

# Health Status of American Indians in Nebraska



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Nebraska Department of Health and Human Services

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## Introduction

We are striving to provide a more comprehensive look at health disparities among racial and ethnic minorities in Nebraska. As a building block toward that goal, the Office of Health Disparities and Health Equity (OHDHE), has compiled this data report based on the most recent statistical information available. This report presents health status facts coupled with socioeconomic status information on the American Indian population in Nebraska, and will illustrate the contrast between this minority population and the Non-Hispanic/Latino White majority population. The statistical information contained here spans several different health issues including mortality, chronic diseases, infectious diseases, intentional and unintentional injuries, maternal and child health and behavioral risk factors.

For the purpose of this report, race and ethnicity are defined by the United States Census Bureau and the Federal Office of Management and Budget (OMB) as “self-identification data items in which residents choose the race or races with which they most closely identify, and indicate whether or not they are of Hispanic or Latino origin (ethnicity).” The racial classifications used by the Census Bureau adhere to the October 30, 1997 Federal Register Notice entitled *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* issued by the OMB<sup>1</sup>. The OMB defines five minimum race categories; White, African American, American Indians, Asian, and Native Hawaiian or Other Pacific Islander. The following definition is provided by OMB and the U.S. Census

Bureau to identify the race related to this report:<sup>2</sup>

**White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as “*White*,” or report entries such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish.

**American Indians:** A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

The data referred to as *American Indian* on the charts in this report contain data for both American Indians and Alaska Natives; however the Nebraska population size for Alaska Natives is so small, this report basically represents the health status of American Indians.

This report is one of a series of four *Nebraska Minority Health Disparities Facts Reports*, each of which focus on one racial/ethnic group. The information, and analysis methodology presented here are consistent in producing the report series which provides a multiple dimensional view and captures/tracks trends in disparities, while quantifying the potential for future progress in meeting quality goals.

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<sup>1</sup> <http://www.whitehouse.gov/omb/fedreg/ombdir15.html>

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<sup>2</sup> <http://www.whitehouse.gov/omb/fedreg/ombdir15.html>

## Executive Summary

### Highlights of the Report Include:

- According to the U.S. Census<sup>3</sup>, there were 18,427 American Indians in Nebraska in 2010. This number represented approximately 1.0% of the total Nebraska population.
- The majority of the state's American Indian population lived in the counties of Thurston (3,963), Douglas (3,731), and Lancaster (2,140).
- Approximately 24% of American Indians ages 25 and older had less than a high school education and only 8.8% had a Bachelor's Degree or more education.
- The median annual income of American Indian households from 2006 to 2010 was about \$26,932; this is nearly \$24,620 less than the median income of White households, which was \$51,552.
- During 2006-2010, American Indian men were 1.2 times as likely to die from all death causes as White men. American Indian women were 1.4 times as likely to die from all death causes as White women.
- American Indians were 342% more likely to die from diabetes mellitus compared to Whites; and 161% more likely to die from diabetes related diseases as compared to Whites.
- In comparing the death rate due to pneumonia, it is 83% more likely for American Indian males and 128% more likely for American Indian females to die when contrasted to the White population.
- During 2006-2010, American Indians were 6.5 times more likely to die from homicide than Whites.
- The incidence rates for all sexually transmitted diseases were higher for American Indians (1056.5 per 100,000) when compared to the White population (256.6 per 100,000 population).
- American Indians had an incidence rate per 100,000 population for Chlamydia of 821.8, which was about 4.4 times higher than that for Whites; the Nebraska total incidence rate for Chlamydia was 299.2 per 100,000 population.
- During 2006-2010, the Infant mortality rate was 1.4 times as high for American Indians than for Whites.
- In Nebraska during 2006-2010, American Indians had a death rate per 100,000 population for motor vehicle accidents of 16.1, which was about 1.2 times higher than that for Whites.
- American Indian (9.5%) adults 18 and older in Nebraska were more likely than White adults (4.8%) 18 and over, to report heavy drinking.

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<sup>3</sup> Source: Population Division, U.S. Census Bureau, 2010 Census

- American Indians (16.1%) experienced significantly higher rates of inability to see a physician due to cost constraints than Whites (9.1%)
- American Indians overall were 8.3 times more likely to die from HIV/AIDS than Whites.
- American Indian adults (approximately 44%) in Nebraska were significantly more likely than White adults (approximately 18%) to be current smokers. A total of 18.5% of Nebraska adults were current smokers.
- American Indians experienced higher rates of physical inactivity than Whites, 28.3% versus 21.6%.

It is our hope this report will serve as a data resource for the Tribal communities in Nebraska and for those who work for and with American Indians in Nebraska. The purpose for writing this report was to provide a one-stop resource data book, so that individuals interested in this type of American Indian data could go to one source for multiple pieces of information. The data in this report represents health facts and socioeconomic status of Nebraska's American Indians. Overall, the death data represents the major causes of death for American Indians in Nebraska. Maternal and child health data shows the Nebraska American Indians' infant health status and the well-being of young American Indian mothers. PRAMS data presents American Indian mothers' breastfeeding situation and the support they are provided. BRFSS data comes from the database of the behavioral risk factor surveillance system which collects data by conducting surveys on the prevalence of major health risk factors among adults.

The data presented in this report can be used to target American Indian health education and risk reduction activities throughout Nebraska to lower rates of premature death and disability. In this report, the American Indian data is summarized and compared to total state of Nebraska data and Non-Hispanic/Latino White data to reveal the disparity status for various health issues.

## Data Sources

The data sources for this report come from the Nebraska Department of Health and Human Services Vital Statistics, Nebraska Behavioral Risk Factor Surveillance System (BRFSS), Cancer Registry, HIV Prevention Program, the Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS), and other programs. From Vital Statistics, different race/ethnic groups' data are presented in the format of age adjusted rate per 100,000 population. Age adjustment is a statistical technique for calculating the rates or percentages for different populations as if they all had the age distribution of a standard population. Rates adjusted to the same standard population can be directly compared or

contrasted to each other, that way any differences attributed to factors of the population are more readily seen. The BRFSS data presented in this fact sheet are age adjusted as well, and surveys have been conducted annually since 1986 for the purpose of data collection on the prevalence of major health risk factors among adults residing in the state. The BRFSS data used in this report is the Nebraska regular BRFSS 2006-2010 combined data. In future editions, more data will be added to this report in order to provide an even more comprehensive look at American Indian health status in Nebraska.

## Demographics and Social Economics

According to the U.S. Census<sup>4</sup>, there were 18,427 American Indians in Nebraska in 2010. This number represented approximately 1.0% of the total Nebraska population. Nearly 1.6% of the total Nebraska population was American Indian alone or in combination.<sup>5</sup>

### Distribution of Nebraska American Indian Population

**Table 1: Distribution of Nebraska American Indian and Alaska Native Population, 2010<sup>6</sup>**

<i>Subject</i>	<i>Number</i>	<i>Percent</i>
<b>RACE</b>		
Total Nebraska population	1,826,341	
<b>One Race</b>		
American Indians and Alaska Native	18,427	1.0
<b>Two or More Races</b>		
American Indians and Alaska Native ;White	7,587	0.4
American Indians and Alaska Native; Black or African American	1,317	0.1
American Indians and Alaska Native; Asian	157	0.0
American Indians and Alaska Native; Native Hawaiian and Other Pacific Islander	37	0.0
American Indians and Alaska Native; Some Other Race	536	0.0
<b>American Indians and Alaska Native alone or in combination *</b>		
American Indians and Alaska Native alone	18,427	1.0
American Indians and Alaska Native in combination	11,389	0.6
<b>HISPANIC OR LATINO</b>		
American Indians and Alaska Native alone, Hispanic or Latino	3,630	0.2
American Indians and Alaska Native alone, Not Hispanic or Latino	14,797	0.8

Source: U.S. Census Bureau, 2010 Census.

Notes: \* The race concept alone or in combination includes people who reported a single race alone and people who reported that race in combination with one or more of the other race groups. The "alone or in combination" concept, therefore, represents the maximum number of people who reported as that race group, either alone or in combination with another race(s). The sum of the six individual race "alone or in combination" categories may add to more than the total population because people who reported more than one race are tallied in each race category.

<sup>4</sup> Source: Population Division, U.S. Census Bureau, 2010 Census

<sup>5</sup> Source: Population Division, U.S. Census Bureau, Annual Estimates of the Population by Sex, Race, and Hispanic Origin for Nebraska

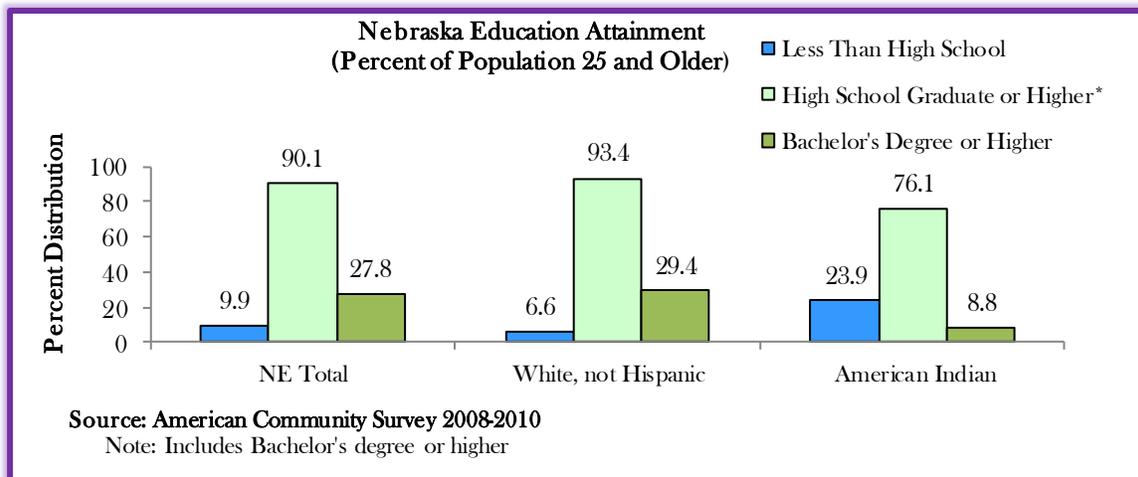
<sup>6</sup> Source: U.S. Census Bureau, 2010 Census.



## Educational Attainment

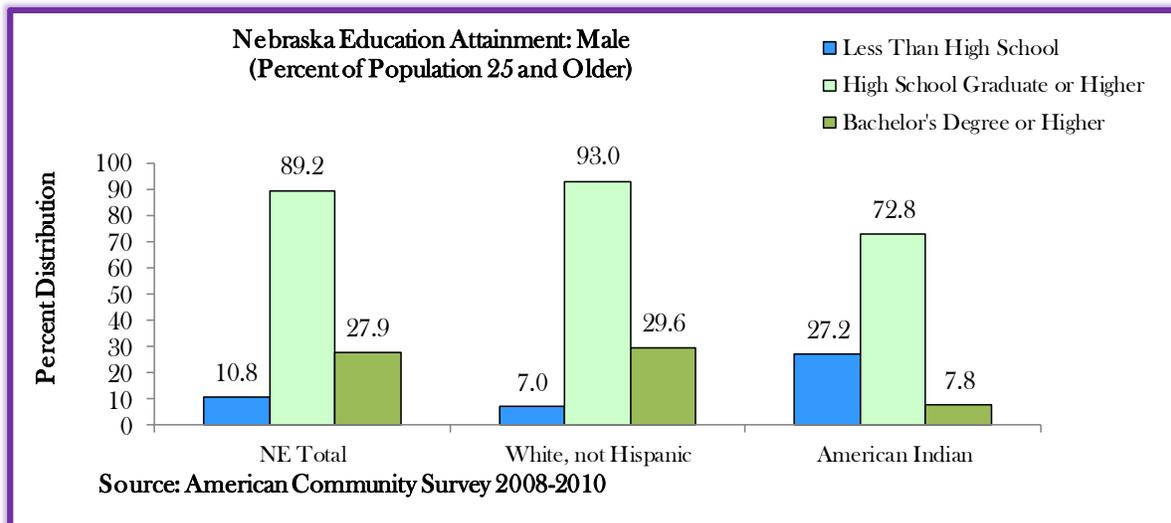
Approximately 24% of American Indians ages 25 and older had less than a high school diploma, and only about 9% had a Bachelor's Degree or greater education.

Among Whites alone ages 25 and older, about 7% were not high school graduates and 29.4% had a Bachelor's Degree or higher education.



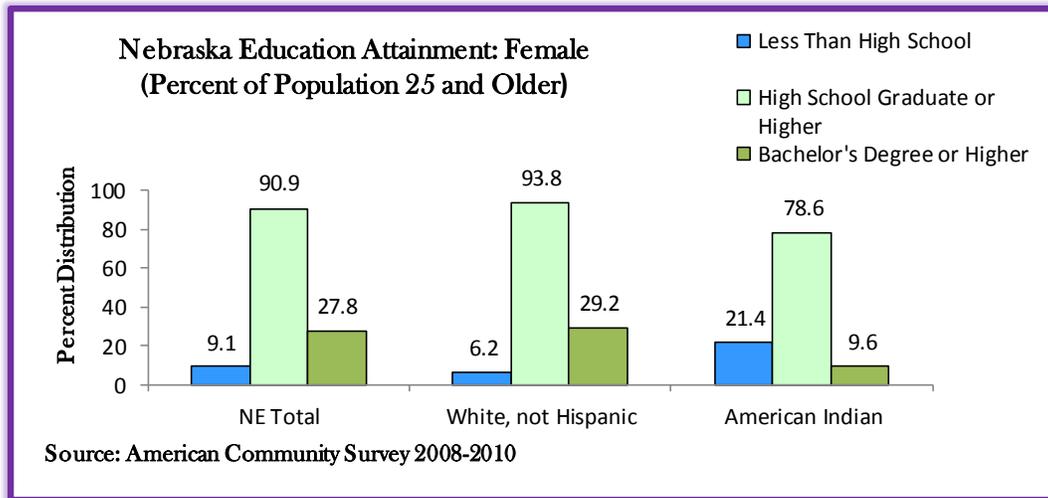
In 2008-2010 27.2% of American Indian males ages 25 and older did not have a high school diploma, and only 7.8% had a Bachelor's Degree or greater education.

Among White males ages 25 and older, about 7.0% did not have a high school diploma, and nearly 30% had a Bachelor's Degree or higher.



21.4% of American Indian females ages 25 and older did not have a high school diploma, and only 9.6% had a Bachelor's Degree or higher education.

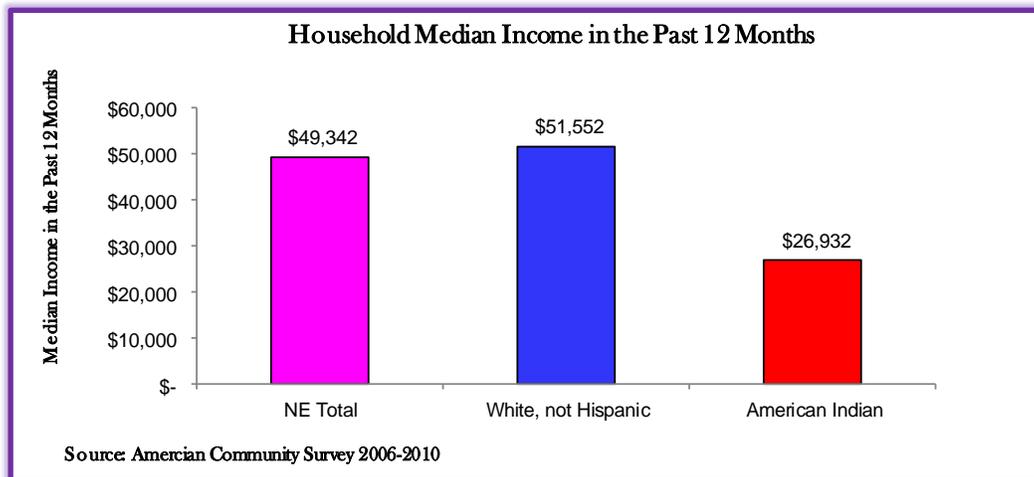
Among White females ages 25 and older, 6.2% did not have a high school diploma, and 29.2% had a Bachelor's Degree or higher education.



## Income

The median annual income of American Indian households for the years 2006 to 2010 was about \$26,932; this was nearly

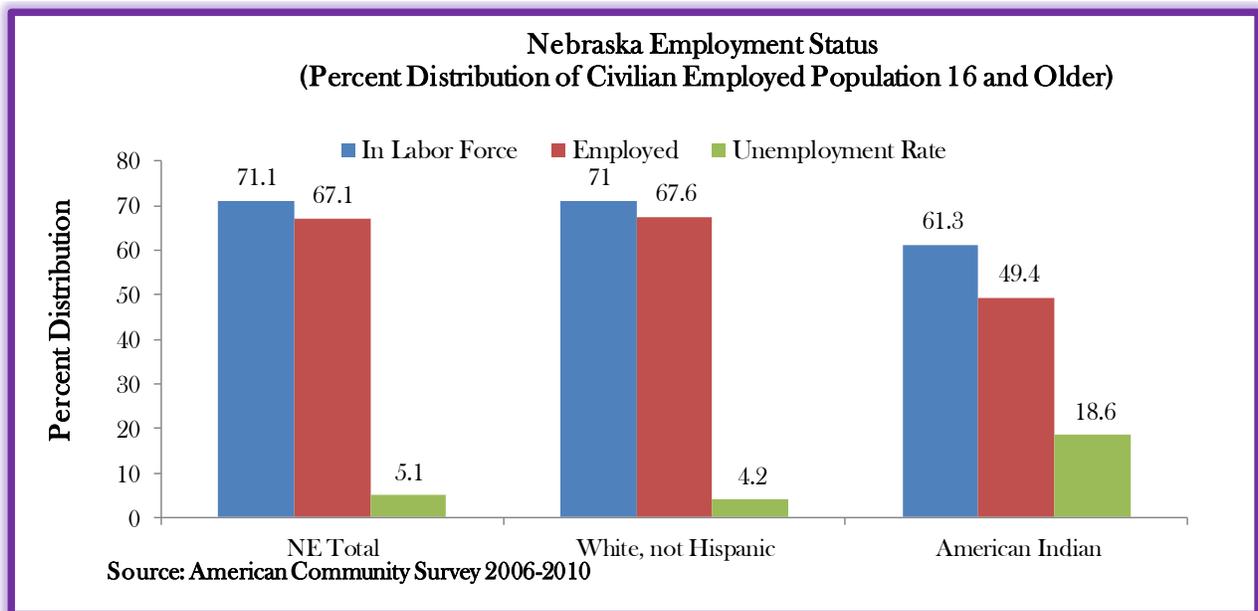
\$24,620 less than the median income of White households, which was roughly \$51,552.



