015 (36). During this period, the trend for lack of coverage varied by racial and ethnic group.

During 1999–June 2015, Hispanic adults aged 18–64 had the highest percentage without coverage (27.2% in the first 6 months of 2015), and non-Hispanic white adults aged 18–64 had the lowest, except in the first 6 months of 2015, when non-Hispanic Asian adults had the lowest percentage without coverage.

The difference between the highest and lowest percentages of adults aged 18–64 without health insurance among the four racial and ethnic groups narrowed from 1999–June 2015. This difference was 24.9 percentage points in 1999 (Hispanic adults compared with non-Hispanic white adults) and 19.9 percentage points in the first 6 months of 2015 (Hispanic adults compared with non-Hispanic Asian adults).

DIFFICULTY ACCESSING NEEDED DENTAL CARE DUE TO COST

During 1999–2014 among adults aged 18–64, nonreceipt of needed dental care due to cost was lowest among non-Hispanic Asian adults.

Oral health is integral to general health and wellbeing, and forgoing needed dental health care can have serious health effects (89). In general, fewer adults have dental coverage than medical coverage, and dental coverage tends to be less comprehensive (90–92). In 2012, 44% of dental expenditures among adults aged 18–64 were paid out of pocket, a higher out-of-pocket percentage than for any other type of personal health care expenditure (93).

The percentage of adults aged 18–64 who did not receive needed dental care in the past 12 months due to cost increased from 9.3% to 17.3% during 1999–2010, and then decreased to 12.6% in 2014 (data table for Figure 27).

During 1999–2014, non-Hispanic Asian adults aged 18–64 had the lowest percentage of not receiving needed dental care due to cost (6.3% in 2014) among the four racial and ethnic groups. No racial and ethnic group consistently had the highest percentage of not receiving needed dental care due to cost during 1999–2014. The difference between the highest and lowest percentages of adults not receiving needed dental care due to cost among the four racial and ethnic groups widened during 1999–2010, and then remained stable from 2010–2014 for those aged 18–64. This difference was 5.9 percentage points in 1999 (non-Hispanic black compared with non-Hispanic Asian) and 9.4 percentage points in 2014 (Hispanic compared with non-Hispanic Asian).

Mrs. BEATTY. Madam Speaker, we have heard a lot tonight. We have heard the call to action by Members. We have heard the relationship to poverty in health disparities, to the socioeconomic conditions of African Americans to health disparities. We have heard the relationship to death by guns to health disparities. We have heard the data and the statistics about the mortality rates from diseases like cardiovascular disease, the leading killer for women and African American women and men. We have heard about the effect of untreated diabetes and how that affects African Americans.

The list goes on and on, Madam Speaker. I could tell you whether it is obesity, whether it is stroke—and certainly as a stroke survivor, I understand firsthand the value and the importance of quality, affordable health care—that there are some Federal programs that actually work and bridge the gap. I could say wonderful things about the United States Health and Human Services Office of Minority Affairs that provides data and research and services for us.

But before I ask my colleague, Madam Speaker, to say a few words, I ran across something that was said, in my opinion, by one of the most powerful individuals that will go down in current history. And 20 years from now, Madam Speaker, if I were standing here talking about his legacy, health care would be one of them. Let me conclude my part with these brief words that he quoted on April 1 of this year:

''Our Nation was built on an enduring belief that we are all created equal—regardless of the color of our skin or the station into which we were born. From the ambitions we hold for ourselves to the way we take care of our health, this founding premise serves as the guidepost of our national life.''

Yet, to this day, Madam Speaker, minorities continue to experience the

healthcare gaps that leave their communities our communities.

I will add this to his ending that, Madam Speaker, tonight, the Congressional Black Caucus asks that we recommit to taking action to overcome these disparities. And that person who will leave a great legacy for these words is no other than our President of these United States, President Barack Obama.

And now as we begin to close our hour, I yield to the gentleman from New York (Mr. JEFFRIES). I could not think of a better colleague, a better coanchor, to come and share with us our call to action.

My colleague and classmate, Congressman JEFFRIES, is a scholar, someone who sits back, listens, and then comes with resolve. He is someone who is no stranger to this process of telling it like it is. He is someone who has spent a lot of time and years with his experience to speak for the individuals of his district. But tonight, Madam Speaker, I asked him to speak for the Congressional Black Caucus. I asked him to close us out on our call for action as we talk about the health disparities in our African American communities.