## Employment Status

A higher proportion (nearly 18.6%) of the American Indian population ages 16 years and older were unemployed; for Whites of the same age group the rate was 4.2%.

Between 2006 and 2010, about 61.3% of Nebraska American Indians ages 16 years and older were in the labor force. In comparison, almost 71% of Whites 16 years and older were in the labor force.



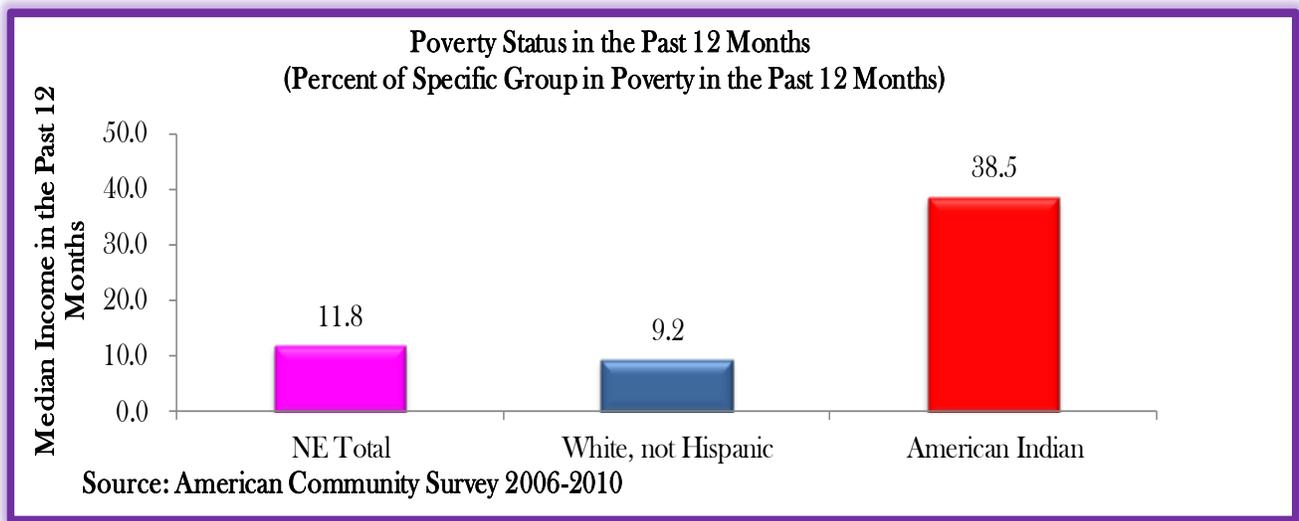
Notes: The category of “Employed” includes all civilians 16 years old and over who either (1) were “at work” – those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were “with a job but not at work”--those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons. Excluded from the employed are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are all institutionalized people and people on active duty in the United States Armed Forces.

Source: U.S. Census Bureau, 2006-2010 American Community Survey, Detailed Tables.

## Poverty

The poverty rate was higher for American Indians than for Whites. 38.5% of American Indians were living below the

poverty level in the 12 months prior to being surveyed, as compared to about 9.2% of Whites.



## Leading Causes of Death for American Indians

The tables below show the leading causes of death for both American Indians and Whites for the years 2006-2010. When looking at total death number, the *top 5* leading causes of death breakdown as follows:

**For American Indians** – cancer, heart disease, diabetes, cirrhosis and non-motor vehicle crashes, are the top 5.

**For Whites** –heart disease, cancer, stroke, chronic lung disease and Alzheimer’s, are the top 5.

Leading Causes of Death Total – Both Genders					
Frequency	Number (American Indians)	Percentage	Frequency	Number (Whites)	Percentage
Cancer	71	14.3%	Heart	16,439	22.9%
Heart	66	13.3%	Cancer	16,293	22.6%
Diabetes	48	9.7%	Stroke	4,192	5.8%
Cirrhosis	34	6.9%	Chronic Lung	4,187	5.8%
Non MV Crash	26	5.3%	Alzheimer’s	2,700	3.8%
Chronic Lung	22	4.4%	Diabetes	2,061	2.9%
Stroke	18	3.6%	Non MV Crash	2,064	2.9%
Homicide	16	3.2%	Pneumonia	1,452	2.0%
Nephritis/Nephrosis	14	2.8%	Nephritis/Nephrosis	1,235	1.7%
MV Crash	13	2.6%	MV Crash	1,149	1.6%
Suicide	13	2.6%	Other Intestinal	1,062	1.5%
Pneumonia	12	2.4%	Suicide	886	1.2%
Septicemia	12	2.4%	Hyper/Renal Disease	841	1.2%
Ill Defined	28	5.7%	Ill Defined	1,848	2.6%
Other	102	20.6%	Other	15,531	21.6%
Total	495	100.0%	Total	71,940	100.0%

**The leading causes of death for men during 2006-2010, were:**

**For American Indians** – The Top 5 causes of death for American Indian men were cancer, heart disease, diabetes, cirrhosis, and non-motor vehicle crashes.

**For Whites** – The top 5 causes of death for White men were cancer, heart disease, chronic lung disease, stroke, and non-motor vehicle crashes.

Leading Causes of Death for Males					
Frequency	Number (American Indians)	Percentage	Frequency	Number (Whites)	Percentage
Cancer	37	14.5%	Cancer	8539	24.7%
Heart	37	14.5%	Heart	7978	23.1%
Diabetes	27	10.5%	Chronic Lung	2136	6.2%
Cirrhosis	19	7.4%	Stroke	1645	4.8%
Non MV Crash	16	6.3%	Non MV Crash	1122	3.2%
Suicide	12	4.7%	Diabetes	996	2.9%
Stroke	11	4.3%	MV Crash	769	2.2%
MV Crash	10	3.9%	Alzheimer's	783	2.3%
Chronic Lung	9	3.5%	Suicide	725	2.1%
Homicide	8	3.1%	Pneumonia	633	1.8%
Pneumonia	6	2.3%	Nephritis/Nephrosis	605	1.7%
Nephritis/Nephrosis	4	1.6%	Parkinson	454	1.3%
Septicemia	4	1.6%	Cirrhosis	407	1.2%
Ill Defined	13	5.1%	Ill Defined	980	2.8%
Other	43	16.8%	Other	6838	19.8%
<b>Total</b>	<b>256</b>	<b>100.0%</b>	<b>Total</b>	<b>34610</b>	<b>100.0%</b>

The leading causes of death for women during 2006-2010 were:

**For American Indians** – cancer, heart disease, diabetes, cirrhosis and chronic lung disease are the top 5.

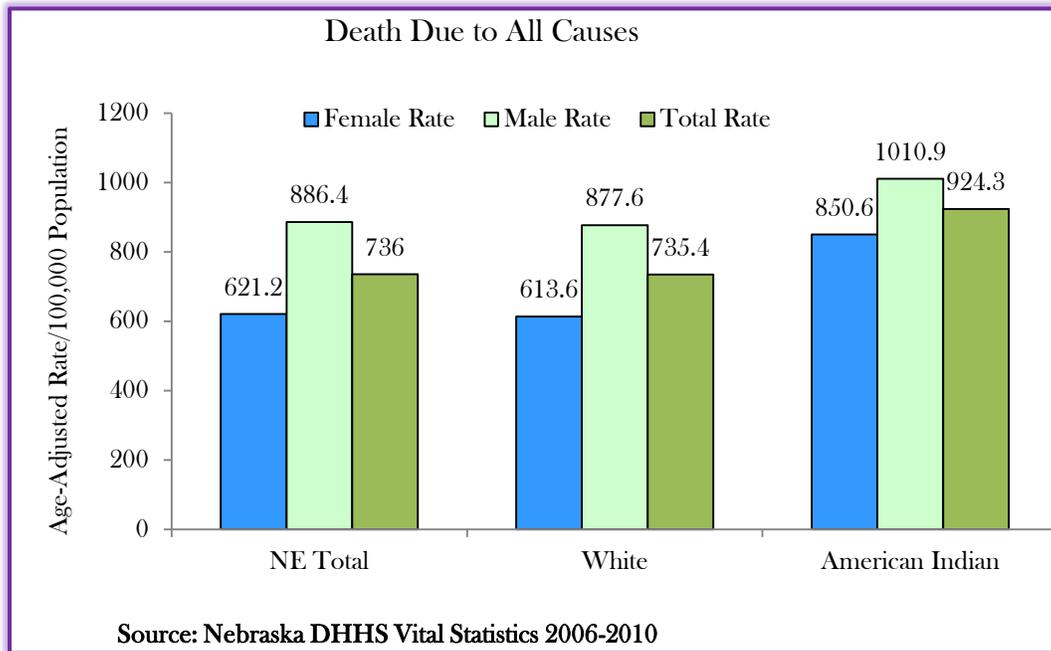
**For Whites** –heart disease, cancer, stroke, chronic lung disease, and Alzheimer’s are the top 5.

Leading Causes of Death for Females					
Frequency	Number (American Indians)	Percentage	Frequency	Number (Whites)	Percentage
Cancer	34	14.2%	Heart	8,461	22.7%
Heart	29	12.1%	Cancer	7,754	20.8%
Diabetes	21	8.8%	Stroke	2,547	6.8%
Cirrhosis	15	6.3%	Chronic Lung	2,051	5.5%
Chronic Lung	13	5.4%	Alzheimer’s	1,917	5.1%
Non MV Crash	10	4.2%	Diabetes	1,065	2.9%
Nephritis/Nephrosis	10	4.2%	Non MV Crash	942	2.5%
Septicemia	8	3.3%	Pneumonia	819	2.2%
Homicide	8	3.3%	Nephritis/Nephrosis	630	1.7%
Stroke	7	2.9%	Other Intestinal	646	1.7%
Pneumonia	6	2.5%	Hyper/Renal Disease	538	1.4%
Allergic Alveoli	5	2.1%	Musculoskeletal	489	1.3%
Perinatal Conditions	4	1.7%	MV Crash	380	1.0%
Ill Defined	15	6.3%	Ill Defined	868	2.3%
Other	54	22.6%	Other	8,222	22%
<b>Total</b>	<b>239</b>	<b>100.0%</b>	<b>Total</b>	<b>37,329</b>	<b>100.0%</b>

## Mortality

Mortality data acts as a mirror for current health problems, and suggests patterns of risk across population subgroups. Many causes of death are preventable or treatable, and therefore warrant the attention of public health prevention efforts. Mortality data is an important indicator of where federal, state, and local prevention efforts should be placed in building healthy communities. Mortality data is one of the best sources of information in relation to the health of communities.

The death rate from all causes is a key measure of health status across populations. An overview chart of the death rates from all causes is shown below. During the years 2006-2010, American Indian men were 1.2 times as likely to die from all death causes as White men. American Indian women were over 1.4 times as likely to die from all causes as White women. American Indians were 26% more likely to die from all causes than Whites.



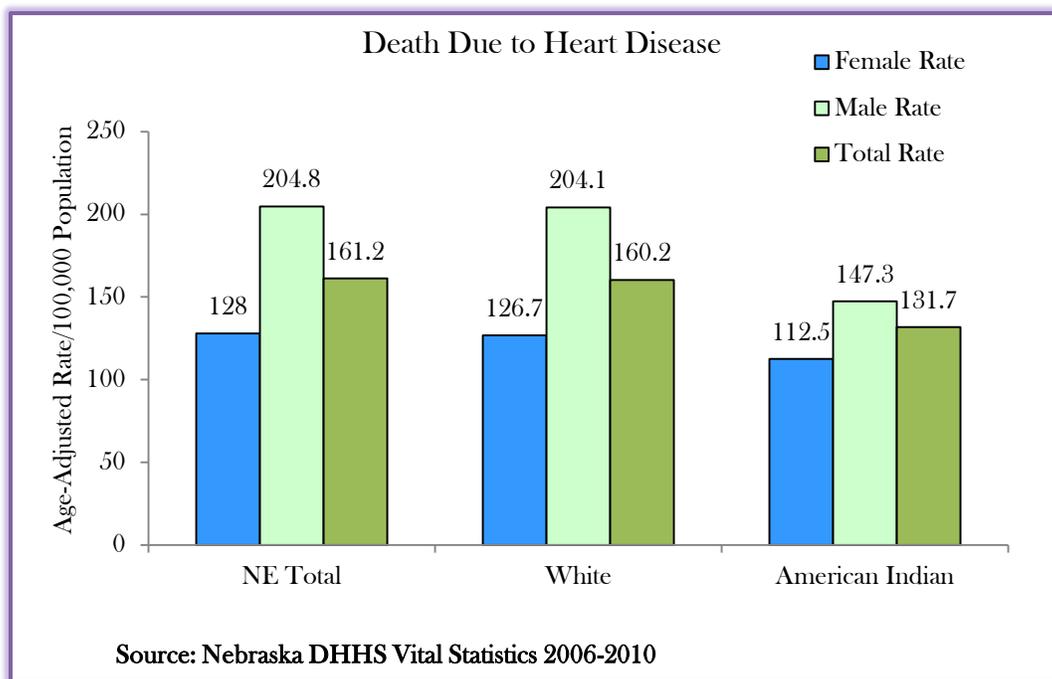
## Chronic Disease

During the 20<sup>th</sup> century, chronic diseases replaced infectious diseases (e.g., pneumonia, tuberculosis, and diarrhea) as leading causes of death in the United States. Chronic diseases – including all cardiovascular diseases, all cancers, diabetes mellitus, and chronic lower respiratory diseases – accounted for a large portion of all deaths among Nebraska residents during 2006-2010. Heart disease, stroke, diabetes, and cancers are discussed in the sections below.

## Heart Disease

Cardiovascular disease involves the body's vascular or circulatory system, which is responsible for supplying oxygen and nutrients to the organs and cells. Heart disease and cerebrovascular disease (stroke) are the major cardiovascular diseases and leading causes of death in Nebraska.

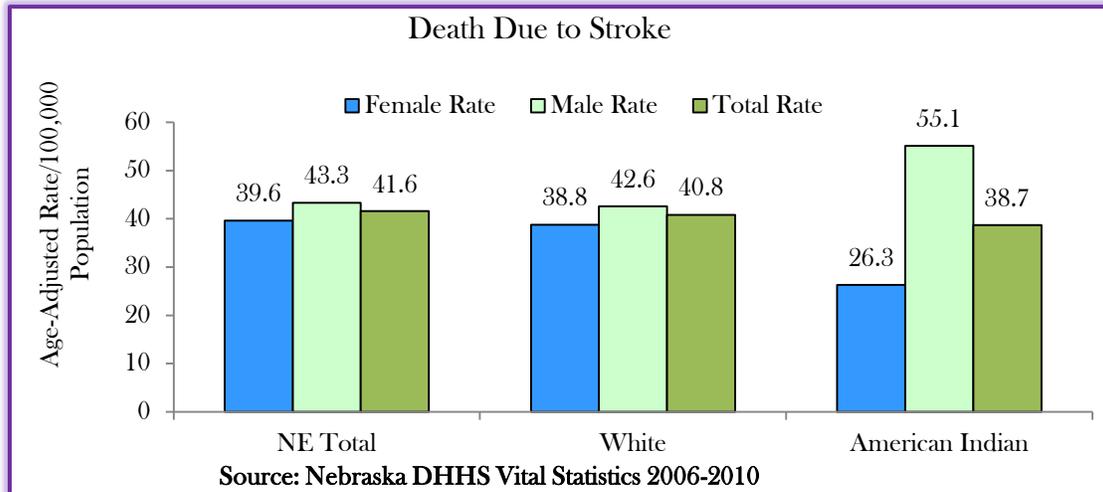
In 2006-2010, American Indian males were less likely to die from heart disease (147.3 per 100,000 population), as compared to White males (204.1 per 100,000 population). American Indian females were less likely as White females to die from heart disease.



## Stroke

Stroke is the most severe clinical manifestation of cerebrovascular disease. From 2006-2010, American Indian males were 29% more likely than their White counterparts to have a stroke. American

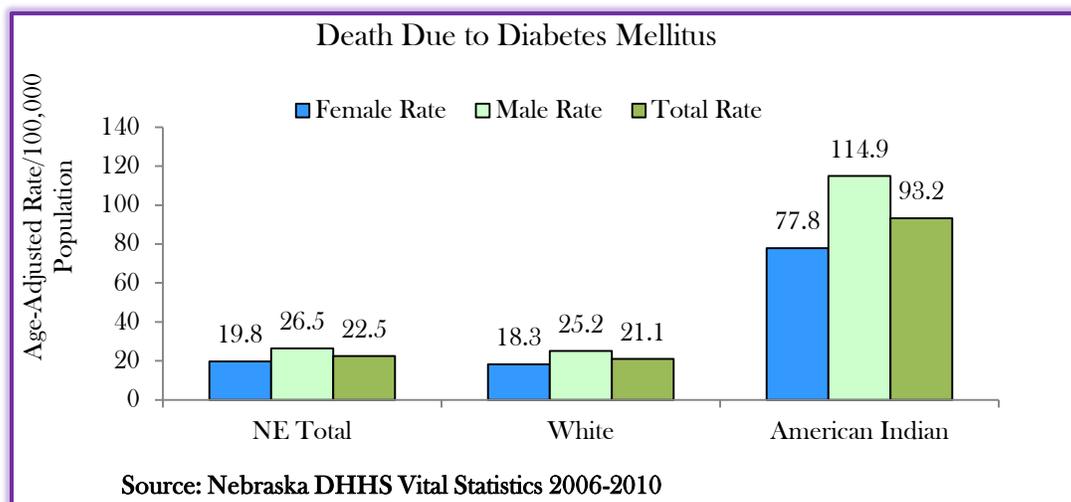
Indian females were less likely to die from a stroke (26.3 per 100,000 population), than their White female counterparts (38.8 per 100,000 population).



## Diabetes

Diabetes mellitus is characterized by high levels of blood glucose, which result from deficient insulin production and/or insulin action. For 2006-2010 the diabetes death rates were much higher for both American Indian males and females as compared with those of Whites. American Indian males were about 4.6 times more likely than

White males to die from diabetes. American Indian females had more than 4.3 times the death rate in contrast to White females for diabetes. American Indians were 342% more likely to die from diabetes compared to Whites.