Mr. JEFFRIES. Madam Speaker, I thank my good friend, the distinguished gentlewoman from Ohio, and our phenomenal anchor for this CBC Special Order hour today and throughout the second session of the 114th Congress. It has been an honor and a privilege to work closely with her. She has done such a phenomenal job, not just on behalf of the people she represents in the great city of Columbus, Ohio, but all throughout the Nation in her various roles, and certainly in her leadership in the Congressional Black Caucus.

It is with a heavy heart that I stand on the floor of the House of Representatives today and, with great sadness, acknowledge the pain and the suffering and extend my condolences to those who have suffered this great tragedy in Orlando, Florida, the worst mass shooting in the history of the United States of America.

It is a complicated shooting. We understand that it most likely is an act of terror, a hate crime of unspeakable proportions. There are indications that the shooter may have some degree of mental illness and a history of domestic abuse. The shooter appeared to have been, in some measure, on the FBI's radar.

But you can add all those things up and there is still something that is missing that we here in Congress have the capacity to deal with, and that is the fact that one individual was able to purchase a weapon of mass destruction—which should be reserved for war, not the hunting of human beings in this great democratic Republic—and inflict death on 49 individuals and maim in ways that are inhumane to more than 50 others.

Martin Luther King, Jr., once said: ''In the end, we will remember not the words of our enemies, but the silence of our friends.''

During the 114th Congress, there have been more than 100 mass shootings. We often come to the floor of the House of Representatives and the Speaker or one of his designees stands at the rostrum and asks us, as Members of the House, to stand in a moment of silence. And then we go on with business as usual, having done nothing about the tremendous gun violence problem that we have in America.

The rest of the world is looking around and saying: What are they doing in the United States of America? Five percent of the world's population, 50 percent of the world's guns. It is estimated that there are more than 300 million guns circulating throughout this great land. The FBI and local law enforcement can't tell you where the overwhelming majority of them are because of legislative silence and malpractice.

This is an issue, of course, that has great impact on the African American community. Homicides are the leading cause of death through guns of younger African American men. So we in the CBC view it as a public health crisis certainly for our community. I think it is one that all Americans should view as a health crisis for the entire country.

But the thing that is also troubling—and we will have time to deal with this tragedy—is hopefully we will be able to take some commonsense steps in the right direction, including making sure that individuals who are on the terrorist watch list can't purchase weapons of mass destruction. How complicated is that to do?

But the thing that is striking for many of us in the African American community is that, when you look at some of the leading causes of death—heart disease being number one, and then, of course, diabetes and childhood obesity being problematic, certain forms of cancer, HIV/AIDS infection—many of these illnesses, these ailments that plague the neighborhoods that I represent in central Brooklyn, in Bedford-Stuyvesant, in East New York, in Ocean Hill-Brownsville, in Canarsie, and in the west end of Coney Island, are preventable, preventable by better exercise, preventable by dealing with some of the environmental racism that many low-income communities of color have been subjected to, resulting in incredibly high rates of asthma and other forms of respiratory illness, preventable by better diet.

Senator BOOKER recently said to many of us—and this has stuck with me—that more African Americans in the United States of America die as a result of drive-throughs, not drive-bys. That is because the diet, the access to healthy food, is limited. The food deserts within which many African Americans, particularly at the lowest socioeconomic level, are forced to reside in are scandalous.

So we in the Congressional Black Caucus believe that we have to deal with these issues in a more meaningful, comprehensive fashion.

I am thankful that back at home in the west end of Coney Island, Coney Island Cathedral, one of the most important religious institutions in Brooklyn, is actively engaged in a public health campaign to deal with diabetes and heart disease and many of the other ailments that result from a poor diet that exists, a lack of access to healthy food in the Black community. It is a campaign that we want to take across the Nation.

We are thankful for the work that has been done by the Congressional Black Caucus and by President Obama through his leadership of the Affordable Care Act. We now know that over 20 million previously uninsured Americans now have access to quality, affordable health care—disproportionately African American.

That is a positive step in the right direction. But instead of trying to dismantle this monumental step forward, as House Republicans have attempted to do more than 60 times over the last few years, they have a clinical obsession with a law that has been declared constitutional—not once, but twice—by the United States Supreme Court.

Let's figure out ways to come together as a nation, despite our racial, religious, and ethnic differences, to deal with the disparities that exist in the African American community and beyond. And let us come together as a Congress and as a nation to deal with the scourge of hate, in its most recent form, directed at the LGBT community down in Orlando in such a horrific and invidious fashion.

We are better than this. We can do much better here in the United States Congress. The Congressional Black Caucus is here to lead the way on issues, worked in partnership hand in hand with our colleagues on the other side of the aisle, if they are just willing to meet us some of the way, to deal with the issues of health disparities in the African American community and deal with the scourge of gun violence that takes our young boys and girls in shocking numbers and also impacts people all across the country.

I thank the distinguished gentlewoman for her leadership and for once again yielding to me and anchoring this Special Order in such a phenomenal way.

Mrs. BEATTY. Madam Speaker, I thank Congressman JEFFRIES.

Madam Speaker, as we close out tonight, I can't think of a better way to take my last 30 seconds than to speak to you and to speak to America and to ask that we take these last seconds in silence as a call to action to prevent the guns being on the street, as a call to action to reduce the health disparities. But in honor of the families in Orlando, we give them our commitment that we stand with them and that I stand with all of my friends and constituents and supporters who belong to the LGBT community.

I yield back the balance of my time.

Ms. EDDIE BERNICE JOHNSON of Texas. Madam Speaker, I rise in honor of the special order hour titled "Bridging the Divide: A Call to Action by the Congressional Black Caucus to Eliminate Racial Health Disparities." I would like to thank my colleagues Congressman HAKEEM JEFFRIES and Congresswoman JOYCE BEATTY for hosting this timely special order.

Historically, racial and ethnic minorities are likely to have the highest uninsured rates and are less likely to receive preventive and quality health care. While the Affordable Care Act has helped minorities afford health insurance and access quality care, there is still a need to eliminate existing disparities. For example, the Department of Health and Human Services is currently working to expand access, end racial and ethnic discrimination, perform outreach to underserved communities, improve workforce diversity, and expand data collection and reporting.

While this is an ambitious plan, it is one that is extremely necessary. Unfortunately, coverage, access, and outreach may not be the only keys to eliminating disparities. Demographic characteristics contribute heavily to racial and ethnic health status. For example, research shows that privately insured African American and Hispanic adults fare worse than privately insured white adults along measures to access and use of care. Unfortunately, African Americans and Hispanics are less likely to have a regular provider than their white counterparts. The same research also showed that privately insured African Americans and Hispanics had less confidence in their ability to pay for medical costs.

Since social determinants like economic stability, education, and environment play such a large role in how we each view and access health care, many of the changes necessary to eliminate racial and ethnic disparities require a much larger plan than just a focus on health-related programs. Reducing disparities in health truly entails addressing racial and ethnic social determinants such as availability of safe housing, affordable food, access to education, job opportunities, community-based resources, public safety, public transportation, and more.

Our society must make many changes before we can truly eliminate racial and ethnic health disparities because that also means eliminating disparities in many other sectors. I thank Congressman JEFFRIES and Congresswoman BEATTY for hosting this poignant special order.

□ 2045

TIBET

The SPEAKER pro tempore (Ms. MCSALLY). Under the Speaker's announced policy of January 6, 2015, the Chair recognizes the gentleman from Massachusetts (Mr. MCGOVERN) for 30 minutes.

GENERAL LEAVE

Mr. MCGOVERN. Madam Speaker, I ask unanimous consent to revise and extend my remarks and to enter additional materials into the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

Mr. MCGOVERN. Madam Speaker, this week, Washington, D.C., is blessed by the presence of His Holiness, the 14th Dalai Lama, Tenzin Gyatso, who is visiting the city from June 12 through June 16 for several events and meetings. This visit provides us not only the opportunity to listen to the Dalai Lama speak about the modern world and confronting conflict, but also to take a look at the crisis that faces Tibet and the Tibetan people and ask why the United States is not doing more to protect the rights and to support the autonomy of the Tibetan people.

As we seek to comprehend the senseless violence of yesterday's massacre of at least 49 people in Orlando, Florida, and the wounding of more than 50 others—most members of the LGBT community and many of Hispanic descent, all just enjoying their lives on a Saturday night—I can think of no better source of words of wisdom, tolerance, and peace than of His Holiness, the Dalai Lama.

Madam Speaker, I include in the RECORD an opinion piece by the Dalai Lama, entitled: ''The Dalai Lama: Why I'm hopeful about the world's future.''