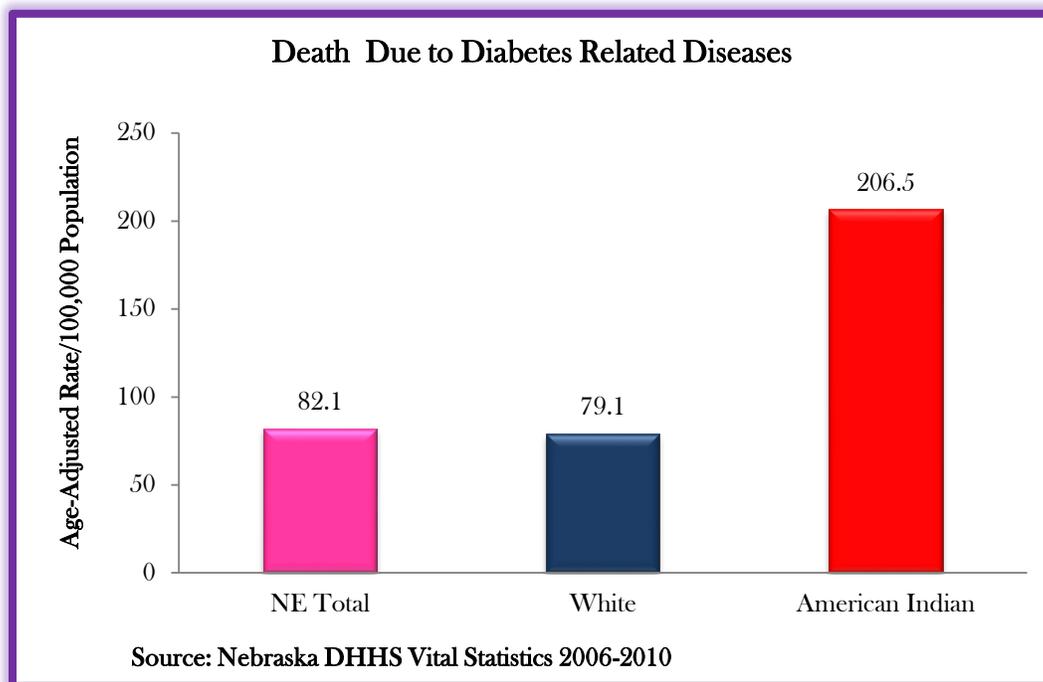


### Diabetes Related Death

Diabetes is associated with serious complications and premature death, and people with diabetes are at increased risk for many adverse health outcomes, including heart disease and stroke. Most people with diabetes die from related complications rather than directly from the disease itself; therefore, examination of diabetes as the underlying cause of death alone does not accurately represent its

extensive contribution to overall mortality. Diabetes was listed as a significant (“diabetes-related”) cause of death for Nebraska residents.

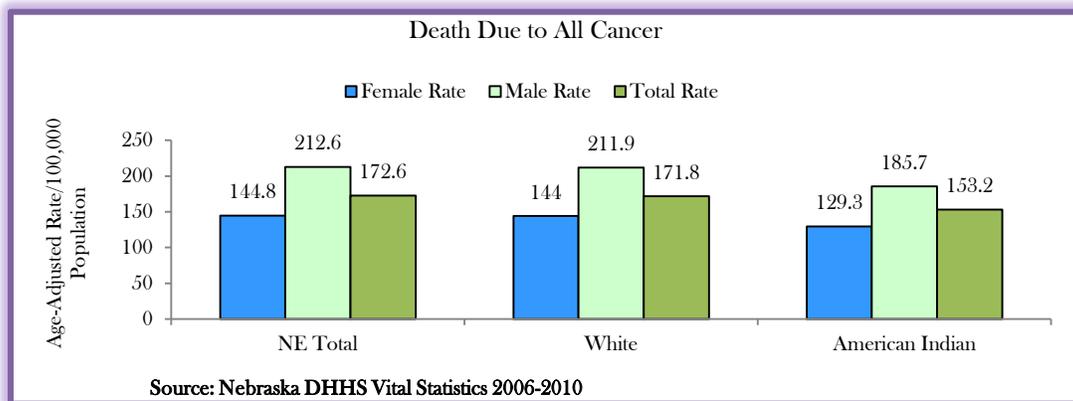
During 2006-2010, diabetes-related death rates were much higher for American Indians as compared with those of Whites. American Indians were 161% more likely to die from diabetes related diseases as compared to Whites.



## Cancer

The figure below shows the death rate of all cancers for American Indians and Whites during 2006-2010. American Indian males were less likely to die from all cancer cases (185.7 per 100,000 population), than White males (211.9 per 100,000 population),

American Indian females were less likely to die from cancer (129.3 per 100,000 population), in contrast to White females (144 per 100,000 population),.



## Cancer Screening

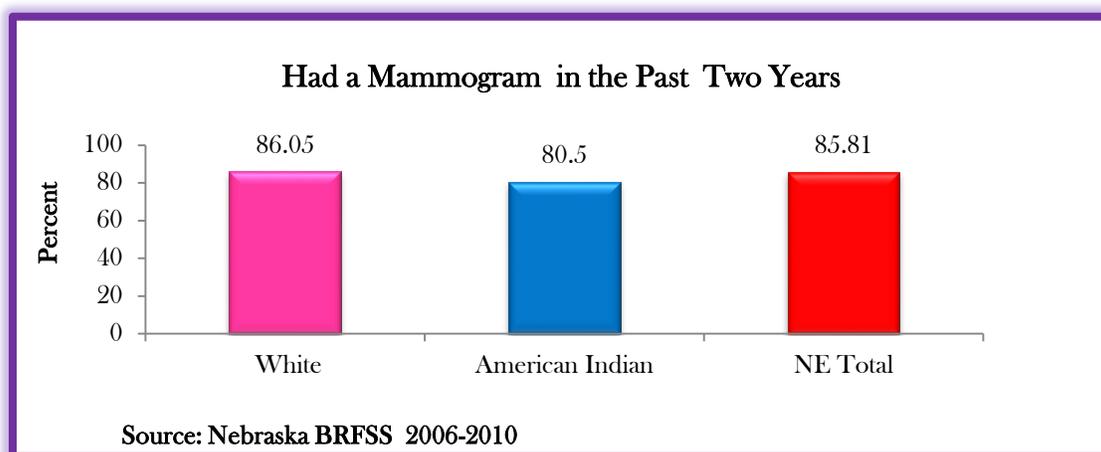
Breast cancer is the most frequently diagnosed cancer among women in Nebraska. The American Cancer Society recommends that women ages 40 and older

have a mammogram every year. Clinical breast exams are recommended every three years for women in their 20s and 30s, and annually for women ages 40 and older.

## Mammogram

Women in the BRFSS survey were asked if they ever had a mammogram in the past two year.

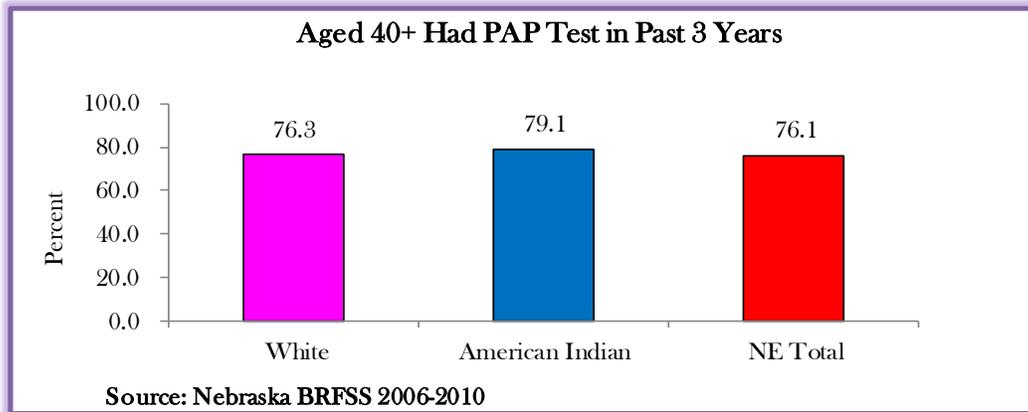
During the period of 2006-2010, 80.5% of American Indian women ages 40 and older had a mammogram in the past two years, compared to 86% of White women.



### Ever Had a Pap Test

Women in the BRFSS survey were given the definition of a pap test as, “a test for cancer of the cervix,” then asked if they “ever had a Pap Test in past three years?” During the period of 2006-2010, 79.1 % of American

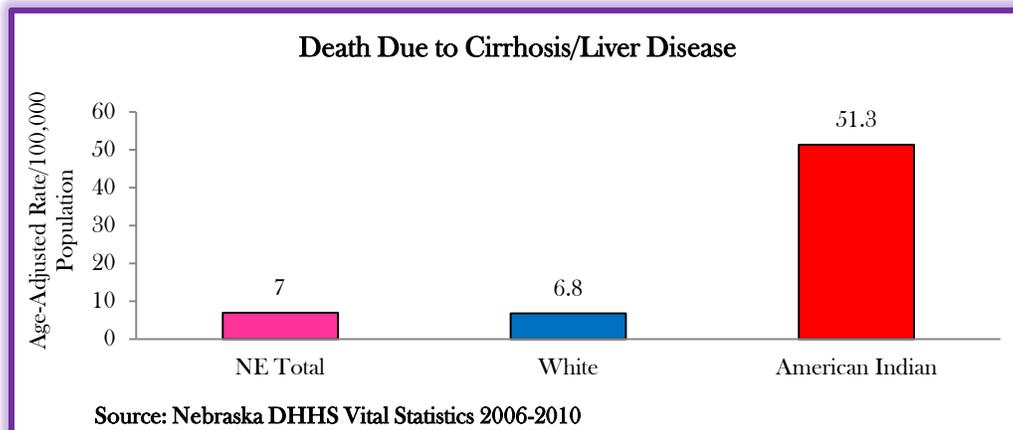
Indian women ages 40 or older had Pap Test in the past three years among all women, compared to 76.3 % of White women.



### Liver Disease

In 2006-2010, American Indian males were 7.5 times more likely to die from liver disease as Whites. American Indians had a death rate of 51.3 per 100,000 populations

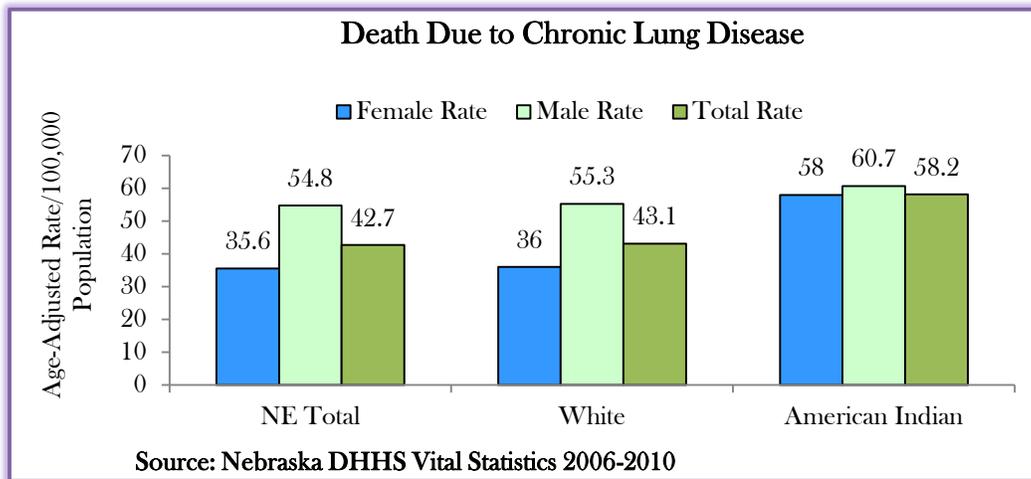
from cirrhosis/liver disease, while Whites had a death rate of 6.8 per 100,000 population.



### Chronic Lung Disease

For 2006-2010, American Indian males had 1.1 times more chronic lung disease deaths than White males. American Indian females were 61% more likely to die from chronic

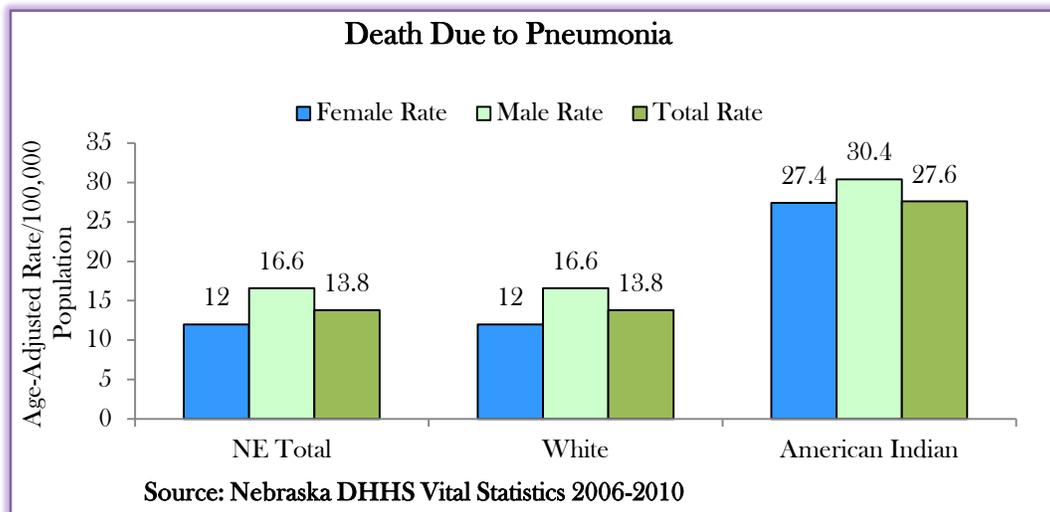
lung disease than White females. American Indians were 35% more likely to die from chronic lung disease as Whites.



### Pneumonia

Death rates due to pneumonia in 2006-2010 for American Indians and Whites were 27.6 and 13.8, respectively. In comparing the death rate due to pneumonia, it was 83%

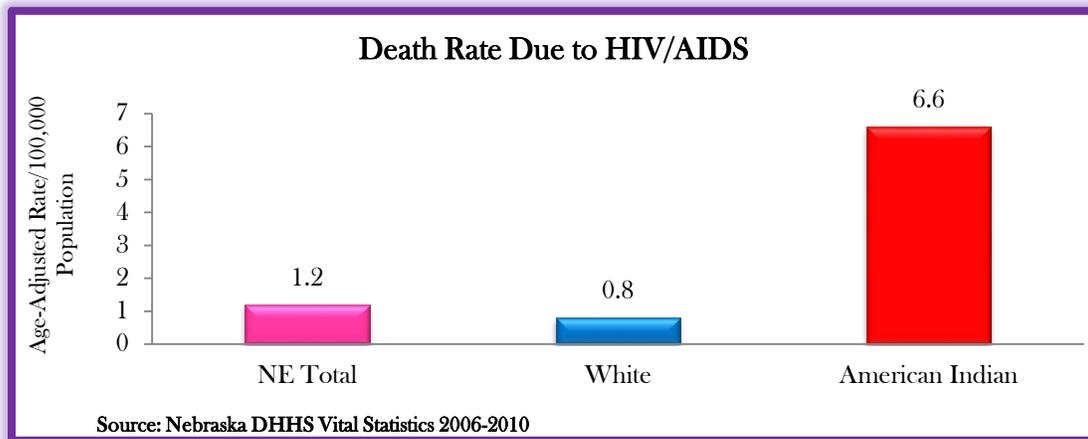
more likely for American Indian males and 128% more likely for American Indian females to die when contrasted to the White population.



## HIV/AIDS

Biomedical research has characterized the infectious agent that causes AIDS as the Human Immunodeficiency Virus (HIV). Much has been learned from anthropological and epidemiological studies about HIV transmission, prevention, and control.

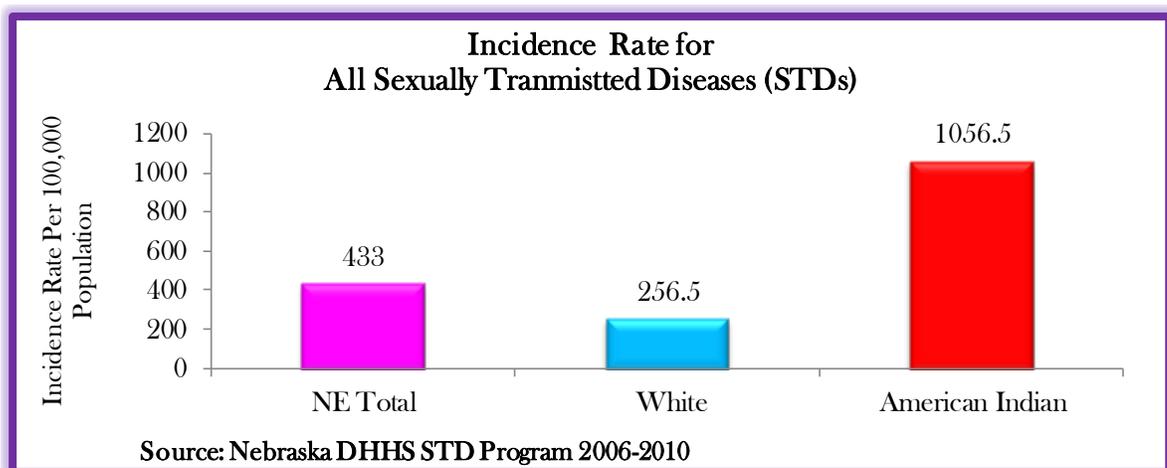
The figure below shows the death rate of HIV/AIDS for American Indians and Whites during the 2006-2010 timeframe. American Indians overall were 8.3 times more likely to die from HIV/AIDS than Whites.



## Sexually Transmitted Diseases

Sexually transmitted diseases (STDs) remain a major public health challenge in the United States. STDs can cause serious complications including infertility, ectopic pregnancy, blindness, fetal and infant deaths, and congenital defects. Racial and ethnic minorities are at higher risk for sexually transmitted diseases, and experience higher rates of disease and disability than the overall population. STDs are also the cause of many harmful and

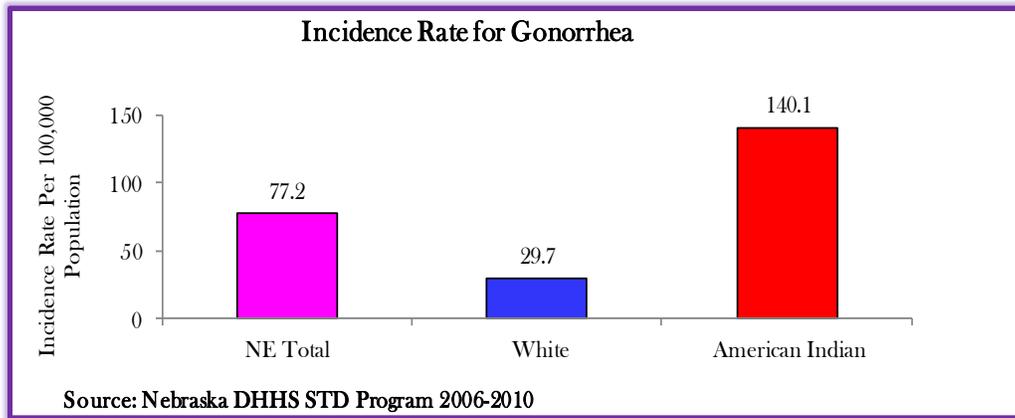
often irreversible complications, such as reproductive health problems, fetal and prenatal health problems, and cancer. In Nebraska, the incidence rates and relative risk of infection of all sexually transmitted diseases for American Indians was 1056.5 per 100,000 population, which was four times greater than for the White population, who had an incidence rate of 256.5 per 100,000 population.