[From the Washington Post, June 13, 2016]

THE DALAI LAMA: WHY I'M HOPEFUL ABOUT THE WORLD'S FUTURE

(By the Dalai Lama)

The 14th Dalai Lama, Tenzin Gyatso, is the spiritual leader of Tibet. Since 1959, he has lived in exile in Dharamsala in northern India.

Almost six decades have passed since I left my homeland, Tibet, and became a refugee. Thanks to the kindness of the government and people of India, we Tibetans found a second home where we could live in dignity and freedom, able to keep our language, culture and Buddhist traditions alive.

My generation has witnessed so much violence—some historians estimate that more than 200 million people were killed in conflicts in the 20th century.

Today, there is no end in sight to the horrific violence in the Middle East, which in the case of Syria has led to the greatest refugee crisis in a generation. Appalling terrorist attacks—as we were sadly reminded this weekend—have created deep-seated fear. While it would be easy to feel a sense of hopelessness and despair, it is all the more necessary in the early years of the 21st century to be realistic and optimistic.

There are many reasons for us to be hopeful. Recognition of universal human rights, including the right to self-determination, has expanded beyond anything imagined a century ago. There is growing international consensus in support of gender equality and respect for women. Particularly among the younger generation, there is a widespread rejection of war as a means of solving problems. Across the world, many are doing valuable work to prevent terrorism, recognizing the depths of misunderstanding and the divisive idea of ''us'' and ''them'' that is so dangerous. Significant reductions in the world's arsenal of nuclear weapons mean that setting a timetable for further reductions and ultimately the elimination of nuclear weapons—a sentiment President Obama recently reiterated in Hiroshima, Japan—no longer seem a mere dream.

The notion of absolute victory for one side and defeat of another is thoroughly outdated; in some situations, following conflict, suffering arises from a state that cannot be described as either war or peace. Violence inevitably incurs further violence. Indeed, history has shown that nonviolent resistance ushers in more durable and peaceful democracies and is more successful in removing authoritarian regimes than violent struggle.

It is not enough simply to pray. There are solutions to many of the problems we face; new mechanisms for dialogue need to be created, along with systems of education to inculcate moral values. These must be grounded in the perspective that we all belong to one human family and that together we can take action to address global challenges.

It is encouraging that we have seen many ordinary people across the world displaying great compassion toward the plight of refugees, from those who have rescued them from the sea, to those who have taken them in and provided friendship and support. As a refugee myself, I feel a strong empathy for their situation and when we see their anguish, we should do all we can to help them. I can also understand the fears of people in host countries, who may feel overwhelmed. The combination of circumstances draws attention to the vital importance of collective action toward restoring genuine peace to the lands these refugees are fleeing.

Tibetan refugees have firsthand experience of living through such circumstances and, although we have not yet been able to return to our homeland, we are grateful for the humanitarian support we have received through the decades from friends, including the people of the United States.

A further source for hope is the genuine cooperation among the world's nations toward a common goal evident in the Paris accord on climate change. When global warming threatens the health of this planet that is our only home, it is only by considering the larger global interest that local and national interests will be met.

I have a personal connection to this issue because Tibet is the world's highest plateau and is an epicenter of global climate change, warming nearly three times as fast as the rest of the world. It is the largest repository of water outside the two poles and the source of the Earth's most extensive river system, critical to the world's 10 most densely populated nations.

To find solutions to the environmental crisis and violent conflicts that confront us in the 21st century, we need to seek new answers. Even though I am a Buddhist monk, I believe that these solutions lie beyond religion in the promotion of a concept I call secular ethics. This is an approach to educating ourselves based on scientific findings, common experience and common sense—a more universal approach to the promotion of our shared human values.

Over more than three decades, my discussions with scientists, educators and social workers from across the globe have revealed common concerns. As a result we have developed a system that incorporates an education of the heart, but one that is based on study of the workings of the mind and emotions through scholarship and scientific research rather than religious practice. Since we need moral principles—compassion, respect for others, kindness, taking responsibility—in every field of human activity, we are working to help schools and colleges create opportunities for young people to develop greater self-awareness, to learn how to manage destructive emotions and cultivate social skills. Such training is being incorporated into the curriculum of many schools in North America and Europe—I am involved with work at Emory University on a new curriculum on secular ethics that is being introduced in several schools in India and the United States.