### Incidence of Gonorrhea

In Nebraska, during 2006-2010, American Indians had an incidence rate for gonorrhea of 140.1 per 100,000 population, which is

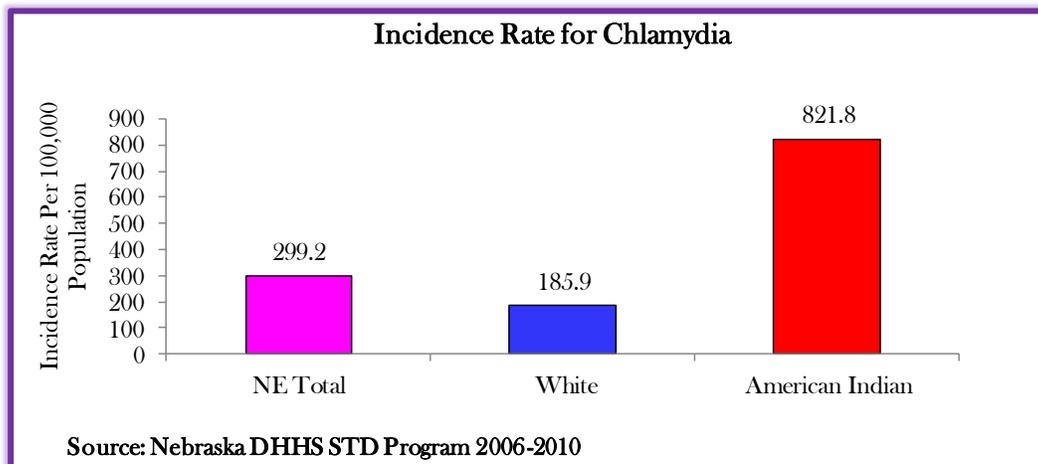
about 4.7 times higher than the incidence rate for Whites (29.7 per 100,000 population).



### Incidence of Chlamydia

Incidences of chlamydia infections have increased in Nebraska, as it has nationwide. Expanded screening and improved testing methods may account for some of these increases. Chlamydia remains the most commonly reported infectious disease in

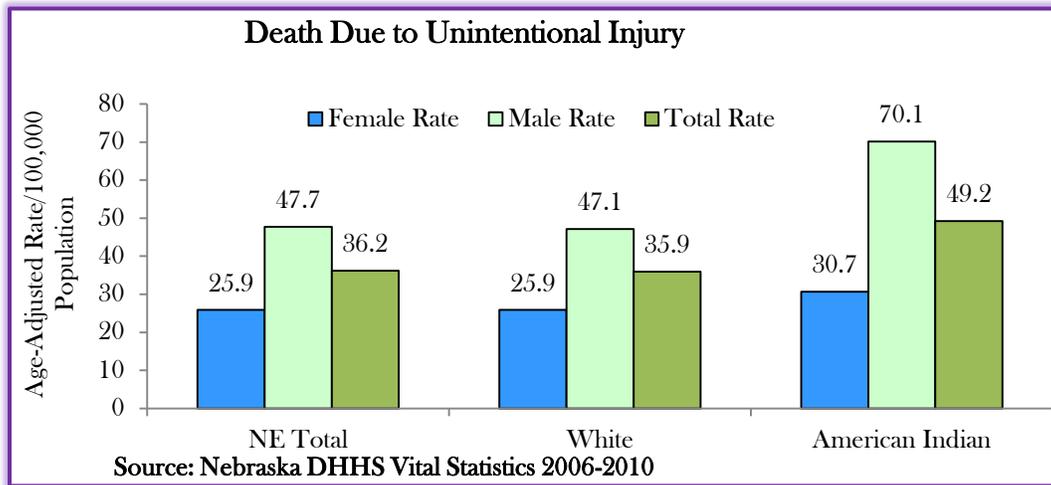
the United States. In Nebraska, during 2006-2010, American Indians had an incident rate per 100,000 population for chlamydia of 821.8, which was about 4.4 times higher than that for Whites; the Nebraska total incidence rate was 299.2.



## Intentional and Unintentional Injuries

Injuries are a leading cause of premature death in the United States and Nebraska. They include unintentional types such as motor vehicle crashes, falls, and suffocation, as well as intentional types including homicides and suicides.

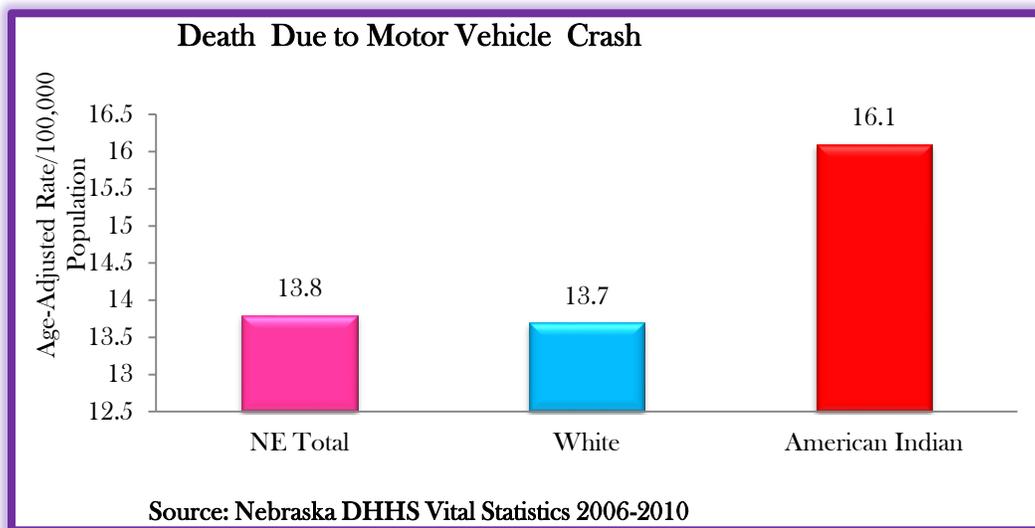
American Indian males were 1.5 times more likely to die from unintentional injuries than White males. American Indian females were 19% more likely to die due to unintentional injury than White females



## Motor Vehicle Crashes

In Nebraska during 2006-2010, American Indians had a death rate 16.1 per 100,000 population for motor vehicle crash death,

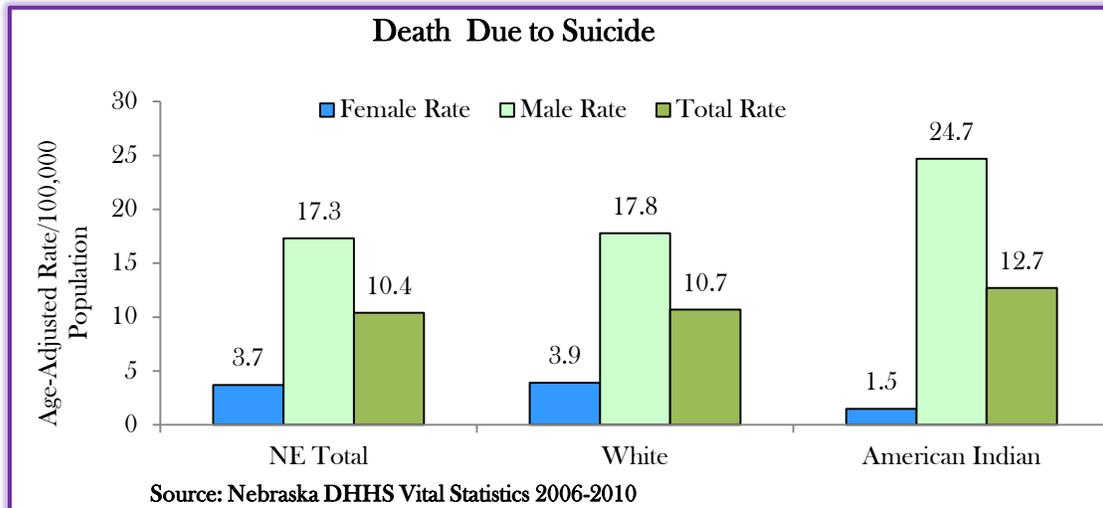
which was about 1.2 times higher than that for Whites.



## Suicide

The death rate of 12.7 per 100,000 population of suicide for American Indians was 1.2 times greater than for Whites at

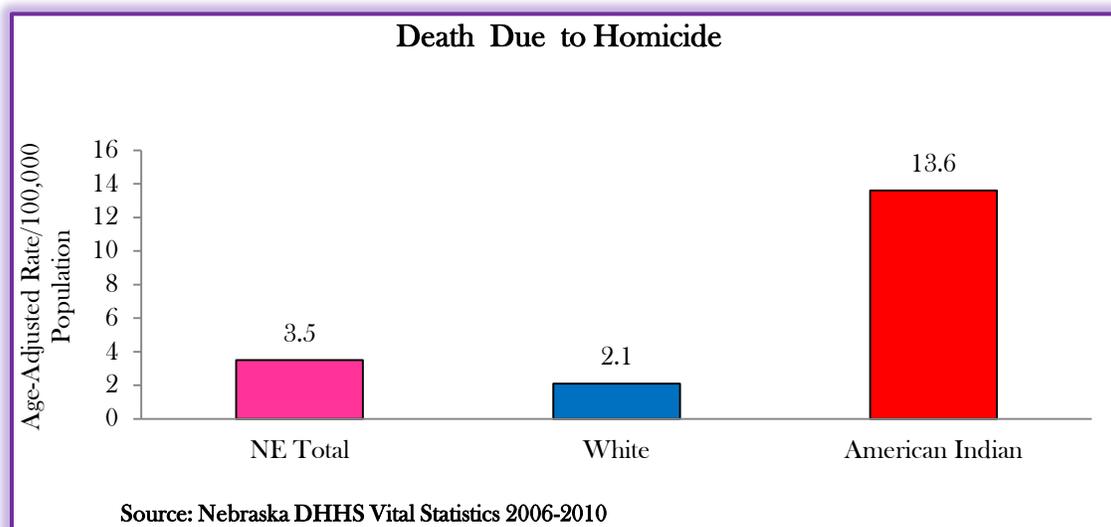
10.7 per 100,000 population. American Indian males were 39% more likely to die from suicide than White males.



## Homicide

Homicide by definition includes deaths inflicted by another person with the intention to injure or kill. During 2006-

2010, American Indians were 6.5 times more likely to die from homicide than Whites.

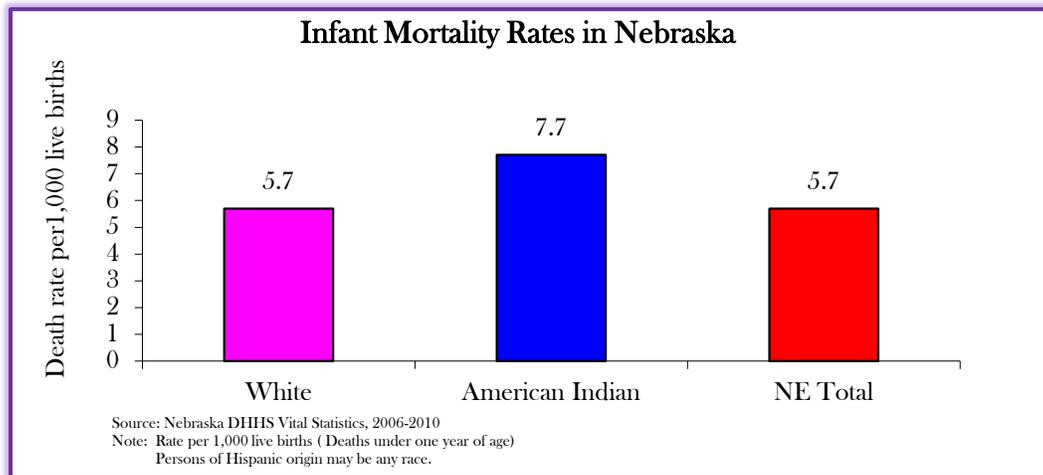


## Maternal and Child Health

### Infant Mortality

Infant mortality is a long-established measure not only of child health but also of the well-being of a society. It reflects the level of health status and health care of a population and the effectiveness of preventive care and the attention paid to maternal and child health. Often considered the benchmark of the existence

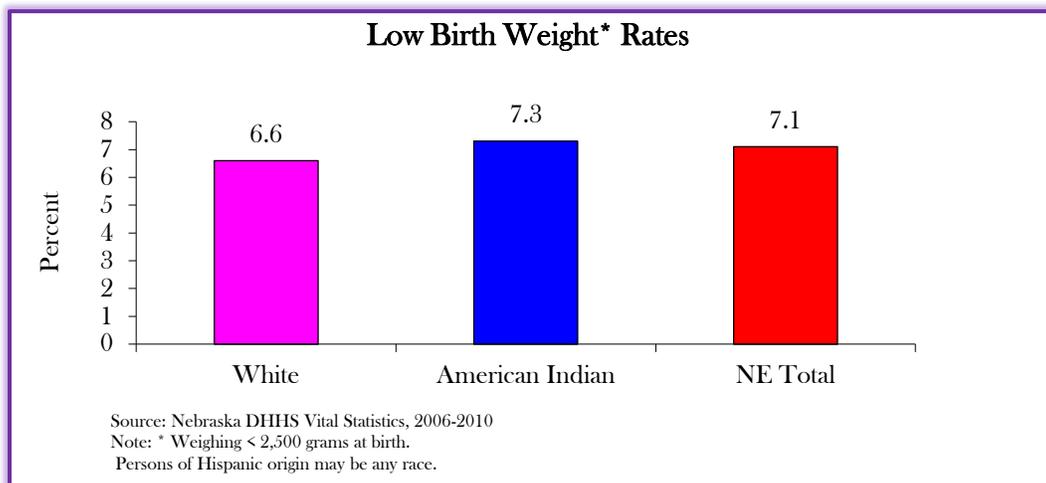
of unmet health needs, maternal and child health in Nebraska is first assessed by infant mortality rates. The figure below shows the infant death rate for American Indians and Whites. In the five-year period of 2006-2010, the infant mortality rate was 1.4 times higher for American Indians than for Whites.



### Low Birth Weight

A newborn is considered to be of low weight if he/she weighs less than 2,500 grams at birth. These babies experience higher rates of illness and death than other

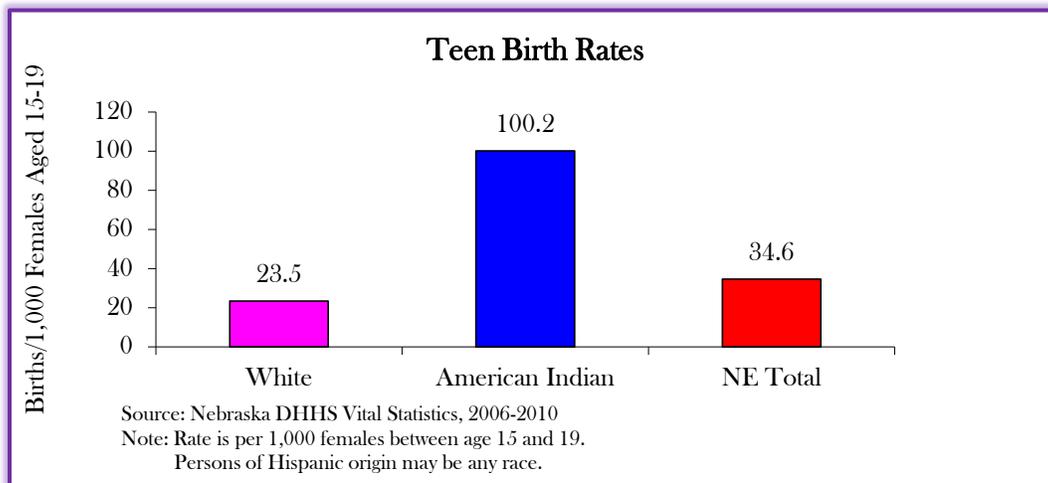
infants. During 2006-2010, the low birth rate American Indians was 7.3 %, compared to 6.6 % for Whites.



### Teen Births

In Nebraska, the teen birth rate for American Indians was higher than the rate for Whites. During 2006-2010, the teen

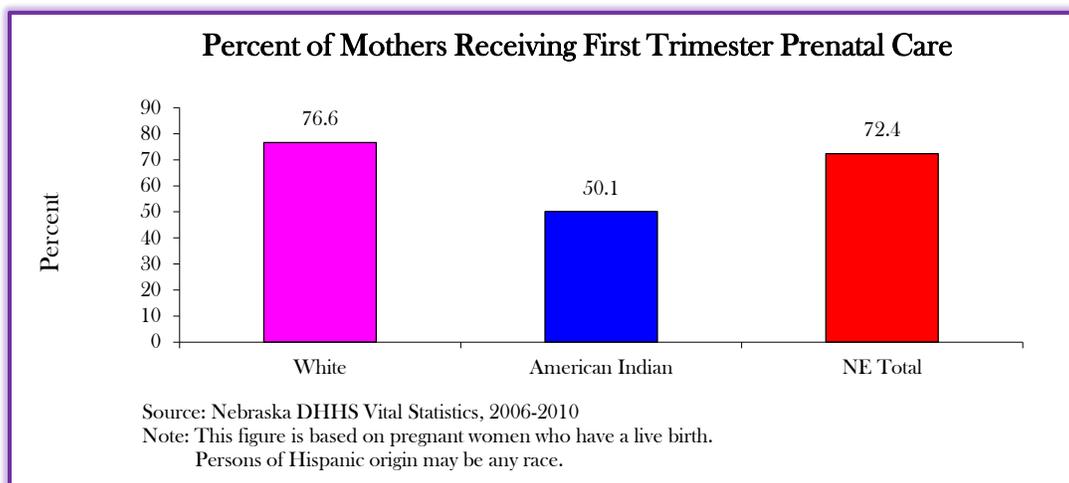
birth rate for American Indian female teens was 4.4 times the rate for White female teens.



### Mothers Receiving First Trimester Prenatal Care

Mothers who initiated prenatal care after the first trimester of pregnancy and those who received no prenatal care at all are considered at risk. In 2006-2010, the

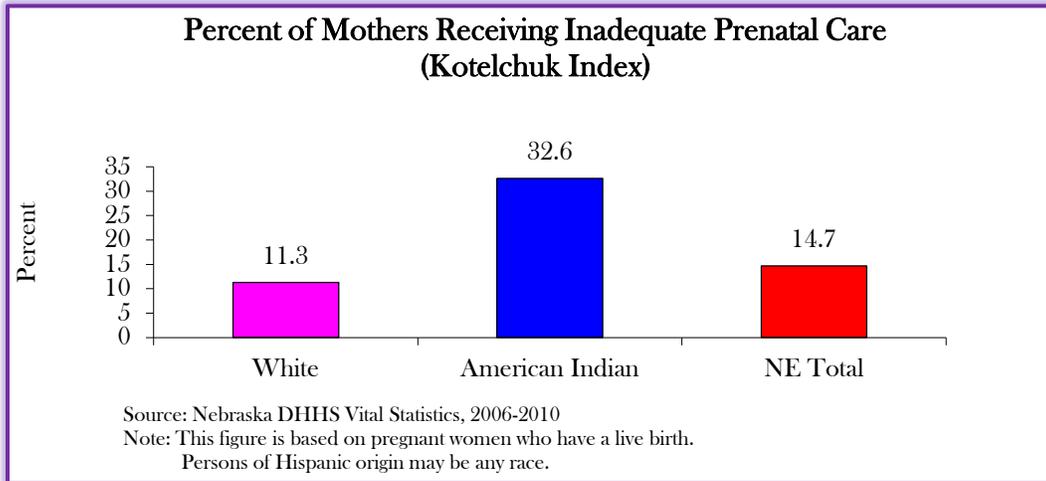
percentage beginning prenatal care in the first trimester for American Indian mothers was 50.1%, compared to 76.6% for White mothers.



### Kotelchuk Index

The Kotelchuk Index is a measure of adequacy or inadequacy of prenatal care by using a combination of number of prenatal visits, gestation, and in what trimester prenatal care was started. Based on the

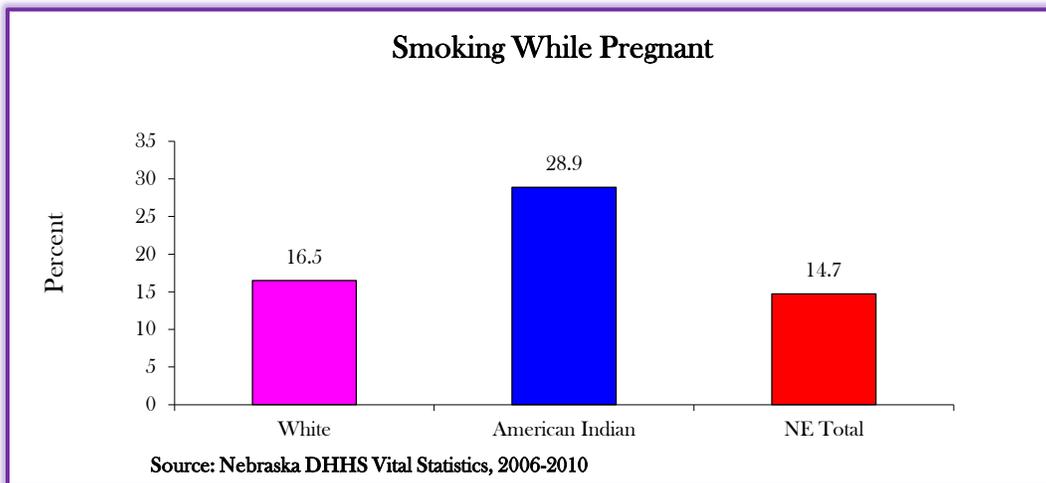
Kotelchuk Index, in 2006-2010, among American Indians mothers, around one third (32.6%) received inadequate prenatal care, as did 11.3% of White mothers.



### Smoking during Pregnancy

During 2006-2010, American Indian women were 1.8 times more likely to smoke while

pregnant than White women.



## PRAMS and Breastfeeding

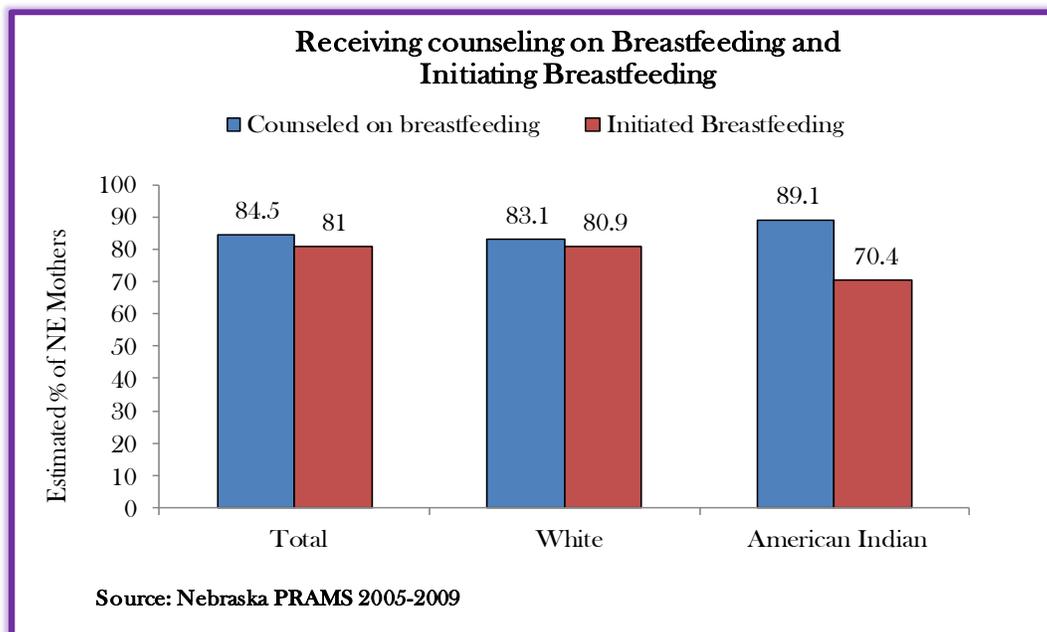
The Nebraska Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing population-based surveillance system of maternal behaviors and experiences before, during, and after pregnancy. It is an initiative to reduce infant mortality and low birth weight infants, and was developed to supplement vital records data by providing State-specific data to be used for planning and evaluating prenatal health programs.<sup>7</sup> Breastfeeding is associated with numerous health benefits for both infants and

mothers. Breastfeeding has also been associated with a decreased risk of premenopausal breast cancer in women. However, breastfeeding rates remain low among some groups of women, such as women who are young, Black, below the federal poverty threshold, unmarried, or not college-educated. Many women also stop breastfeeding soon after initiation for various reasons such as smoking, medication use, physical and mental health issues, or the need to return to work.<sup>8</sup>

### Receiving Counseling on Breastfeeding & Initiating Breastfeeding

The question asked on the PRAMS survey for breastfeeding initiation was “Did you ever breastfeed or pump breast milk to feed your newborn after delivery?” The prevalence of breastfeeding initiation among White mothers during this period

was 80.9%, while American Indian mothers’ breastfeeding initiation was 70.4%. When asked about receiving counseling on breastfeeding, 89.1% of American Indians mothers received counseling while 83.1% of White mothers received counseling.



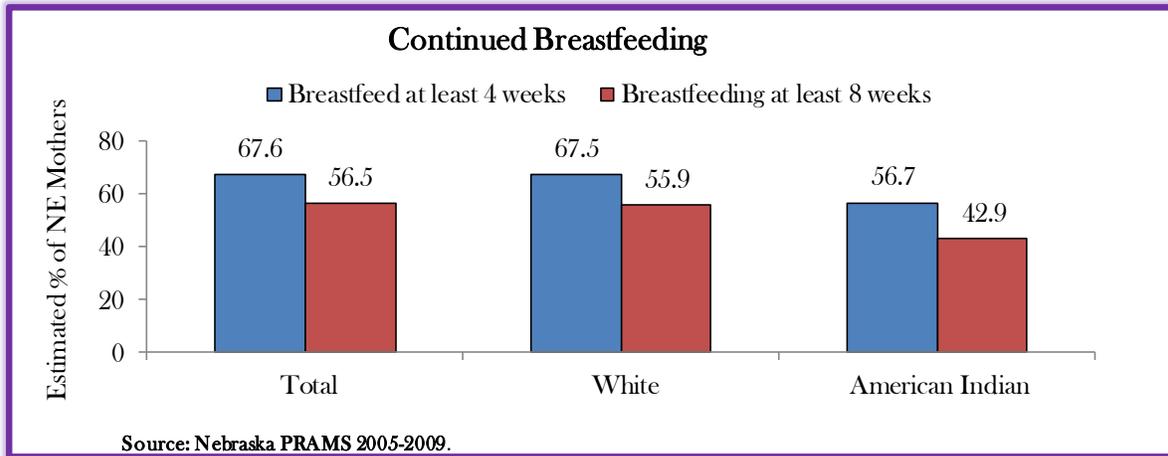
Source : <sup>7</sup> <sup>8</sup> Nebraska PRAM breastfeeding fact sheet, Lifespan Health Services ,Public Health Division, Nebraska Department of Health and Human Services

### Continued Breastfeeding

Continued breastfeeding is estimated among those who initiated it after giving birth. Exclusive breastfeeding at four weeks is based on the age when an infant received anything other than breast milk. Based on Nebraska PRAMS 2005-2009 data, a total of 56.7% of American Indian mothers

continued to breastfeed at least four weeks, compared to 67.5% of White mothers.

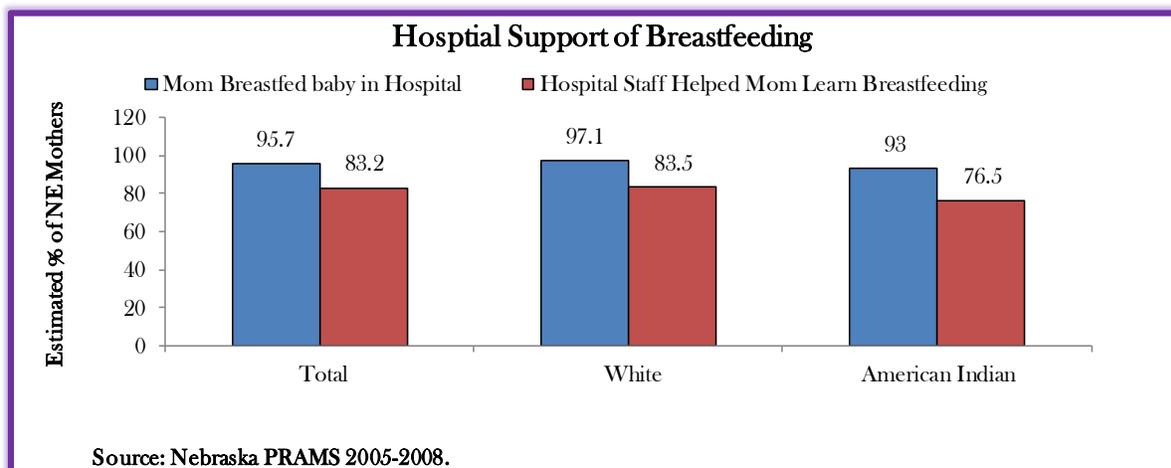
42.9% of American Indian mothers continued to breastfeed at least eight weeks, compared to 55.9% of White mothers.



### Hospital Support of Breastfeeding

There was a 7% difference in hospital staff supporting breastfeeding in favor of White mothers as compared to American Indian

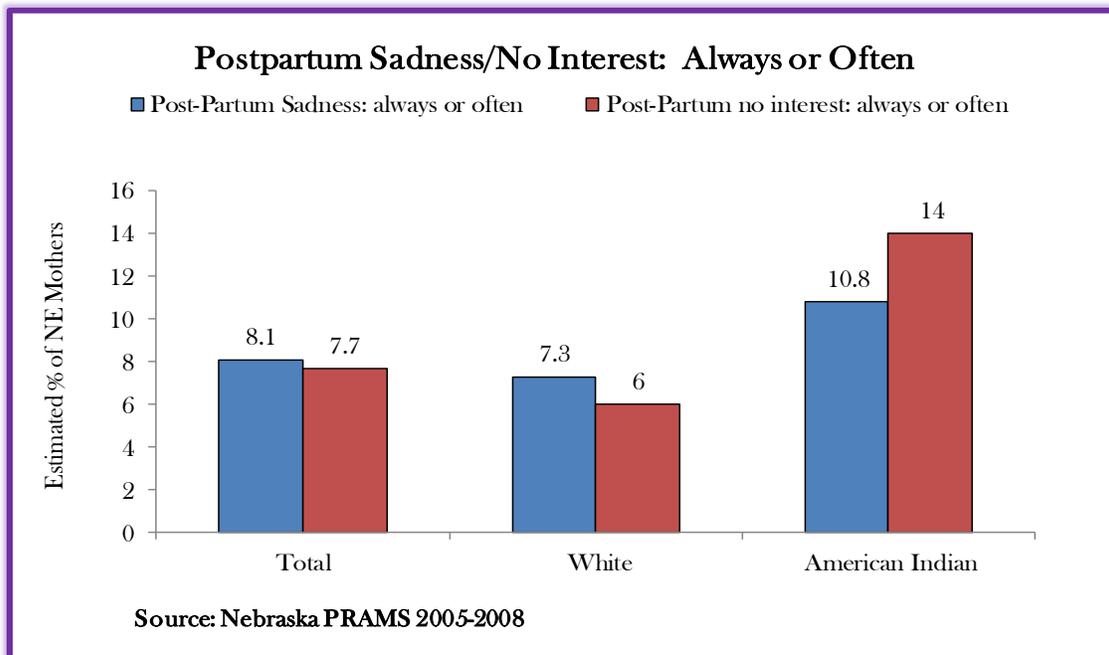
mothers. 93% of American Indian mothers breastfed their baby in the hospital, compared to 97.1% of White mothers.



### Postpartum Depression Risk

Postpartum depression is an affective mood disorder that usually starts within the first two to three months after a woman gives birth. Symptoms include persistent sadness, feelings of worthlessness, inadequacy or guilt, and somatic symptoms, such as headaches and chest pains.

The chart below shows that 10.8% of American Indian mothers always or often had post-partum sadness after the birth of their baby compared to 7.3% of White mothers. Fourteen percent of American Indian mothers always or often have postpartum no interest in doing things, compared to 6% of White mothers.



## American Indian Leading Causes of Hospital Discharge (Inpatient)

The following table summarizes the number and percent information for the leading causes of hospital inpatient discharges. During the period of 2007-2008 a total number of 1,938 records who were identified as American Indian. The first

three leading causes for the hospitalization were heart disease, puerperal state, and live born infants. Approximately one-third of the total number or 31.7% of the hospital inpatient discharges could be found in these three categories.

Causes	Number	Percent
Heart	320	16.5
Puerperal State	155	8
Live Born Infant	140	7.2
Musculoskeletal	100	5.2
Adverse Effects	96	5
Other Genito Urinary	82	4.2
Ill Defined	78	4
Cancer	70	3.6
Other Metabolic Disorders	58	3
Lower Limb Fracture	56	2.9
Other Intestinal Diseases	46	2.4
Stomach Diseases	41	2.1
Skull Fracture	41	2.1
Intracranial	39	2
Neck & Trunk Fracture	34	1.8
Infectious/Parasitic	33	1.7
Pneumonia	33	1.7
Chronic Bronchitis	31	1.6
Mental/Psychoses	28	1.4
Poisoning	27	1.4
Skin Infections	26	1.3
Stroke	24	1.2
Nephritis/Nephrosis	24	1.2
Diabetes	23	1.2
Open Wound	22	1.1
Other	311	16.8
Total	1,938	100

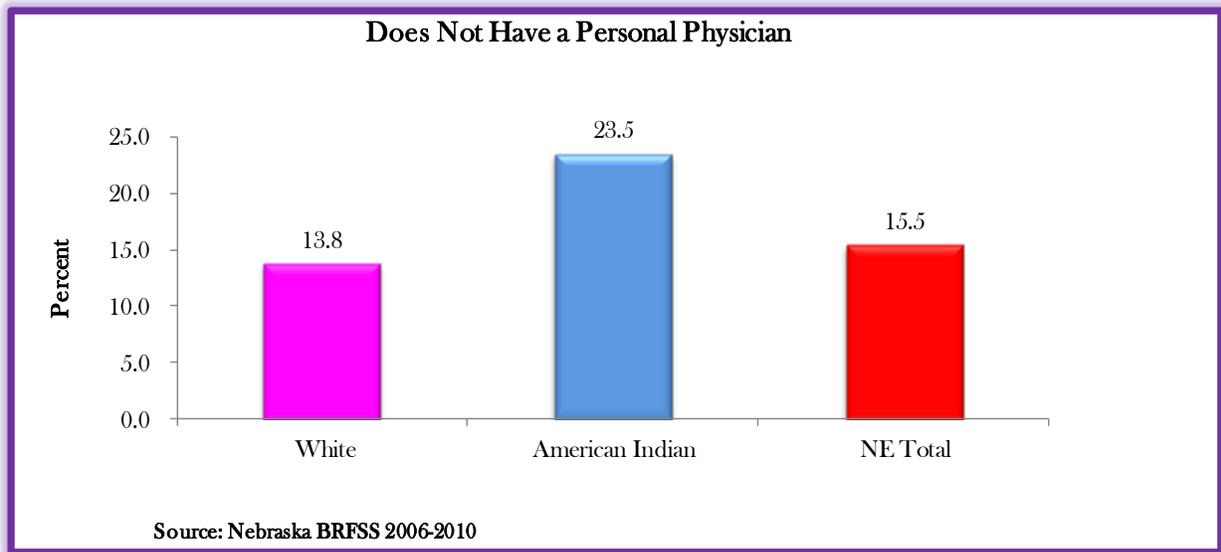
## Behavioral Risk Factors

### Access to Health Care

#### Does not have a Personal Physician

Altogether, 15.5% of adults in the 2006-2010 Nebraska BRFSS said they did not have a personal physician. American Indians (23.5%)

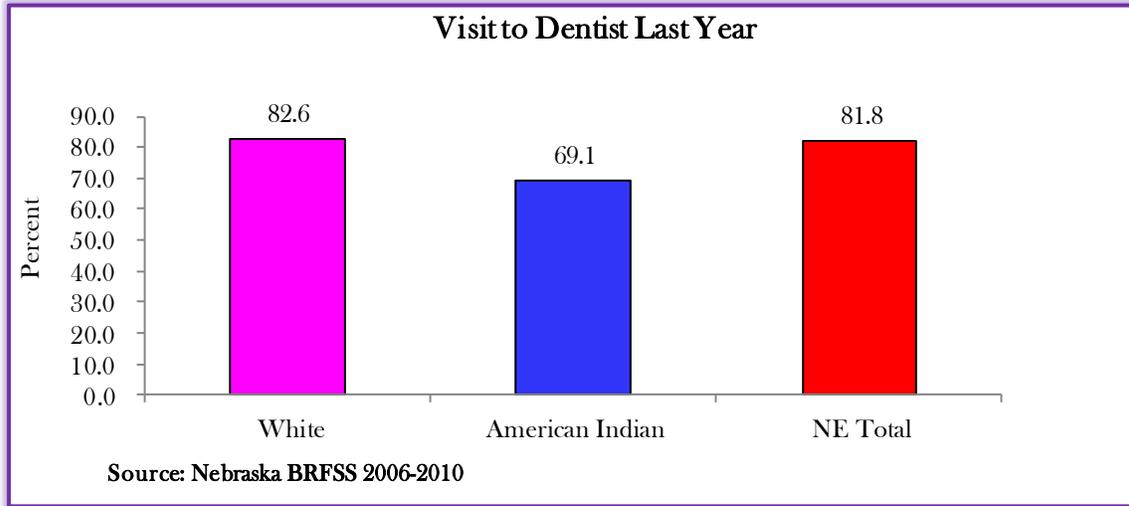
experienced significantly higher rates of not having a personal physician than Whites (13.8%).



### Visit to Dentist Last Year

Altogether, 81.8% of adults in the 2006-2010 Nebraska BRFSS said they visited a dentist last year. American Indians (69.1%)

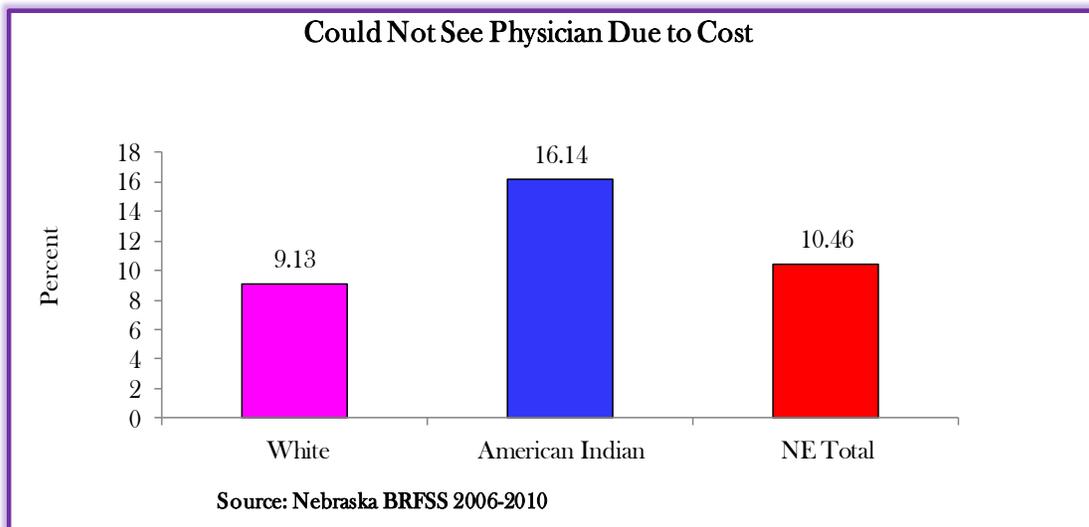
experienced lower rates of visits to the dentist within the last year than Whites (82.6%).



### Couldn't see Physician due to Cost

Altogether, 10.5% of adults in the 2006-2010 Nebraska BRFSS said they couldn't see a physician due to cost. American Indians (16.1%) experienced significantly higher

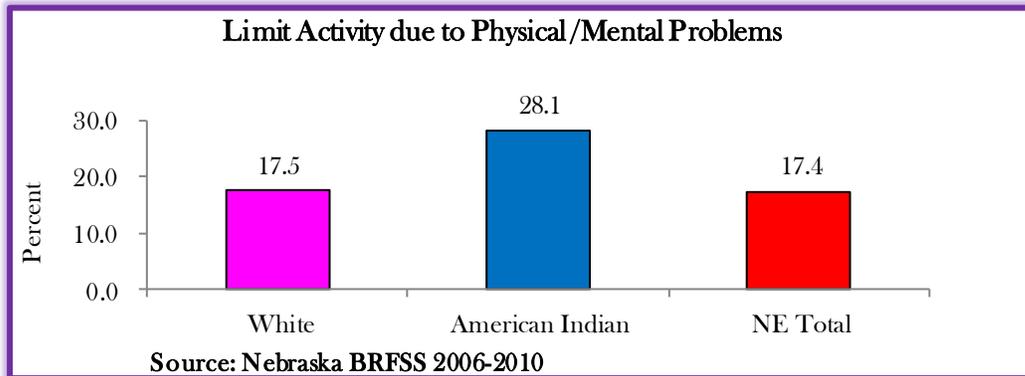
rates of inability to see a physician due to cost than Whites (9.1%).



### Activity Limitation

Adults in this survey were read the following description of activity limitation: “Are you limited in any way in any activities because of physical, mental, or emotional problems?” Altogether, 17.4% of adults in the 2006-2010 Nebraska BRFSS said they

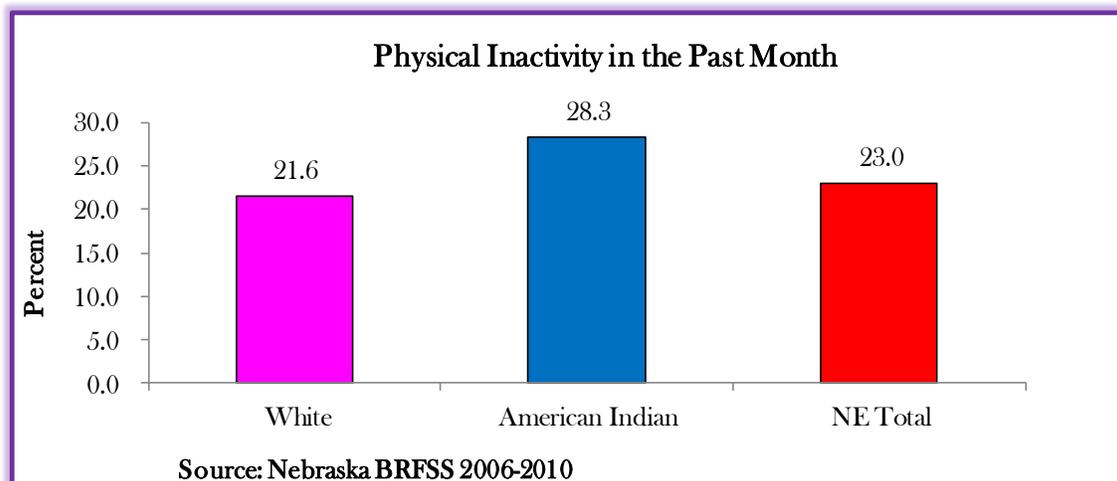
had limited activity due to physical and/or mental problems. American Indians adults (28.1%) experienced significantly higher rates of limited activities than White adults (17.5%).



### Physically Inactive

For good health it is recommended that people engage in at least 30 minutes of moderate-intensity physical activity, such as brisk walking, on five or more days per week or engage in vigorous physical activity for at least 20 minutes on three or more days per week. Respondents were counted as inactive if they “no” to the question, “During the past month, other than your

regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?” Altogether, 23% of adults in the 2006-2010 Nebraska BRFSS said they were physically inactive. American Indians at 28.3%, experienced higher rates of physical inactivity than Whites at 21.6%.

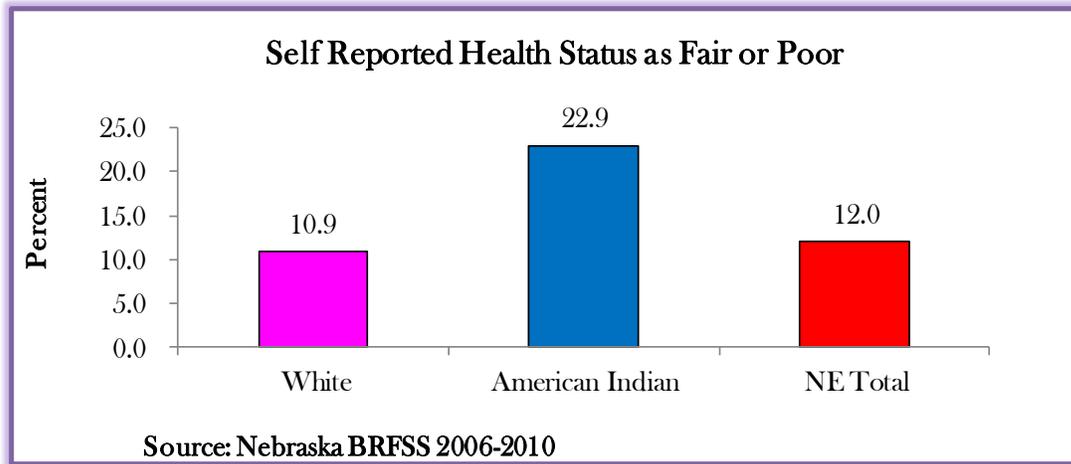


### Reported Health Status

Health-related quality of life measures seek to determine how adults perceive their own health, and how well they function physically, psychologically, and socially during their usual daily activities. Respondents were asked, “Would you say that in general your health is: Excellent?

Very Good? Good? Fair? or Poor?”

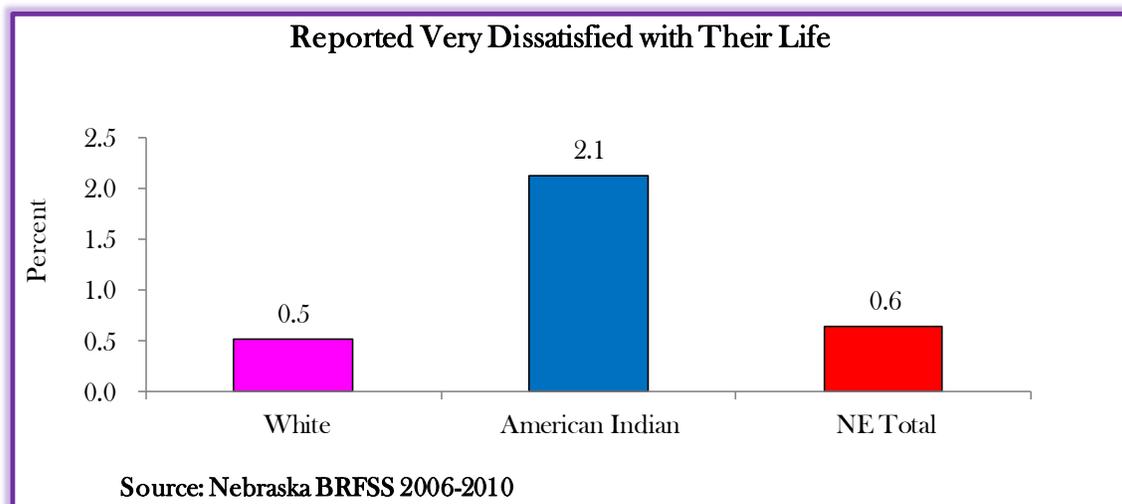
American Indian adults in Nebraska were significantly more likely (23%) than White adults (11%) to have fair or poor health. A total of 12% of Nebraska total adults had fair or poor health.



### Life Satisfaction

According to the responses to the question; “In general, how satisfied are you with your life: Very satisfied? Satisfied? Dissatisfied? Very Dissatisfied?” American Indian adults (2.1%) in Nebraska were significantly more

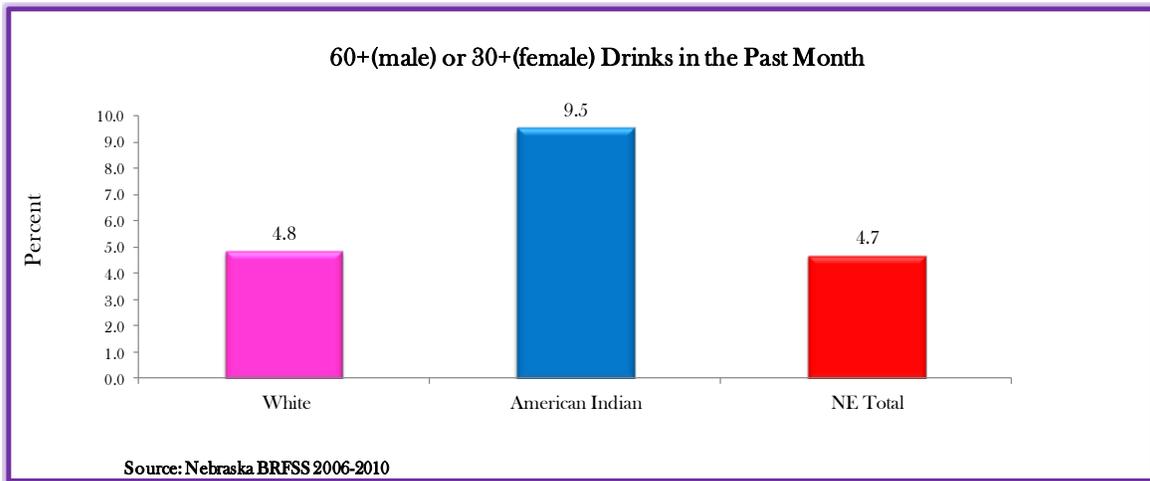
likely than White adults (0.5%) to be very dissatisfied with their life.



### Heavy Drinking

Heavy drinking refers to the self-reported consumption of more than 60 drinks for men (an average of more than two drinks per day) and 30 drinks for women (an average of more than one drink per day)

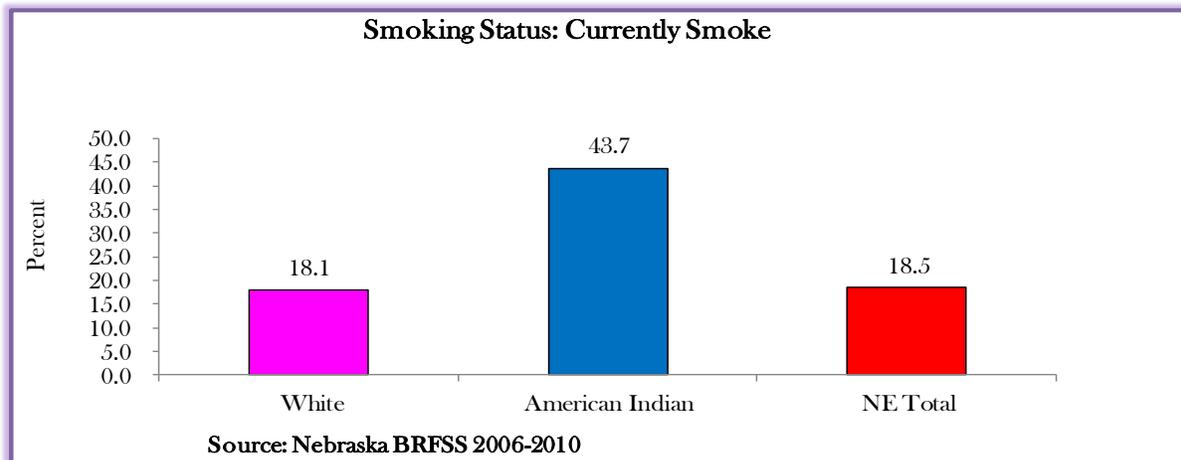
during the past month, or 30 days preceding the survey. American Indian (9.5%) adults 18 and older in Nebraska were more likely than White (4.8%) adults 18 and over to report heavy drinking.



### Tobacco Use

Cigarette smoking is a major risk factor for heart disease, stroke, lung cancer, and chronic lung disease. Smoking may also result in injuries, death, and environmental damage due to fire. Respondents were classified as current smokers if they reported smoking at least 100 cigarettes in

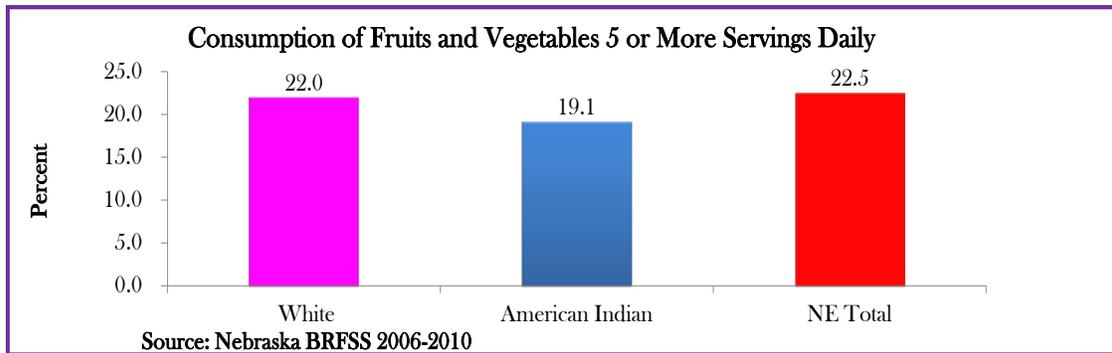
their lifetime, currently smoked, and smoked all of the past 30 days. American Indian (approximately 44%) adults in Nebraska were significantly more likely than White (approximately 18%) adults to be current smokers. A total of 18.5% of all Nebraska adults were current smokers.



### Consumption of Fruits and Vegetables

The 2000 Dietary Guidelines for Americans recommended five or more servings of fruits and vegetables per day for good nutrition. These guidelines serve as the basis for BRFSS questions on fruits and vegetables. BRFSS respondents were asked a series of questions about the foods and

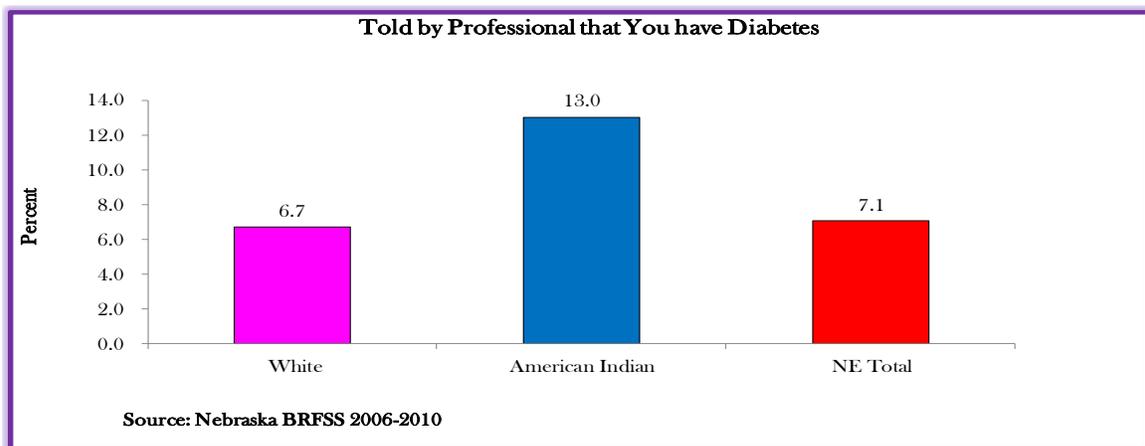
drinks they usually consumed. American Indian adults (19.1%) in Nebraska were slightly less likely than White adults (22%) to have five or more servings of fruits and vegetables per day, which is slightly less than 22.5% of all Nebraska adults.



### Prevalence of Diabetes

Respondents were asked whether they had ever been told by a doctor that they had diabetes. These numbers do not include women who were told by a doctor of the presence of gestational diabetes during their pregnancy. Altogether, 7.1% of adults

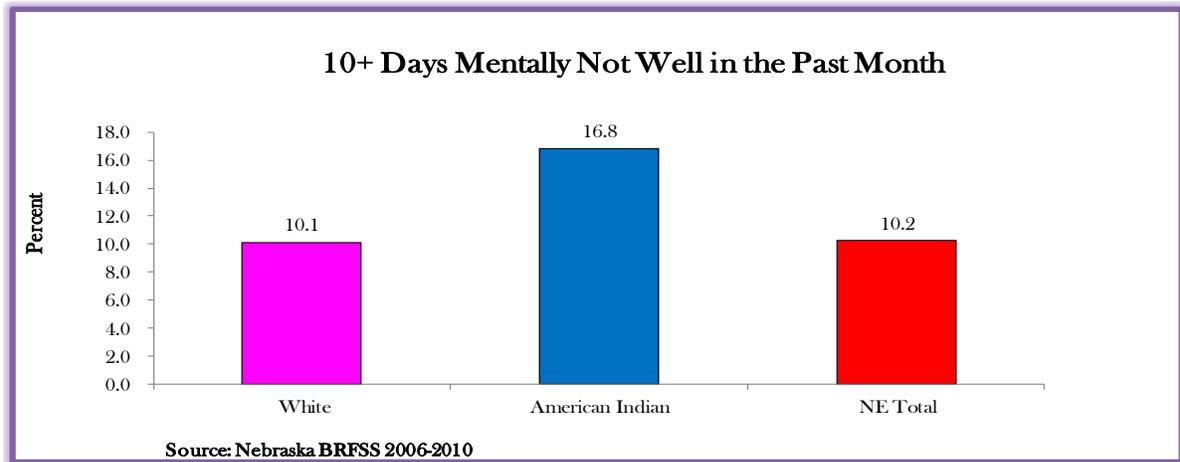
in the 2006-2010 BRFSS reported a doctor had told them they have diabetes. American Indians (13%) experienced significantly higher rates of diagnosed diabetes than Whites (6.7%).



## Mental Health

Respondents were asked about the average (mean) number of days that one's mental health was not good. In 2006-2010, 10.2% of Nebraska adults reported not being mentally well at least 10 days in the past

months. The rate was significantly higher for American Indians (16.8%), than for Whites (10.1%).



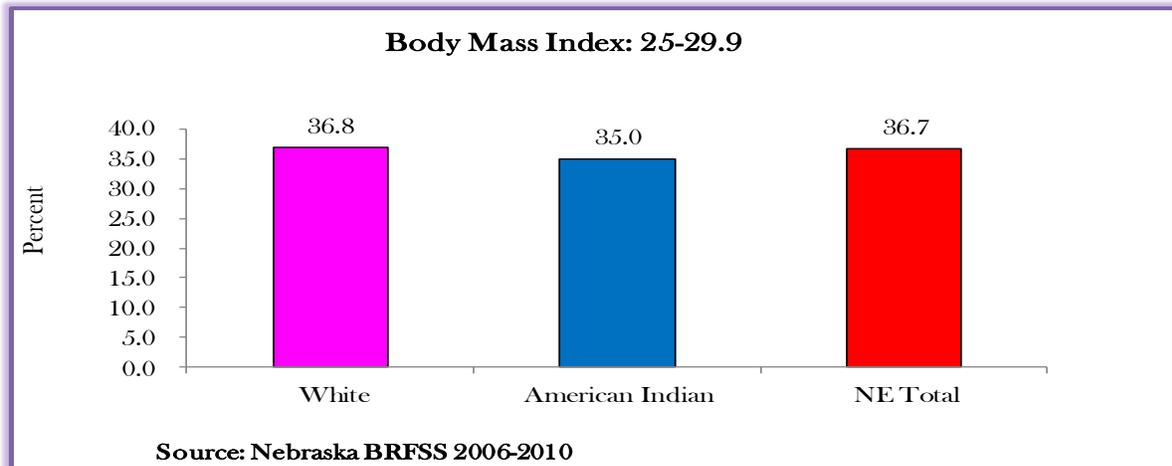
## Overweight and Obesity

Being overweight or obese has been linked to increased risk of death. In addition, being overweight or obese substantially raises the risk of illness from heart disease and stroke, high blood pressure, elevated blood cholesterol levels, type 2 diabetes; endometrial, breast, and colon cancers; liver and gallbladder disease, arthritis, sleep disturbances, and breathing problems. Obese persons, both children and adults, may also suffer from social stigmatization, discrimination, and low self-esteem. The Body Mass Index (BMI) is used as a proxy measure for overweight and obesity in adults, until a better method of

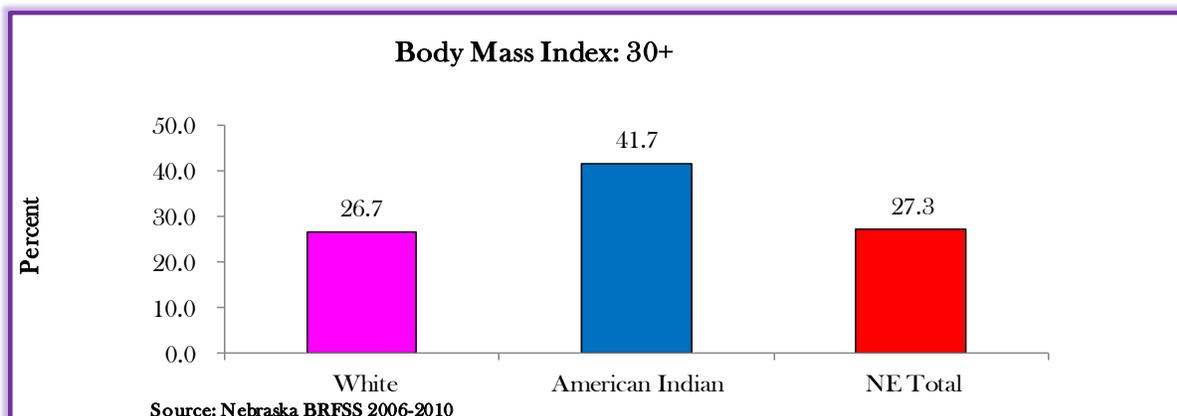
determining actual body fat is developed. BMI is calculated by dividing a person's weight in kilograms by the square of the person's height in meters.

- Overweight or obese: A BMI reading of 25.0 or greater
- Obese: A BMI reading of 30.0 or greater
- Overweight but not obese: A BMI reading of 25.0 to 29.9

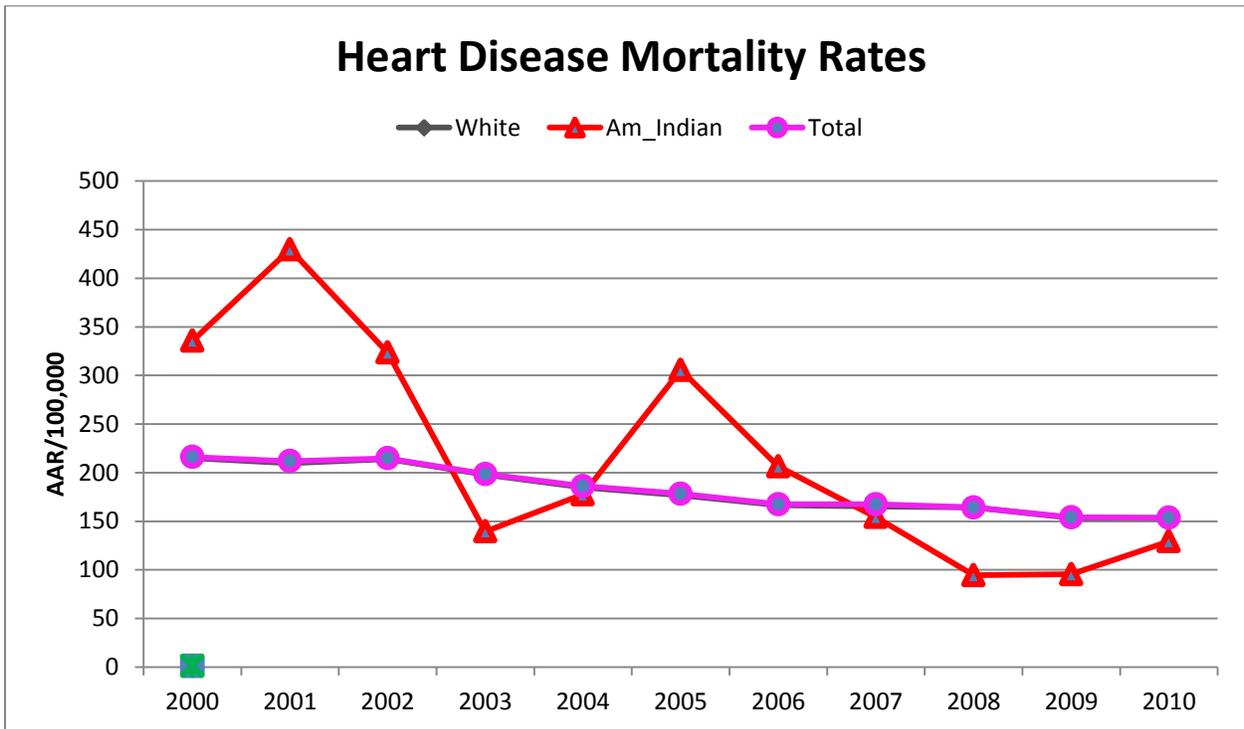
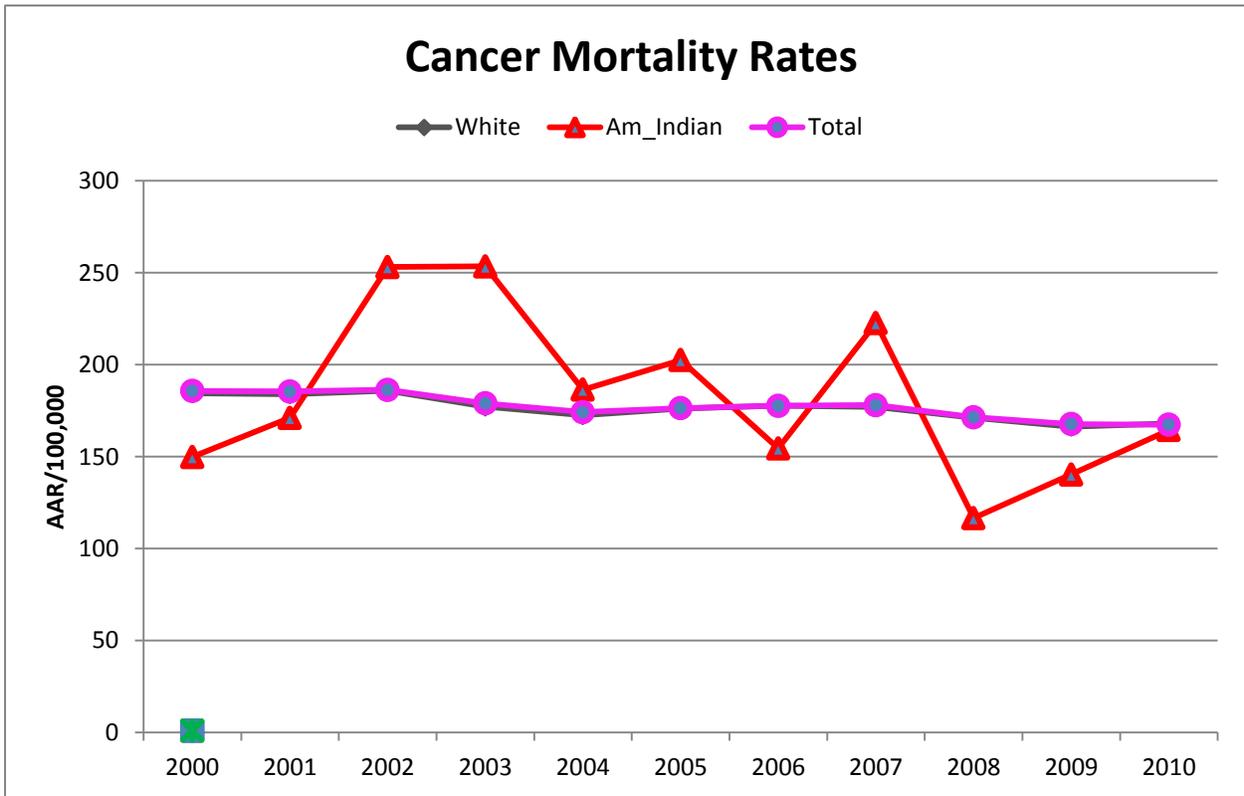
In the 2006-2010 BRFSS, 36.7% of Nebraska adults reported their BMI from 25-29. The rate of reported BMI from 25 to 29 was lower for American Indians (35%) than for Whites (36.8%).

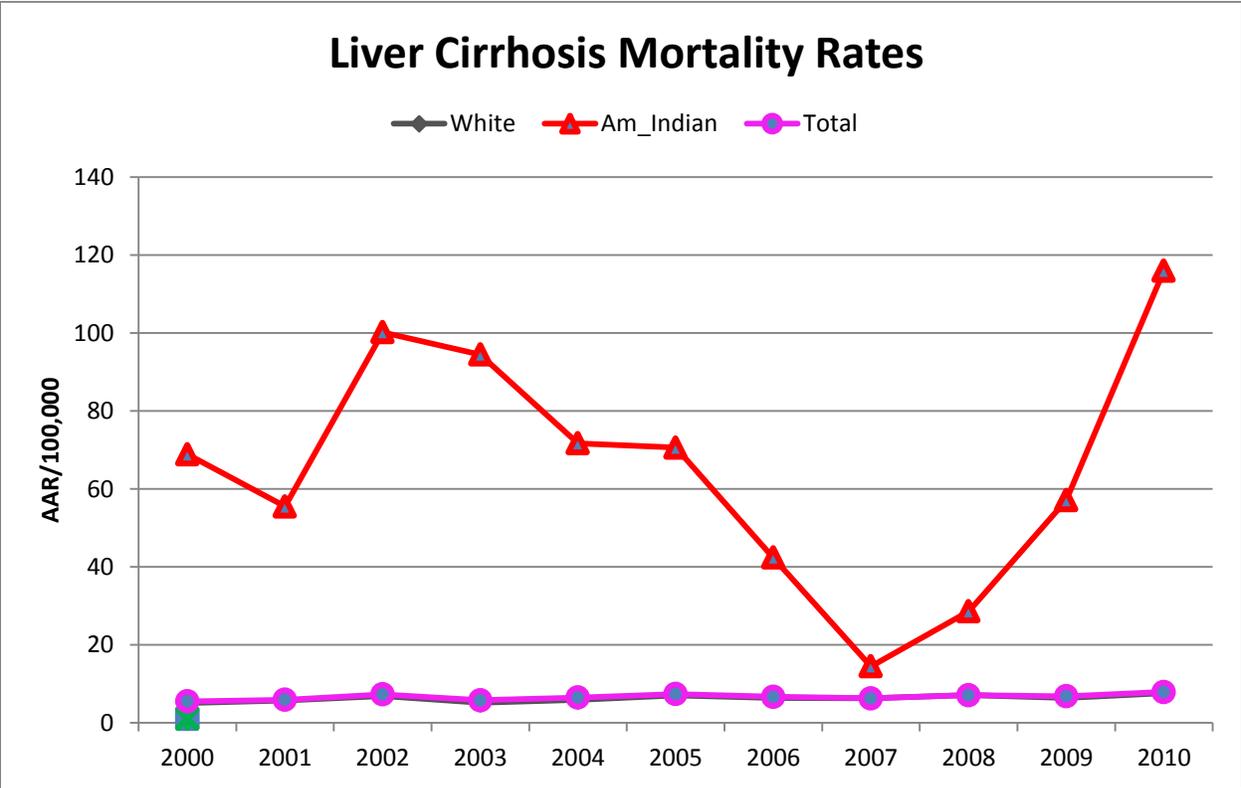
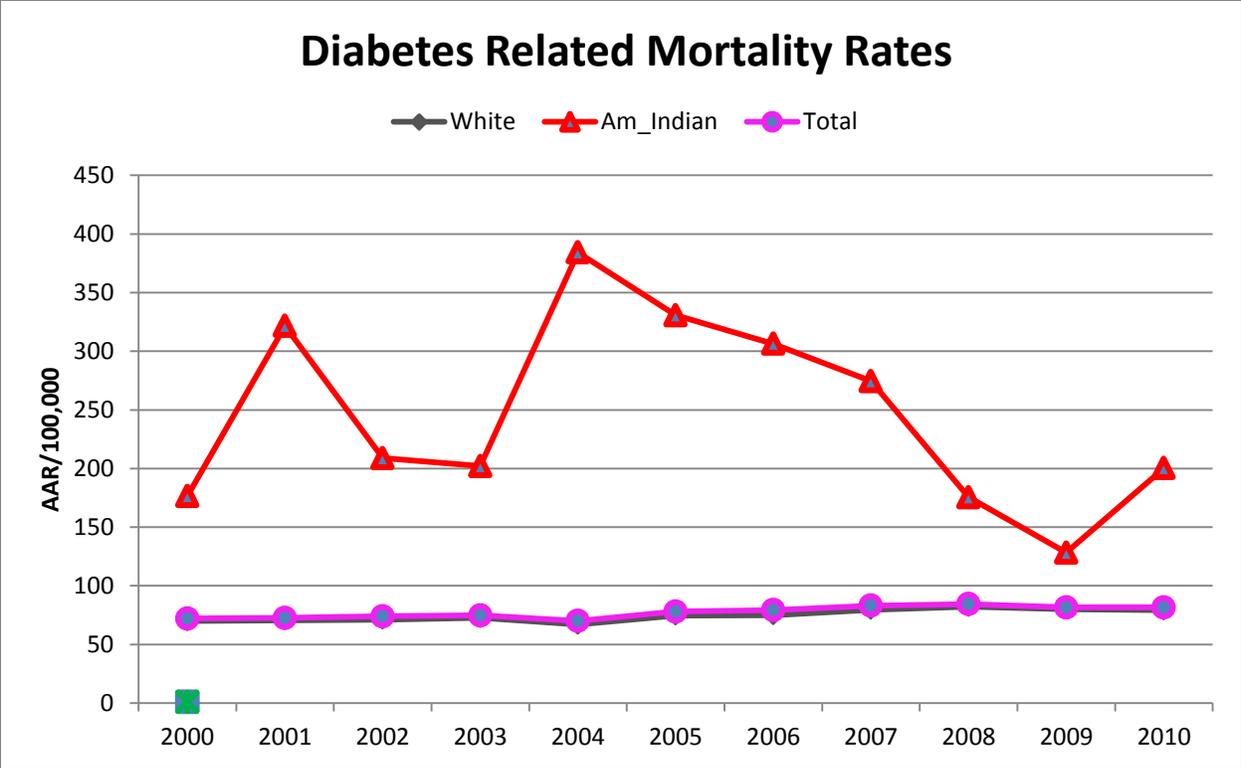


In the 2006-2010 BRFSS, 27.3% of Nebraska adults reported their BMI of 30 and above. The rate of reported BMI 30 and above was higher for American Indians (41.7%) than for White (26.7%).

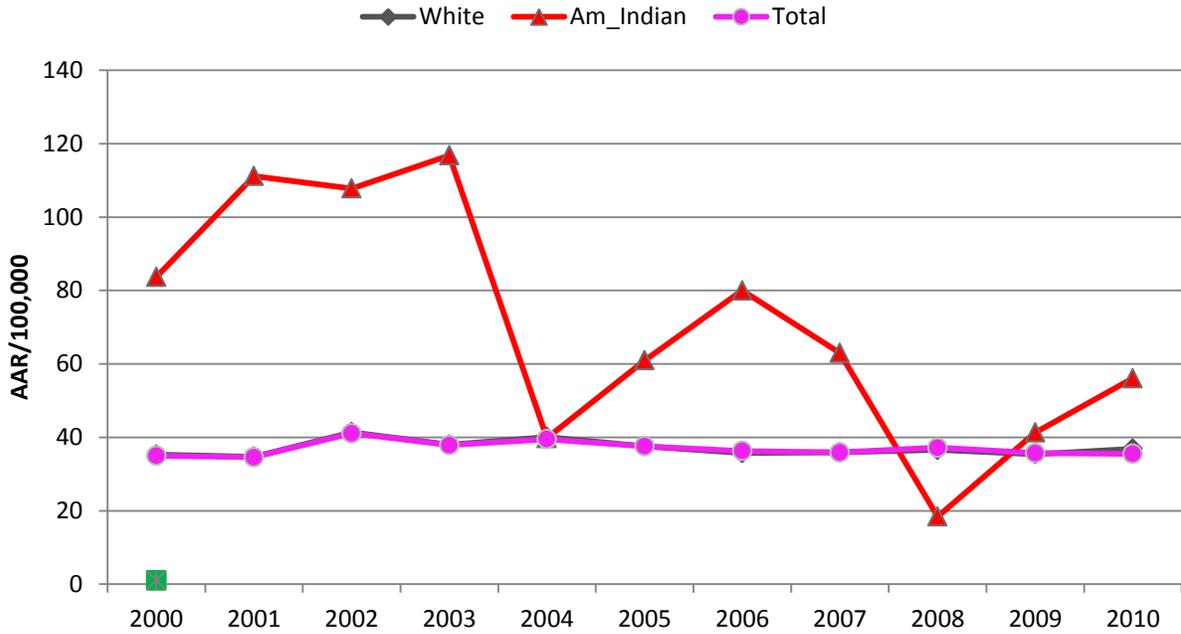


## Appendix Trends in Nebraska 2000-2010

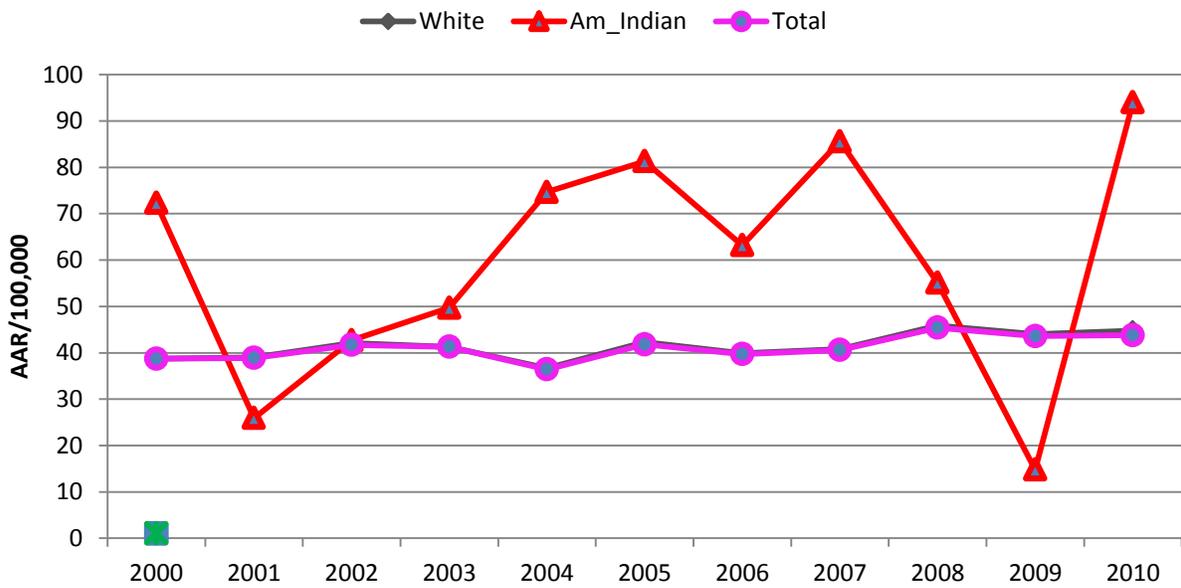


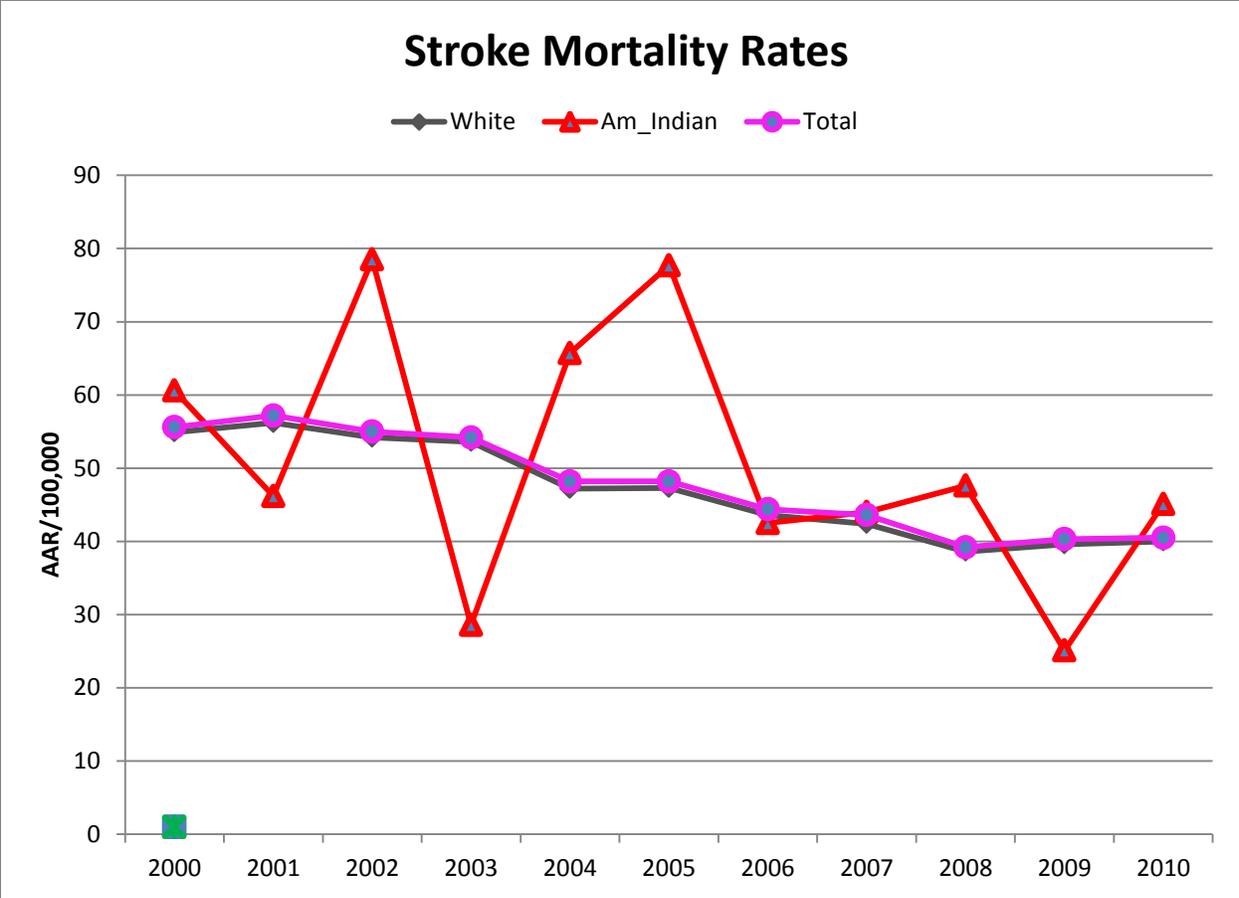


## Unintentional Injury Mortality Rates



## Chronic Lung Disease Mortality Rates





**Average annual age-specific mortality rates for the ten leading causes of American Indian (AI) death relative to mortality rates of whites in Nebraska, 2001-2011.**

	Race	Death Number	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80+	Crude Rates	Age-adjusted Rates
All Causes	AI	1135	133.3	74.6	154.9	277.2	557.3	1313.7	2709.8	4956.5	7752.4	557.9	1080.1
	White	159247	76.3	38.7	66.4	106.8	221.6	479.4	1281.6	3166.2	10478	897.5	749.1
	Rate Ratio		1.7	1.9	2.3	2.6	2.5	2.7	2.1	1.6	0.7	0.6	1.4
1. Heart Disease I00-I09, I11, I13, I20-I51	AI	178					95.8	181.0	599.4	725.3	1896.3	87.5	192.2
	White	38621	1.3	1.0	3.1	12.1	39.8	92.5	250.1	658.5	3062.1	217.7	175.2
	Rate Ratio						2.4	2.0	2.4	1.1	0.6	0.4	1.1
2. Cancer C00-C97	AI	165					52.2	221.9	574.4	1015.5	1227.0	81.1	178.6
	White	35603	4.8	15.0	55.3	172.1	492.0	987.7	1518.8	200.6	1518.8	200.6	175.1
	Rate Ratio						0.1	0.2	0.4	5.1	0.8	0.4	1.0
3. Unintentional Injury V01-X59, Y85-Y86	AI	104		41.1	71.5	80.9	56.6	87.6				51.1	66.2
	White	7180	8.9	21.7	30.4	26.7	31.2	30.7	38.0	73.8	279.1	40.5	36.8
	Rate Ratio			1.9	2.4	3.0	1.8	2.8				1.3	1.8
4. Diabetes E10-E14	AI	90						140.1	249.8	531.9	669.3	44.2	93.1
	White	4353			0.6	2.0	5.7	15.5	44.8	101.2	259.8	24.5	20.8
	Rate Ratio							9.1	5.6	5.3	2.6	1.8	4.5
5. Liver Disease K70, K73-K74	AI	88				38.5	104.5	192.7	187.3			43.3	65.4
	White	1236				2.1	8.9	13.6	20.1	20.3	16.7	7.0	6.4
	Rate Ratio					18.1	11.8	14.2	9.3			6.2	10.2
6. Respiratory Disease, J40-J47	AI	48						58.4		314.3	948.1	23.6	64.6
	White	10075				0.8	3.5	17.6	95.6	305.6	619.1	56.8	48.1
	Rate Ratio							3.3		1.0	1.5	0.4	1.3
7. Stroke I60-I69	AI	43								314.3		21.1	49.4
	White	10028				2.3	6.8	14.2	46.9	182.9	855.5	56.5	45.2
	Rate Ratio									1.7		0.4	1.1
8. Suicide U03, X60-X84, Y87.0	AI	28			327.8							151.4	14.1
	White	1933		6.6	10.4	16.1	15.9	14.2	12.5	13.7	11.6	10.9	10.8
	Rate Ratio				31.5							13.9	1.3
9. Homicide U01-U02, X85-Y09, Y87.1	AI	24										11.8	9.7
	White	341	1.8	0.8	3.0	3.1	2.7	1.5	1.1			1.9	2.0
	Rate Ratio											6.1	4.9
10. Influenza/ Pneumonia J09-J18	AI	21										10.3	25.4
	White	3630	0.8		0.6	1.2	2.3	4.6	13.3	52.3	331.6	20.5	15.9
	Rate Ratio											0.5	1.6

Note 1: Empty cells indicate age-specific rates suppressed when the number of deaths is below 10 in any age group.

Note 2: Rates are per 100,000 population; age-adjusted rates use the 2000 US standard population. Note 3: Some rate ratios may not appear to equal the age-specific rates because of rounding error in the age-specific rates.

## Glossary of Terms

**Age-Adjusted Death Rate:** A weighted average of a crude death rate according to a standard distribution. Age adjusting is a process by which the age composition of a population is held constant so that changes or differences in age composition can be eliminated from the analysis. This is necessary because older populations have higher death rates merely because death rates increase with age. Age adjusting allows the researcher to make meaningful comparisons over time and among groups in the risk of mortality. The death rates in this report have been adjusted according to the age distribution of the United States population in 2000 so that these rates are stabilized from fluctuation due to changes and difference in age composition of the population under study. This is calculated by the sum of age-specific death rates for each age group, multiplied by standard population in each age group, and divided by the total standard population.

**Death Rate:** A death rate is a ratio between mortality and population; the number of deaths per specific number of people. This is the most widely used measure to determine the overall health of a community. Death rates are usually computed per 100,000 population. Rates allow meaningful comparisons between groups of unequal size.

**Body Mass Index (BMI):** A measure of weight relative to height. A BMI of less than 25 is considered ideal or healthy; a BMI of 25-29 is considered overweight; and a BMI greater than 30 is considered to be indicative of obesity. BMI is calculated by dividing an individual's weight in kilograms by the individual's height in meters squared.

**Diabetes:** Often times called diabetes mellitus, is a disease of the pancreas in which the body does not produce or properly use insulin, a hormone that is needed to convert glucose into energy. According to the Centers for Disease Prevention and Control and Prevention(CDC), "Diabetes mellitus is a group of diseases characterized by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can be associated with serious complications and premature death, but people with diabetes can take steps to control the disease and lower the risk of complications."

**Incidence:** Incidence is an estimate of the number of new cases of disease that develop in a population in a specified time period, usually one year. Incidence is often used as an indicator of the need for preventive measures, or to evaluate the effectiveness of existing programs.

**Infant Death:** Death of a person under one year of age.

**Infant Death Rate:** The number of infant deaths per 1,000 live births, calculated as number of infant deaths divided by number of live births, multiplied by 1,000.

**Kotelchuk Index:** It is a prenatal care index. “Special natality data summaries are prepared by the Office of Health Care Information. The office uses special programs to create an adequacy of prenatal care index, as formulated by Dr. Milton Kotelchuk. The index characterizes births as inadequate, intermediate, adequate and adequate plus as evaluated for when prenatal care began, weeks’ gestation, and number of recommended physician's visits. The Adequacy of Prenatal Care Utilization Index (APNCU), also known as the Kotelchuck Index, is one of the methods used to assess adequacy of prenatal care. Data for assessing prenatal care is taken from information collected on birth certificates. This index combines the month of pregnancy when prenatal care began with the number of prenatal visits to their health care provider during pregnancy. It also takes into account the length of gestation. Using these criteria, prenatal care is rated inadequate, intermediate, adequate, or intensive use.’

**Morbidity:** A term used to describe disease, sickness or illness, as a departure from normal physiological and psychological conditions. It is normally expressed as a morbidity rate. Morbidity rates give the closest frame of the quality of life and health status in a given population.

**Mortality:** A term used to describe death. It is normally expressed as a rate, expressing the proportion of a particular population who die of one or more diseases or of all causes during a specified unit of time, usually a year. It is also the probability of dying within a specified time period. This rate is also called the “crude death rate.”

**Ill-defined causes of death:** The block R95-R99 of ICD-10 is titled ‘Ill-defined and unknown causes of mortality’. This block contains Sudden Infant Death Syndrome (R95) which is often presented separately in COD statistics.

**Injury deaths:** Include deaths that are caused by forces external to the body. Examples of causes of injury death include drowning, fall, firearm, fire or burn, motor vehicle traffic, poisoning, and suffocation.

**Labor Force:** All people classified in the civilian labor force plus members of the U.S. Armed Forces (people on active duty with the United States Army, Air Force, Navy, Marine Corps, or Coast Guard).

**Not in Labor Force:** All people 16 years old and older who are not classified as members of the labor force. This category consists mainly of students, housewives, retired workers, seasonal workers interviewed in an off season who were not looking for work, institutionalized people, and people doing only incidental unpaid family work (less than 15 hours during the reference week).

**Employed:** Employed includes all civilians 16 years old and over who were either (1) "at work" -- those who did any work at all during the reference week as paid employees, worked in their own business or profession, worked on their own farm, or worked 15 hours or more as unpaid workers on a family farm or in a family business; or (2) were "with a job but not at work" -- those who did not work during the reference week but had jobs or businesses from which they were temporarily absent due to illness, bad weather, industrial dispute, vacation, or other personal reasons. Excluded from the employed are people whose only activity consisted of work around the house or unpaid volunteer work for religious, charitable, and similar organizations; also excluded are people on active duty in the United States Armed Forces. The reference week is the calendar week preceding the date on which the respondents completed their questionnaires or were interviewed. This week may not be the same for all respondents.

**Unemployed:** All civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness.

**Unemployment Rate:** The unemployment rate represents the number of unemployed people as a percentage of the civilian labor force. For example: if the civilian labor force equals 100 people and 7 people are unemployed, then the unemployment rate would be 7%.

**Household:** A household includes all the people who occupy a housing unit. (People not living in households are classified as living in group quarters.) A family household consists of a householder and one or more people living together in the same household who are related to the householder by birth, marriage, or adoption. It may also include people unrelated to the householder. The occupants may be a single family, one person living alone, two or more families living together, or any other group of related or unrelated people who share living arrangements.

**Poverty:** Following the Office of Management and Budgets (OMBs) Directive 14, the U.S. Census Bureau uses a set of money income thresholds that vary by family size and composition to detect who is poor. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family or unrelated individual is classified as being "below the poverty level."